Selwyn Care Limited

Edward House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection was unannounced and took place on 4 and 5 April 2017. The last comprehensive inspection of the service was on 24 and 25 September 2015 and there were no breaches of regulations at that time. Edward House is a residential care home and provides accommodation and personal care for up to 12 people with learning and physical disabilities. At the time of our inspection there were 12 people living at the home.

There was no registered manager in post. The registered manager had not been working in the home since January 2017 when an internal quality audit by the provider had identified some concerns. The registered manager had de-registered with CQC on 11 March 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibilities for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The provider had employed an 'acting manager' from another service who had been working at Edward House for two months.

The service was the subject of on-going monitoring by the local authority. This was because when they visited in 2016, they found that the service required improvement. An action plan was put in place with specific actions required and a timeline for this. This was still in progress during our inspection.

We received information prior to this inspection from a health and social care professional telling us that people were at risk. This was because staff were not adequately trained and people were being placed at risk due to high numbers of agency staff being employed. The local authority had completed a visit to the service on 22 March 2017 and found concerns relating to people's safety. Our inspection highlighted shortfalls where some regulations were not met. We also identified further areas where improvement was required.

People did not receive a service that was safe. The provider did not have effective systems to assess, review and manage risks to ensure the safety of people.

Sufficient numbers of staff were available to keep people safe; however a high number of agency staff were being employed. This reduced staff consistency and this in turn negatively impacted on people's care. Some people were not being supported to reach their full potential.

The service did not provide effective care and support. Staff had not received suitable training enabling them to effectively support the people living at Edward House such as people living with autism or with behaviours that may challenge. Many of the staff team had not attended mandatory training courses such as adult safeguarding, face to face first aid, MCA and DoLS and infection control.

There were some positive comments from relatives and health professionals about the care provided and the staff members who cared for their loved one.

The service was not responsive to people's needs. Support plans and risk assessments were out of date and lacked detail required to provide consistent, high quality care and support. People did not always have sufficient activities to support them to socialise and lead a fulfilling life. Complaints were not documented or dealt with appropriately.

The provider had governance systems in place to monitor the quality of the service provided. However, these systems had not identified the concerns we found around recording of information and assessing risks.

Staff we spoke with said they felt anxious about the service provided and that the morale was low. We observed staff trying to support people in a caring and patient way during the inspection; however staff did not appear to know the people they were caring for well. Staff were not respecting people's choices on two occasions.

The service was not well led. The registered manager had left the service along with many staff members. The registered manager and provider had governance systems in place to monitor the quality of the service provided. However, these systems had not identified the concerns we found around recording of information, identifying staff training needs, ensuring staff were treating people with dignity and respect and assessing risks.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Staff were not familiar with safeguarding procedures and had not received adequate training on keeping people safe.

People were at risk of inappropriate care as their risk assessments were not always accurate or reviewed. Some systems, such as recording incidents were not always followed.

Recruitment procedures were safe. There were enough staff to meet people's needs however a high number of agency staff were being employed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not supported and did not receive regular supervision to develop their day to day practice. No appraisals had been completed for staff members in the previous 12 months.

Staff did not receive adequate training to deliver effective care.

It was unclear from the records if people were supported to access health and social care professionals.

The premises were in need of decoration and were not always clean.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were clearly trying to provide good care and support.

There were positive comments from relatives about the staff who were caring for their loved ones.

People were not always treated with dignity and respect. We saw staff members refusing to give people food on two separate occasions.

Is the service responsive?

Inadequate

The service was not responsive.

People were not always supported to take part in meaningful activities.

Daily notes were detailed and thorough. However, these notes were not monitored for patterns or trends.

Complaints were not recorded or dealt with appropriately.

Is the service well-led?

Inadequate

The service was not well led.

Systems for monitoring and improving the service had not always been effective.

There was a lack of clear, supportive leadership from the registered manager and provider. Staff morale was low and they told us they were concerned about the service.

Accurate records on the care and treatment people received were not maintained.

Edward House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Prior to the inspection, we looked at information about the service including notifications and any other information received from other agencies. Notifications are information about specific important events the service is legally required to report to us. We reviewed the Provider Information Record (PIR). This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make.

The inspection took place on 4 and 5 April 2017. This was an unannounced inspection, and was carried out by one adult social care inspector. The last comprehensive inspection of the service was on 24 and 25 September 2015 and there were no breaches of regulation at that time.

As part of our inspection we spoke with ten members of staff, four relatives and we spoke with, or had feedback via email from three health and social care professionals. This included the Local Authority who had carried out a quality review before our inspection. There was no registered manager on the day of our inspection. An 'acting manager' who had commenced employment in January 2017 was available on the day.

During our visit, we briefly spoke to four people using the service. Because we were unable to speak to everyone because of their communication or learning disabilities we spent time observing what was happening at the home.

We looked at the care records for three people living at the service, six personnel files, organisational records, staff rotas and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Although people we spoke with said they felt safe and liked living at Edward House, we identified concerns where safety was compromised and people were at risk.

People were not kept safe by staff who knew about the different types of abuse. Some staff had not been provided with training on how to recognise abuse and how to report allegations and incidents of abuse. A large number of staff working at the home had not been trained in adult safeguarding. There were concerns about the recording and reporting of safeguarding concerns when the Local Authority visited in September 2016. One person had four body maps in their daily notes in March 2017 showing bruises. It was unclear whether this had or had not been reported to the adult safeguarding team or CQC as records had not been monitored appropriately. At this inspection we also found that it was unclear if any incidents or safeguarding concerns had been reported appropriately. We asked staff what their understanding of their responsibilities around safeguarding were but they were not able to adequately articulate what safeguarding meant and their responses did not reassure us that they knew how to keep people safe and how to report concerns.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding services users from abuse and improper treatment.

Risks to people's health and safety had not been assessed appropriately and the provider was not doing all that was reasonably practicable to mitigate any such risks. Support plans and risk assessments were not being reviewed regularly to assess changing needs. For example it had been identified that one person required a 2:1 staffing ratio and specific guidelines for travelling in the car due to risks associated with behaviours. There were conflicting information and guidance to support staff on how they managed these risks. Due to the amount of agency worker's being used at the service at the time who needed up to date guidance on managing people's risk, this meant people and staff were at risk.

There were no written accident and incident documentation. There were four body maps in one person's daily notes showing bruises and marks for March 2017 but these were unexplained. We saw no evidence that the registered manager had taken any action to address this, therefore it was unclear whether accidents were avoidable and whether there were any patterns or themes. There was no accident book available. The provider had identified in the audit completed in January 2017 that there was a lack of understanding regarding which events constituted an incident and how to record this. Additional training had been booked but had not yet been completed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Areas of the service were in need of decoration and were not always clean. One person's bedroom had stains on their floor and on their door from spilt hot drinks. Another person's living room floor was covered in pen marks and had old writing over a large area. One relative expressed concerns about their relative's

bedroom and told us, "It's not up to scratch. Around the window needs replacing and also the floor". We were told a recent meeting had identified these issues and that this had been rectified. The senior managers reassured us in our feedback that maintenance at the home was on the list of priorities and would be dealt with appropriately.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment.

Sufficient numbers of staff were available to keep people safe and meet their needs; however a high number of agency staff were being employed. This reduced staff consistency and this in turn negatively impacted on people's care. Staff did not know people well enough to ensure safe care and treatment. Many permanent members of staff had recently left the service; this included the registered manager and many of the team leaders. The rota showed us that approximately 50% of agency staff were being employed at the service. Three days before our inspection, the acting manager had identified that between the hours of 20.00pm and 22.00pm there were only two members of staff to support 12 people. The rota's had been changed and two extra staff had been employed during those hours. This ensured a sufficient number of staff were on shift.

The acting manager told us they used consistent agency staff where possible to ensure continuity for people living at Edward House. We were told agency workers were never working alone and that permanent staff members were available at all times. Relatives we spoke with expressed concerns over the lack of permanent staff and felt this was having a negative impact on people's care needs. One relative said, "[The person] has lived there for over eight years and it used to be great. In the last few months there seems to be different staff and managers and [The person] requires consistency. There are always different faces". We were told by staff that due to funding and staffing issues those people who were on a 2:1 staffing ratio when in the community were not always accessing social events and activities. A grab sheet which gave specific important information had been introduced for agency workers.

People received their medicines when they needed them. Staff had completed an assessment of each person's ability to manage their own medicines. This ensured the support they received matched their actual needs. One person's support plan said, 'I like to take my medication at dinnertime with a glass of water'. People had been able to consent to staff giving their medication and where lack of capacity had been identified; a best interest meeting had taken place with relatives and families being involved. Medicines were either stored safely in a locked cabinet within each individual person's flat or in a locked room for medicines. The cabinets were stored appropriately. The medicine administration records (MAR) were completed after each dose was given. Two members of staff told us that more staff who had been trained to administer medicines would be useful at times as they sometimes felt overloaded. We addressed this with the acting manager who told us there was always a medication trained staff member on duty and assured us this would be discussed with the senior management team.

We were assured that new employees were appropriately checked through robust recruitment processes to ensure their suitability for the role. The records detailing whether a person had a Disclosure and Barring Service (DBS) check in place were held at a different location. We received an email from a Human Resources Administrator confirming that a DBS check had been carried out and two references had been sought for six staff members who we asked to see records for. A DBS check allows employers to see if an applicant has a police record for any convictions that may prevent them from working with vulnerable people.

Health and safety checks were carried out. Fire checks and fire evacuation drills had taken place. It had taken the staff just over three minutes to evacuate the building in March 2017. There were policies and procedures in the event of a fire and each person had a personal emergency evacuation plan (PEEP) to ensure their support needs were identified in an emergency situation.
From our observations, it was evident there were sufficient food safety practices at Edward House. There were different coloured chopping boards used for different foods to minimise the risk of cross contamination. We were also shown records of fridge and freezer temperatures which had been recorded daily.

Requires Improvement

Is the service effective?

Our findings

Training records confirmed that staff had not received the appropriate training to support people effectively. Not all staff members had training in adult safeguarding, MCA and DoLS, face to face first aid, epilepsy, autism, conflict management training (MAYBO) and infection control. One staff member who had been working in the home since October 2016 had not had training in any of the areas listed above. There were people living at Edward House who had epilepsy at the time of our inspection. Early in March 2017 one person who suffered with epilepsy had a seizure and required treatment. There were no staff members on duty who could administer a rescue medication. This had been identified by the acting manager and training had been booked for May 2017. An email sent to us after the inspection showed that five staff members had received epilepsy training in February 2017.

Staff were able to complete an induction when they first started working at the home. This was a mixture of face to face training, online training and shadowing more experienced staff. The Care Certificate had been introduced and newer members of staff were completing this as part of their induction. Records showed new staff had been given some training on the systems and processes of the home but training was not up to date and some areas such as health and safety and reading some areas of people's support plans were not completed. There were no records to show that the provider had assured themselves that the agency provided staff who had received up to date training.

Staff had not consistently been receiving regular one to one supervision or an appraisal with a line manager. Individual supervision and appraisals are an opportunity for the line manager and staff to evaluate performance and plan to improve their effectiveness in providing care and support to people. When we viewed supervision records for staff we saw an improvement in records since January 2017 and that supervisions were now taking place. However, these had identified staff concerns but did not have outcomes. This meant the registered manager/provider had not been formally monitoring staff performance, supporting the staff to work together as a team or monitoring staff morale. One staff member said, "I don't feel supported at all. There are lots of changes right now. I may just leave but I don't want to". There had been no appraisals in the previous 12 months.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

Each person had a separate health file which gave extra information on how to support them with any health issues. It was unclear looking at people's health files whether they had access to health and social care professionals or not. One person's records for 2016 showed they had visited the dentist in June but there were no other records for the doctor, hospital, chiropodist, annual health check or opticians. Another person's records showed they had refused an optician appointment in 2013 but this had not been updated or reviewed. Nobody knew whether this person had visited the optician since then. There were no lists of professionals or medical contacts for each person. One relative said, "I am not sure when [The person] last visited the dentist".

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

People were able to choose what they liked to eat. We received positive feedback from people and relatives about the menus and food and drink at the home. Pictures of food were visible in the kitchen acting as a visual aid so that people could see what was being served. One relative said, "[The person] has a healthy appetite and eats well. They are encouraged to food shop". Records showed what people's likes and dislikes were with regard to eating and drinking.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack the mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

The provider had policies and procedures in place regarding the MCA and DoLS. Everyone's mental capacity had been assessed and records confirmed this. DoLS applications had been made appropriately for some people and the registered manager was awaiting further contact from the local authority regarding the outcomes. A DoLS assessor had visited the service in March 2017 and left a compliment which said, 'Very welcoming and helpful staff. Records were clear, full and up to date making my job as easy as can be'.

Requires Improvement

Is the service caring?

Our findings

There were some positive comments from people and relatives who told us that staff were caring. One person said "Yes it's good here, the staff are nice". One relative said, "The staff are good. I am pleased with the support [The person] receives". Despite this we observed some practices that were not caring.

We were shown around the home by the acting manager who showed respect to people's privacy and dignity by knocking on people's doors before entering. The acting manager asked people if we were able to enter their room or flat. On entering one person's flat we witnessed one person giving the staff a banana to open. The staff member said "No you've had two bananas already". The acting manager then intervened and told the staff member to open the banana and allow the person to eat it. We could not be satisfied that, had we not been there, this person would have been refused the snack. We then entered another person's flat and the person was shouting, "sandwich". We then witnessed a staff member saying, "You will have to wait for lunch at 12". It was approximately 10.30am. This meant the person may have needed some food or a snack but was being refused. We addressed both of these incidents with the acting manager who reassured us that staff would allow people to have regular snacks if needed. We were told a culture of routine had developed over time and this would be addressed.

This was a breach of regulation 10 of the Health and Social Care Act (2008) regulations 2014. Dignity and respect.

Staff communicated effectively with people. We observed staff chatting with people throughout the day. Where people were unable to communicate verbally, staff were able to communicate in a way that met their needs. One person communicated well but some responses to questions were slow. Staff gave the person plenty of time to respond and did not try to guess what the person might have been going to say. Staff told us they enjoyed working at Edward House and they cared for the people who lived there. One staff member said, "I really love it there. I started in December 2016 and all of the staff are friendly".

People chose where they spent their time. We observed one person going into the courtyard and pacing around in the sunshine. Staff members were in the vicinity but allowed the person space and time to be outside. The person appeared calm and content. One person was sitting in the kitchen chatting with staff and said to us, "I like sitting in here".

People were supported to dress accordingly to their individual tastes. They looked well-presented and well cared for. People's choices around clothes and what they liked to wear were documented in their support plans. People were encouraged to help with looking after their clothes. One person's daily notes said, "Put their own socks in the washing machine".

Care records contained the information staff needed about people's significant relationships including maintaining contact with family. All of the relatives we spoke to told us they were able to visit when they wanted to and were made to feel welcome by the staff that were on duty.

Inadequate

Is the service responsive?

Our findings

Not all people had access to meaningful activities. We received conflicting comments from people and their relatives about activities. We found that some people led busy and active lives whilst others had fewer opportunities to participate in activities that met their needs .One relative told us that there were a good range of activities on offer at Edward House. They said, "[The person] goes out lots. Now they have their own car it is better. They do their own food shopping and go to the disco at the day centre every Wednesday". One person told us, "I am going swimming and hiking today". Another relative said, "[The person] used to go swimming but that has stopped now". One staff member said, "It does depend if there are drivers on shift, as to whether people are able to go out".

Each person had a support plan which was personal to them but they were not always up to date. The support plans were in a large ring binder and contained large amounts of information therefore it was hard to decipher which records were current or were old. Some of the information recorded about people was not regularly updated and there were records with no dates; therefore they did not always reflect current needs. There was a risk that staff not familiar with each person could be misled by the records. Examples of this included; Risk assessments giving conflicting information about how to support people and some behaviours that may challenge were not clear. One record showed that one person was required to sit behind the driver with a staff member in the back sitting next to them when accessing the community. Records and risks associated with this were not clear and gave conflicting information. This could put people and staff at risk.

The support plans were in the process of being streamlined and old documents being archived. We saw one support plan that had been completed and this was a lot better although the risk areas were still not clear to read. It was evident staff had not fully read the care files or knew people's likes and dislikes well. For example, one person's daily notes showed us that they had eaten chips for 12 days in a 14 day period. On the days they had not eaten chips, the notes stated they had eaten a pie. It was clear on their one page profile that pies were something the person disliked.

People's daily notes had a section for targets and goals to promote independence and improve the quality of their lives. These were all blank and we were unable to see any records relating to targets and goals. This meant that there was no evidence that staff were supporting people to meet their aspirations and goals. One person's daily notes said that they had 'put their own socks in the washing machine' on one day. There were no attempts to encourage this person to further their independence or continue to achieve positive outcomes. Without detailed and regularly reviewed person centred supporting goals we were unclear whether people were achieving the quality of life they wished or that people were being supported to be as independent as possible.

Each person had been given two keyworkers who had extra responsibility for supporting that person. There was a list on the wall of each person's appointed keyworkers. A keyworker is a staff member who would hold regular sessions to see if any extra support was needed or deal with issues. A keyworker would liaise with

families and friends and help to organise social events and buy presents for events such as Birthdays and Christmas. However there were no records for any sessions having taken place. The 'acting manager' said, "These are not being done at the moment".

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

The section in the daily notes about what people did each day were thorough and contained a good level of detail of how people had spent their day. The daily notes contained information around what support had been provided to people, what they had to eat and drink and any activities they had taken part in. This gave staff a good overview of how people were feeling and if any emotional support was needed. If people were feeling anxious or upset this was clearly documented.

Staff and resident team meetings were not being held regularly. There were one set of team meeting notes for the previous 12 months. This was completed in February 2017. One staff member said, There are no keyworkers, no meetings and morale is low". There were no records of meetings for people using the service to discuss issues arising within the home.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 201. Good Governance.

Staff and relatives we spoke with said that they had made complaints to the registered manager before they left but that there had been no investigations or outcomes. We found one complaint regarding a staff member in the complaints file. There were no records of people raising a complaint or concern since 2015. One staff member said, "I am not confident any complaint would be dealt with". During our inspection we noted many concerns and complaints from staff but these were not logged or monitored. We discussed this with the senior management team who told us they had found this issue during the quality audit completed in January. We were told there was not currently any openness or transparency in dealing with complaints. People did not have access to an easy read complaints form as these were stored in their support plan folders which were kept in the office. The service improvement plan identified that complaints needed to be encouraged and this would be addressed.

This was a breach of Regulation 16 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014. Receiving and acting on complaints.

Reports and guidance had been produced to ensure unforeseen incidents affecting people would be well responded to. For example; if a person required an emergency admission to hospital, each care file contained a hospital passport. This contained information such as; current medication, support needs and any behaviour that may challenge. These were colour coded to support hospital staff. One person's passport said, 'I will tell you if I am in pain' and 'I may abscond'.

Inadequate

Is the service well-led?

Our findings

There was no registered manager in post during our inspection as they had left the service when a Caretech quality team had completed an audit in January 2017 and a number of concerns had been identified. A team of staff from other Caretech homes had been drafted in to support the staff team since the quality audit. There had been a new acting manager in post since the quality audit. A service improvement plan had been completed on 23 January 2017 which had identified all of the concerns that we found during our inspection. This gave actions to be done within a specific timescale and a responsible person for ensuring they were completed. The provider told us they were taking this seriously however we were unable to ascertain when this would be completed.

We were unable to speak with people using the service about the managers due to their communication difficulties. Relatives and health professionals knew who the registered manager was but had not been formally told when they had left the service. There was mixed feedback from everyone we spoke with regarding the management of the home. One relative said, "There are lots of changes, so many that it's hard to know who to go to". Another relative said, "Communication has been good. We had a meeting recently with the new 'acting manager' and some other senior staff and it was good. We feel they are keen to support now".

Until January 2017, internal auditing and quality assurance systems were not planned or carried out regularly. As a result the provider had not identified errors or omissions in people's care records. This meant that records had not been updated or reviewed and people were at risk. It appeared that, with so many changes of managers and staff over the last four months, it was difficult for Caretech to manage the service safely with so many issues at the time. However; it appeared that the new senior manager and acting manager were passionate and willing to support the people living at Edward House and gave us reassurances that things would improve.

The registered manager and provider had failed to identify that staff were not receiving regular supervision and appraisals, as a result staff had received supervision inconsistently and none of the staff had received an appraisal for 12 months. This meant staff morale was low and they felt unsupported.

Record keeping was not robust. As discussed in other parts of the report, risk assessments and care plans were not always up to date.

Written accident and incident documentation did not contain enough detail including the lead up to events, what had happened and what action had been taken. One person's daily notes showed a body map for unexplained bruising. These were the same for four days. There were no records to show how these occurred. We saw no evidence that action had been taken to address this; therefore it was unclear whether accidents and incidents were avoidable and whether there were any patterns or themes that could be used to drive improvements.

Feedback from people using the service was not sought. Comments and views were not recorded in care

records, minutes of meetings held with people, comments or complaints received or as a result of satisfaction surveys. The failure to assess the quality and safety of the service provided meant regular monitoring and plans to improve the service provided were not in place.

Staff team meetings were not being held regularly. There were one set of team meeting notes for the previous 12 months. This was completed in February 2017. One staff member said, There are no keyworkers, no meetings and morale is low". There were no records of meetings or keyworker sessions for people using the service to discuss issues arising within the home.

As there were no accident and incident reports, it was unclear if the provider was reporting to us appropriately. The provider has a legal duty to report certain events that affect the well-being of the person or affects the whole service. The Local Authority had raised a concern on their visit in March 2017 that incidents were not being recorded and reported appropriately.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 201. Good Governance.

The senior managers were responsive to our concerns during our feedback and assured us they would take action. However, we were concerned about the ability of the management team to take these forward without access to considerable further resources and support from the provider.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 HSCA RA Regulations 2014. Dignity and Respect. 10 (1) The registered person had failed to ensure people were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Regulation 15 HSCA RA Regulations 2014. Premises and equipment. The registered person did not ensure the premises were adequately maintained and cleaned. 15 (1) (a) (e)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA RA Regulations 2014. Person centred Care. 9 (1) (3)(b) The registered person had failed to ensure people were receiving person centred care that reflected their personal preferences. The registered person failed to ensure support plans had goals and outcomes.

The enforcement action we took:

NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014. Safe care and treatment. The registered person had failed to assess risks to the health and safety of people living at Edward House and they had not always been assessed or reviewed. 12(2)(a) The provider had not done all that was reasonably practicable to mitigate risks. 12 (2)(b)

The enforcement action we took:

NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA RA Regulations 2014.

	Safeguarding service users from abuse and improper treatment. The registered person had failed to ensure that all staff had safeguarding adults training. 13(2)

The enforcement action we took:

Warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Regulation 16 HSCA RA Regulations 2014. Receiving and acting on complaints. Complaints were not investigated. There were no systems in place to identify record and respond to complaints. 16(1)(2)

The enforcement action we took:

NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014. Good governance. There were no regular audits in place to improve the quality of the service. 17(2)(a) No systems were in place to identify risks to the health and safety of people who lived there. 17 (2)(b) The registered person failed to ensure records relating to people were up to date and reviewed regularly. 17 (2)(c)

The enforcement action we took:

NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA RA Regulations 2014. Staffing. The registered person failed to ensure staff had

received sufficient training to provide effective care and support.

Staff had not received appropriate management support through regular supervision and performance management reviews.18 (2)(a)

The enforcement action we took:

NOP.