Mr and Mrs Bradley

Edenhurst Rest Home

Inspection report

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Date of inspection visit:
10 January 2018
18 January 2018

Date of publication:
06 March 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected the service on 22 November 2017 and, 10 and 17 January 2018. The inspection was unannounced. Edenhurst Rest Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Edenhurst Rest Home accommodates up to 24 people in one building, the home has 22 bedrooms, two of which are intended for two people to share. On the days of our inspection 23 people were living at the home, all of these were older people, some of whom were living with dementia.

We carried out our first inspection visit in November 2017. During the course of our inspection we received concerns in relation to the quality and safety of the home. As a result we returned to the service in January 2018 to look into those concerns.

There was a registered manager in post at the time of our inspection. 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 responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection we found the service was not safe. People were not always adequately protected from risks associated with their care and support such as falls, or pressure ulcers. There were no formal systems in place to learn from accidents and incidents. People were not protected from improper treatment or abuse, as action was not taken to conduct thorough and robust investigations, or to refer to the local authority safeguarding adults team as required. People were not consistently protected from risks associated with the environment, risks associated with areas such as the stairs and windows had not been adequately assessed or managed and this placed people at risk of harm. The environment and equipment used in people's care and support was not always clean.

Medicines were not always stored safely this increased the risk of error. However, people received their medicines as required. There were not always enough staff available to ensure people's safety. Safe recruitment practices were not always followed.

Where people lacked capacity to make choices and decisions, their rights under the Mental Capacity Act (2005) were not always respected. Some people had restrictions imposed upon their rights but we could not be assured this was in their best interests. People who had the capacity to make decisions were supported to have choice and control of their lives. Staff did not receive sufficient training to enable them to effectively meet people's individual needs. Staff were provided with regular supervision and support.

People's day to day health needs were met and they were supported to access healthcare as required. Where people had specific health conditions more information was needed in care plans to ensure they got the support they needed. The physical environment had been adapted to meet people's needs, further work

was required to ensure people's needs associated with dementia were met by the design and decoration of the home. People had enough to eat and drink and were provided with choices and assistance as needed.

People were supported by staff who were kind and compassionate and treated them with respect. People's rights to privacy and dignity were respected. Staff understood how people communicated and people were provided with information in a way that was accessible to them. People were enabled to have control over their lives and were supported to be as independent as possible.

People were at risk of receiving inconsistent support as care plans did not provide an accurate or up to date description of their needs. People and their families were not consistently offered opportunity to be involved in planning their care and support. People knew how to raise issues and complaints, and were confident action would be taken to address any concerns raised. People were given opportunities to get involved in meaningful social activity within the home and the local community.

There was a lack of formal audit and quality assurance systems and those in place were not effective. This meant risks to people's health and safety were not always identified or addressed. Timely action was not always taken in response to known issues. Accurate and up to date records were not kept of people's care and support. The provider had not kept up to date with current guidance and legislation. People who used the service, staff and visiting health professionals were positive about the home and had some opportunities to share feedback about the quality of the service provided at the home.

During this inspection we found multiple breaches of the 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 the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always adequately protected from risks associated with their care and support. Effective action had not been taken to protect people from risks associated with the environment.

People were not protected from improper treatment or abuse.

Medicines were not always stored safely, however people received their medicines as required.

There were not always enough staff available to ensure people's safety. Safe recruitment practices were not followed.

The environment and equipment used in people's care and support was not clean.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights under the Mental Capacity Act (2005) were not respected at all times.

People were supported to attend health appointments. However, there was a risk that people may not receive appropriate support with specific health conditions.

Staff did not receive sufficient training to enable them to effectively meet people's individual needs. Staff were provided with regular supervision and support.

People were supported to have enough to eat and drink.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate and treated people with respect. People's rights to privacy and dignity were promoted.

Staff understood how people communicated and people were provided with information in a way that was accessible to them.

People were enabled to have control over their lives and were supported to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a risk people could receive inconsistent support as care plans did not always contain adequate information to inform staff how to support them. People and their families were not consistently offered opportunity to be involved in planning their care and support.

People were given opportunities to get involved in social activity and were supported to maintain relationships with family and friends.

People were supported to raise issues and staff knew how to deal with concerns if they were raised. People were invited to give feedback on the service.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a lack of formal audit and quality assurance systems and those in place were not effective. This meant some risks to people's health and safety were not identified or addressed.

Timely action was not always taken in response to known issues. Accurate and up to date records were not kept of people's care and support.

The provider had not kept up to date with current guidance and legislation.

People who used the service, staff and visiting health professionals were positive about the home and had some opportunities to share feedback about the quality of the service provided at the home.

Edenhurst Rest Home

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, to look at concerns we received about the quality and safety of the service and to provide a rating for the service under the Care Act 2014.

We carried out our first inspection visit in November 2017. During the course of our inspection we received concerns in relation to the quality and safety of the home. As a result we returned to the service in January 2018 to look into those concerns.

Prior to our inspection we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events which the provider is required to send us by law, such as, allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views. We used this information to help us to plan the inspection.

The inspection was undertaken by three inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. During our inspection visits we spoke with seven people who lived at the home. We also spoke with six members of care staff, the trainee manager and the registered manager who was also the owner of the home. We also received feedback from two health professionals who visited the home regularly.

To help us assess how people's care needs were being met we reviewed all or part of seven people's care records and other information, for example their risk assessments. We also looked at the medicines records of four people, four staff recruitment files, training records and a range of records relating to the running of the service. We carried out general observations of care and support and looked at the interactions between staff and people who used the service. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We did not request a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Inadequate

Is the service safe?

Our findings

During our inspection we found concerns about the safety of the service and the ability of the service to protect people from the risks associated with their care and support. Risks to people's health and safety were not always appropriately assessed or managed. This left people exposed to the risk of harm.

Risks associated with people's care and support were not always effectively identified, assessed or mitigated. People were not always adequately protected from the risk of falls. The provider's rationale for decisions made about control measures to reduce the risk of falls was unclear and this placed people at risk of harm. For example, we observed one person had a crash mat and sensor on one side of their bed. However, there was no crash mat or sensor on the other side of their bed which meant there was a risk the person may fall from this side and potentially sustain an injury. This did not assure us that all reasonable steps had been taken to reduce the risks of the person falling from their bed and exposed them to the risk of harm.

There were no effective systems in place to analyse patterns of falls to try and reduce recurrence. For example, records showed that one person had sustained seven falls in the past two years. Although basic details had been recorded on accident forms there was no evidence of any analysis of patterns such as type of fall, location or time of day. We noted two other people who had repeatedly had falls but again no analysis had been completed. This meant opportunities to reduce the recurrence of these incidents may have been missed.

The risk assessment system used at Edenhurst Rest Home did not facilitate safe and effective care delivery. Risk assessment forms were basic; risks were rated as low, medium or high but the assessments did not record any rationale for how these risk ratings had been reached. For example, one person had been assessed as being at 'medium' risk of pressure ulcers, but it was unclear what factors had been taken into account to reach this decision. In addition there was no consideration of the level of risk remaining after control measures had been put in place. This meant it was not clear if the risk reduction measures were effective in reducing the risk of pressure ulcers. Although the person did not have any pressure ulcers at the time of inspection we were not assured that all reasonable steps had been taken to reduce the risk.

The approach to risk management was reactive rather than preventative. For example, a member of staff told us one person had a number of risk factors connected with their skin health care needs which may lead to an increased risk of developing pressure ulcers and said they took some actions, such as use of a pressure cushion, to reduce the risk of pressure ulcers. Despite this increased risk the person's tissue viability care plan and risk assessment were blank. The registered manager told us there was no need for a care plan as the person had never had a pressure ulcer. This did not assure us that a preventative approach was taken to pressure ulcers and meant people were at risk of inconsistent care as staff did not have sufficient guidance to follow.

Risks associated with people's behaviour had not been effectively assessed or managed. There were no behaviour management risk assessments or care plans in place for people who may be resistive to care or

who may behave in ways that put them and others at risk. For example, prior to our inspection we received concerns about how the risks associated with one person's behaviour were managed. During our inspection we found their care plan did not reference their resistance to personal care or provide any guidance for staff about how to safely support them. The registered manager told us they were aware there were times when the person could be resistive to personal care but they had not found this to be an issue as they knew how best to support them. However, this approach was not reflected in their care plan. This lack of guidance had resulted in staff using restrictive practices in order to deliver personal care. In the course of a local authority safeguarding investigation a staff member disclosed they were restricting the person's movement in order to perform personal care tasks as they did not know how else to support them. The failure to ensure sufficient guidance for staff had resulted in practices which did not respect the person's rights and placed them at risk of sustaining injury.

Risks associated with people using the stairs had not been thoroughly risk assessed. During our inspection we observed there were limited measures in place to reduce risks posed by the stairs to people who were at risk of falls, who had impaired mobility and / or reduced mental capacity. Although some people had individual stairs risk assessments in place, the risk reduction measures stated on these were not adequate or effective. For example, one person had a history of falls and had a stairs risk assessment in place stating 'avoid use of stairs, use lift at all times'. Despite this, the registered manager told us there were times when the person chose to use the stairs independently. The person's care plan documented they lacked capacity to consent to many aspects of their care and support. However there were no other formal measures in place to mitigate the risk. This placed people at risk of harm. Following our inspection we were informed the provider had taken action to reduce the risk of people falling down the stairs.

An inconsistent approach had been taken to managing other environmental risks. We saw some large, heavy items in bedrooms, such as wardrobes, were unstable and had not been secured to the walls. This was not in line with national good practice guidance on ensuring peoples safety in care homes. This placed people at risk of sustaining injury from falling objects. This risk was exacerbated by the nature of people's support needs which meant that some could be unsteady on their feet at times and may potentially hold on to furniture to steady themselves. Risks associated with windows were not always managed safely. Window restrictors had not been installed on all windows and consequently people were not always protected from the risk of accident and injury. This posed a risk of people falling from windows and resultant injury. An inconstant approach had been taken to mitigating the risk of people falling against or through windows and this exposed them to the risk of harm. Whilst we saw that protective glazing had been installed on some windows we found windows were not all adequately glazed to ensure people's safety. The failure to ensure the safety of windows placed people at risk of serious harm.

Medicines were not always stored safely. During our inspection we found medicines for people who had passed away had not been returned in a timely manner. We found a medicines dating back to January 2017 in a filing cabinet drawer, some of these would potentially be dangerous if taken by the wrong person, or, if too much was taken. Medicines which were in use were also stored in the same drawer and were mixed together with the returns. This was confusing, unsafe and increased the risk of error. Furthermore these medicines were not stored securely. The lock on the office door was broken and awaiting repair, we observed that the drawer containing the medicines was left unlocked throughout the duration of our inspection on 10 January 2018. This meant there was a risk people may have been able to access and potentially take the medicines. This placed people at risk of harm.

All of the above information was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Action was not taken to conduct thorough and objective investigations of allegations of abuse. In November 2017 the registered manager had received multiple concerns about the quality and safety of the service. Some of the concerns were allegations of abuse. Despite the seriousness of these concerns the registered manager had not completed a thorough investigation and had not taken action to escalate these concerns to the local authority safeguarding adults team to enable an independent investigation to take place. The registered manager told us they had spoken to all staff at the home as soon as they had been made aware of the concerns. However, there was no written record of the investigation. Due to the lack of record keeping we were unable to assess the adequacy of the investigation conducted and consequently we were not assured that everything reasonably practicable had been done to investigate allegations of abuse and ensure people's safety.

In late December 2017 we received multiple concerns about the quality and safety of the service. This included specific allegations of people at the home being verbally abused by staff. During our inspection the registered manager confirmed they were aware of the allegations. However they had not taken action to escalate these concerns to the local authority safeguarding adults team as they told us they did not have any "Proper proof," of the allegations and they trusted the staff the allegations were made against. This demonstrated a lack of understanding of safeguarding processes and did not assure us that allegations of abuse were treated objectively regardless of who raised the concern.

The management and staff team at Edenhurst Rest Home did not have sufficient practical knowledge of indicators that people may be subject to abuse or improper treatment. Although the training matrix showed most staff had received safeguarding training, we found evidence to demonstrate this had not provided staff or managers with adequate skill and competency to ensure people's safety. Consequently, we found further evidence of a number of incidents which had not been formally investigated and had not been referred to the local authority safeguarding adults team. For example, records showed three people had sustained falls resulting in serious injuries in 2017. No referrals had been made to the local authority safeguarding team to notify them of these serious injuries. This meant we were not assured that action would be taken to refer serious incidents to the safeguarding adults team to enable further investigation if required.

The provider had not ensured effective systems were in place to in place to record, communicate or investigate unexplained bruising or injuries to people living at the home. We reviewed daily records and found both explained and unexplained injuries which gave us cause for concern as there was no evidence of investigation or reporting. A recent 'daily book' entry for one person, documented they had a graze to their cheek. This injury was unexplained and there were no records to demonstrate action had been taken to investigate the cause of this injury. A body map completed for another person documented they had 'slight bruising' to their hands and recorded 'tends to grab hold of items on nearby table'. This was not a sufficient explanation of the cause of bruising. Neither of these injuries had been investigated or referred to the safeguarding adults team.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could not be assured the service was clean and hygienic. The registered manager told us cleaning was the responsibility of care staff, and said they had recently developed a cleaning rota to try to ensure staff understood their responsibilities in this area. Despite this we found areas of the service were not cleaned to an adequate standard. People's bedrooms were not sufficiently clean, some bedrooms where furniture had a thick layer of dust and we saw furniture and equipment in two bedrooms, such as mattresses, which had been penetrated by bodily fluids and were stained and odorous. Bathrooms were also not clean. One toilet was encrusted with old waste matter and we observed a bath seat which was

dusty and water marked. We also observed other unhygienic practices, for example, liners were not used communal toilet bins and bathroom bins. Some of these bins had been used to dispose of continence waste and we found a used dressing in one bin. This was not a hygienic practice and it also did not promote the control and prevention of infection. Furthermore, soap and disposable handtowels were not available in all bathrooms.

Effective cleaning procedures were not in place for some items of equipment used in people's care and support. We observed that some equipment such as hoists and wheelchairs were sticky, dusty and marked with food debris. A member of staff informed us that they cleaned wheelchairs "As needed." However, this system was not effective in ensuring the cleanliness of equipment.

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

There were not always sufficient numbers of staff to ensure the safety of people who lived at Edenhurst Rest Home. Although staff and people living at the home told us there were enough staff we identified concerns about staffing levels at night time. Two staff were deployed on night shifts, one allocated to each side of the home. A member of staff told us if someone required the assistance of two members of staff at night, the staff member from the other side of the home would be utilised. Due to the layout of the home this meant that 12 people would be left unattended in one side of the home. Given the risks associated with people's care and support, and the environment, such as unrestricted stairwells this placed people at risk of harm. Following our inspection we were advised by the local authority that the provider had increased staffing levels to ensure that each side of the home was supervised to ensure the safety of residents. However it remains of concern this had not been identified and addressed prior to our inspection.

Adequate steps had not always been taken to ensure people were protected from staff that may not be fit and safe to support them. Pre-employment checks designed to help providers ensure staff were suitable to work at the service were not always completed. Three of the four recruitment files we looked at had shortfalls in safe practice. For example, applications forms for two staff had not been fully completed and were missing information about the staff member's employment history or their reason for leaving previous posts. This meant that the provider did not have all the relevant information to make a decision about the suitability of the staff members to work at the service. We spoke with the registered manager about this who told us they would address this.

Other than the aforementioned concerns regarding the storage of medicines we found that, in other areas, medicines were managed and administered safely. People told us they received their medicines on time and as needed. We found that medicines were well organised and medicines records were completed accurately to demonstrate that people had been given their medicines as prescribed. However, where people were prescribed medicines to be taken 'as required' there were not always protocols in place to ensure that these were given as needed. We shared these concerns with the registered manager who informed us they would take action to address this. Prior to our inspection we received concerns about the procedures for administering medicines covertly (the administration of any medicine to a person without their knowledge, for example in food). This remained under investigation by the local authority safeguarding team at the time of our inspection.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act (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 they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

People's rights under the MCA were not always protected as the Act had not always been correctly applied to ensure decisions were made in people's best interests. People's care plans did not always contain information about whether they had the capacity to make their own decisions. For example, one person was in a shared a bedroom and used a commode which was located in the bedroom. We asked staff how they ensured the person's privacy when using the commode in a shared room and they told us they used a privacy screen. This was a restriction on the person's right to privacy and had not been considered in line with the MCA. The person's care plan documented they lacked the capacity to make similar decisions of this nature. Despite this, there was no documentation in place to demonstrate that the decision about this arrangement had been considered as part of a best interests decision making process. Another person was subject to continuous supervision either by staff or movement sensors. They did not have capacity to consent to this arrangement. However, the decision about monitoring had not been considered under the MCA. We also found other areas where people's capacity to consent to restrictions on their freedom had not been formally assessed, such as, the use of bedrails and motion sensors.
Staff and managers did not have the required competency to ensure the MCA was correctly applied. Staff did not have training in the MCA and consequently lacked practical knowledge of the MCA. This had resulted in blanket approaches to the MCA being adopted, such as routinely assessing the capacity of people who were able to make their own decisions.
The above information was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had made applications for DoLS where appropriate. These applications were still being processed by the local authority at the time of our inspection.
The treatment and care people received at the home was not always delivered in line with current legislation, standards and evidence based guidance. For example, nationally recognised good practice risk assessments, such as pressure ulcer risk assessments, were not used by the service. The provider had developed their own methodology for risk assessments and we found this was not always effective in managing risk.
People living at Edenhurst Rest Home told us they felt staff had the required skills and competency to support them. Although records showed staff had recent training in some areas including safeguarding adults, first aid and the safe administration of medicines this had not always been effective in ensuring staff competency. For example, although most staff had safeguarding training, appropriate action had not been

taken to ensure people were protected from the risk of abuse and improper treatment. We also found that some staff did not have training in some key areas and this had resulted in negative outcomes for people. For example none of the staff had any recent training in the Mental Capacity Act. Consequently we found staff lacked practical skills and competency in this area. This meant staff did not always have the required knowledge or competency to ensure people received the support they required.
New staff were provided with an induction period when starting work at the service. The registered manager told us that staff induction included training and shadowing of more experienced staff. New staff had completed the Care Certificate. The Care Certificate is a nationally recognised set of standards for staff working in health and social care to equip them with the knowledge and skills to provide safe, compassionate care and support. Staff told us that they felt supported and records showed they had received regular supervision.
People told us they were supported with their health and well-being and staff made contact with relevant healthcare professionals as needed. One person told us, "They take us to the doctor or the doctor comes here." A GP visited the home regularly and the provider funded a podiatrist (a health professional trained in foot care) and physiotherapist to support people as needed. The outcomes of appointments with professionals including GP's, dieticians and specialist nurses were recorded in people's care plans. We received positive feedback about the support provided by staff from health professionals involved with the service. One health professional told us, "[Registered manager] and the team have a very sensible, individually tailored approach to the healthcare needs of the residents."
Despite the above, we found that when people had specific health conditions, care plans did not consistently contain adequate detail in order for staff to provide effective support. For example one person had diabetes; however, there was only very limited information about this in the person's care plan. This lack of information placed people at risk of not receiving the required support.
Systems were in place to ensure information was shared across services when people moved between them. For example, the trainee manager told us they had implemented the 'red bag' scheme. This scheme is designed to share information and important items, such as medicines, between care homes and hospitals, to ensure care is person centred and effective.

People who used the service and their relatives were positive about the food served at Edenhurst Rest Home, they told us they were offered a choice and had enough to eat and drink. One person told us, "We love the food here, it's alright we get tea, coffee and biscuits, and a light tea in the evening." Another person said, "The food is great. You have lots of choice, there is a menu, we are asked what food we like at the beginning of the week and the menu is planned around this. But you can always have something else like soup or a salad." A relative commented, "My [relation] loves their food they do not leave anything." During our inspection we observed a meal time and saw people appeared to enjoy their food and were provided with timely assistance when needed. People who chose to eat in their bedrooms were offered timely assistance. People's cultural needs were catered for and there were cold and hot drinks available throughout the day. This demonstrated people had enough to eat and drink and were provided with choices and assistance as needed.
We spoke with a member of catering staff who was knowledgeable about people's dietary needs and preferences and had systems in place to ensure these were catered for. When people were at risk of losing weight, staff monitored their weight regularly and made referrals to specialist health professionals as needed.
Edenhurst Rest Home is situated in two, large, adjoined Victorian houses. Consideration had been given to people's needs in the design and decoration of the building. For example, aids and equipment had been installed in some areas to enable people with mobility needs to navigate around the building and the provider had installed a call bell system to ensure people could request staff as required. There were two communal lounge areas, with separate dining areas, which meant people had ample space to spend time socialising with friends and family. There was limited evidence to demonstrate that people's needs

associated with dementia had been taken into account in the design and decoration of the environment. A number of people were living with dementia and we observed that some had difficulty navigating their way around the building. Some signage on doors was confusing and an inconsistent approach had been taken to helping people orientate themselves. The use of dementia friendly signage and colour schemes was also inconsistent throughout the home. This meant we were not assured the provider had taken all reasonable steps to accommodate people's diverse needs in the design and decoration of the building. On the final day of our inspection we observed the provider was in the process of making improvements in this area.

Good

Is the service caring?

Our findings

People and their relatives were unanimously positive about the service provided at Edenhurst Rest Home. People commented on the homely atmosphere of the home and the caring approach of both staff and managers. One person said, "We are so lucky here." Another person said, "The staff are really lovely, they are all nice. If you are worried about anything you can just speak to them." A relative said, "The care is personalised, staff work across both buildings and get to know everyone really well. The manager is very approachable, even for small things." Another relative said, "The quality of care is a top priority for me. The home is not clinical, it's like home from home." A visiting health professional also commented positively about the approach of the staff team. They told us, "Staff are extremely caring and know what residents like and dislike."

During our visit staff treated people with warmth and kindness. We observed positive interactions between people and staff. For example, one person was seeking reassurance, a staff member responded quickly using physical affection to reassure them. People told us they felt staff knew them and made an effort to find out about their history and likes and dislikes. People's care plans contained information about people's backgrounds and their preferences. People's care and support was based upon what was important to them. A visiting health professional told us, "[registered manager] takes a couple of the ladies to a singing group which they love. Recently he took an elderly veteran to their squadron's reunion many miles away."

People were involved in day to day decisions about their support. One person told us, "I can make choices about when I get up, or wake up, and, I can go in to the garden when its fine." Another person said, "I can make my bed, I can get up when, I want I can stay in the lounge or in my room. I can choose my own clothes and wander around." During our visit we saw that staff routinely checked with people about their preferences for care and support. People were offered choices about what they ate and drank and how and where they spent their time. Staff we spoke with had an understanding of their role in ensuring that people had choice and control. We observed that staff had a good understanding of people's communication needs and used this to inform their support. Most care plans contained information about people's communication and staff demonstrated a good knowledge of this. For example, one member of staff described how they used flash cards to communicate with people. The registered manager told us people had access to an advocate if they wished to use one and there was information about advocacy displayed in the service. Advocates are trained professionals who support, enable and empower people to speak up. No one was using an advocate at the time of our inspection.
People were supported to maintain their independence. This was reflected in feedback from those living at the home. A relative praised the home about the approach they took to encourage their relation's independence. However, we found more information was required in care plans to ensure people received consistent support to maintain their independence. For example, one person's care plan stated they were independent many aspects of their care. However staff told us the person's needs had changed significantly, which meant they now needed significant support from staff. Their care plan had not been updated to reflect this, and consequently, this placed them at risk of not getting consistent support that promoted their independence. The registered manager told us they would be reviewing all care plans based upon our feedback.

On the whole, people's right to privacy was respected. During our inspection we identified one instance where a person's right to privacy was not respected, we asked the registered manager to take action on this. Despite this, people living at home told us staff respected their privacy and said they could have privacy in their bedroom if they wished. One person told us, "They are very good and they always knock first." Staff understood how to respect people's right to privacy and we observed this was put into practice for the duration of our visit. For example we observed staff knocking on bedroom doors and waiting for an answer prior to entering. A visiting health professional told us, "The staff give residents appropriate privacy. For example, (consultation) is always either in their bedroom or in the office."

Requires Improvement

Is the service responsive?

Our findings

People were at risk of receiving inconsistent support. Each person living at the home had an individual care plan; however the quality of these was variable. Whilst some parts of care plans contained sufficient information other parts lacked detailed information and had not been updated to accurately reflect people's needs. For example, one person's care plan stated they were able to make choices and communicate their needs. Staff told us this was no longer the case, but their care plan had not been updated to reflect their needs. Although care plans had be marked as being reviewed daily, the reviews were not effective in ensuring they were up to date. For example, two care plans had been reviewed monthly and marked as 'no change' by staff. Through discussion with staff and observation we found both of these people's support needs had increased significantly, this was not reflected in their care plan. Other care plans had not been updated to reflect learning from adverse incidents, so did not detail how best to support people to ensure their safety. These deficiencies in care plans placed people at risk of not getting the support they required.

Although people and their families were consulted about their day to day support there was little evidence that they were offered the opportunity to be involved in developing and reviewing their care plans. The registered manager told us care plans were written by the management team and they were trying to explore ways of getting care staff and others more involved in their development and review.

Although the service did not support anyone who was coming toward the end of their life at the time of our inspection, people had been offered the opportunity to discuss their wishes for the end of their lives and this was recorded in their care plans. A visiting health professional commented positively about the approach of staff in this area. They said, "Discussions around end of life care are brought up wisely and sensitively with relatives."

People were provided with a range of activities and opportunities for meaningful occupation. The provider employed an activity coordinator who had responsibility for planning and facilitating activities in the home. People told us there were a range of activities provided. One person told us, "They (staff) are really good to us in here, there is always something going on." Another person said, "There is a singing club and we do Zumba and exercises, we have chair exercises."

Throughout our inspection we observed people were offered a range of things to do. For example, people were provided with the opportunity to play games and pursue their hobbies such as drawing. Staff offered encouragement and praise and we saw people appeared to be enjoying themselves, laughing with the staff. One member of staff told us, "Some afternoons, we sit and look at photos. We go to the library and get the 'Reminiscence Bag' which has lots of things in for us to look at and talk about.' When staff had spare time they sat with people and chatted with them. A member of staff told us, "We can share our hobbies with the residents. Some will stay up late to talk to us. [Person's name] loves curry and opera and I do too so we talk about the opera and sing together. I might bring them a curry in and we'll watch opera together." There were links with the local community, such as local schools and places of worship. People were offered support to access the local community for trips to local attractions, theatres, shopping and meals.

People were supported to maintain relationships with friends and family and people's friends and relations were welcome to visit Edenhurst Rest Home. One person told us, "My [relative] comes with the grandchildren and they make them very welcome." The staff team had a good knowledge of who was important in each person's life and supported people to maintain relationships with family members. Relationships had developed between people using the service and we saw friendly interactions between people.

People's diverse needs were recognised and accommodated. Staff and the manager recognised the importance of respecting people's individual needs such as their cultural heritage. The trainee manager shared an example of how they had used technology to enable them to communicate with a person's whose first language was not English. People were supported to attend local places of worship and religious ceremonies were also held at the home.

The management team explained how they met their duties under the Accessible Information Standard by providing information in different formats as required. The Accessible Information Standard ensures that all people, regardless of impairment or disability, have equal access to information about their care and support.

There were systems and processes in place to deal with and to address complaints. People told us they would feel comfortable telling the staff or manager if they had any complaints or concerns. One relative said, "We just go to [registered manager] he puts it right straight away." Staff we spoke with knew how to respond to complaints if they arose and were aware of their responsibility to report concerns to the manager. Staff told us they were confident that the manager would act upon complaints appropriately. There was a complaints procedure on display in the service informing people how they could make a complaint. The registered manager told us they had not had any complaints. There were also suggestion and complaints boxes in the entrance area which meant people had a range of ways to provide feedback.

Requires Improvement

Is the service well-led?

Our findings

Governance systems at Edenhurst Lodge not effective. This meant risks to the health and safety of people living at the home had not been identified prior to our inspection. There were no formal audit processes to ensure infection control procedures were followed. Consequently during our inspection we found people were not sufficiently protected from the risk of infection. There was no effective system to monitor and audit the quality of care plans. The registered manager told us they looked at care plans on an informal basis to check the quality of them, but there were no records of these informal checks. The registered manager told us there was no formal health and safety audit. The lack of formal auditing systems, meant some areas for improvement had not been identified or addressed.

Where quality assurance processes were in place these were not always effective. For example the registered manager informed us they had recently implemented a cleaning schedule. Staff were completing these to evidence they had cleaned the home and, the registered manager told us they conducted informal checks to ensure cleaning jobs had been completed to a satisfactory standard. Despite this, we found the home was not clean. This demonstrated quality assurance processes were not effective.

Action had not been taken in response to known issues. An audit had been conducted by the local authority in December 2016. This audit highlighted that daily records were too brief and not completed on a daily basis for each person and also recommended that detailed handover notes should be kept. However at our inspection we found this had not been addressed. Daily records were still not completed on a daily basis and there were no formal systems to record staff handovers.

There was no formal system for analysing, investigating and learning from accidents and incidents across the service. Trends of accidents and incidents, such as the location or timing, were not analysed. This failure to analyse accidents and incidents meant that opportunities may have been missed to identify ways of preventing future incidents and exposed people to the unnecessary risk of potential harm and injury. The registered manager told they had learnt from the incidents, but confirmed there was no formal record of any investigation or action taken in response to these incidents. This meant we could not be assured all reasonable steps had been taken to improve the quality and safety of the service.

The provider had not kept up to date with current guidance and legislation. The approach to quality assurance was reactive rather than proactive, furthermore they did not use the nationally recognised risk assessments formats. Consequently the provider lacked knowledge of the current good practice and this had a negative impact on the quality and safety of the service provided at Edenhurst Rest Home.

The above information was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not ensured that we were notified of incidents at the service, which they are required to by law. There had been a failure to notify us of safeguarding incidents which had occurred at the home. A failure to notify us of incidents has an impact on our ability to monitor the safety and quality of the service.

We discussed this with the registered manager who told us they would ensure we were notified of incidents going forward. Following our inspection we received notifications as required.

Despite the above, people living at the home, relatives, staff and visiting health professionals were positive about the ethos and atmosphere of the home. A relative told us, "Edenhurst is an absolute treasure my [relation] gets excellent care I have every confidence in the staff."

The registered manager was very passionate about the home and had genuine affection for people who lived there and the staff team. We observed he knew each person living at the home and treated them with warmth and compassion. People living at the home told us the registered manager was friendly and approachable. Staff also commented positively on the approach of the registered manager. One member of staff told us, "[Registered manager] is one in a million. If we clean, he cleans. He is kind. If there are problems he sorts them out. We don't always agree, but we can talk and agree our differences. We all have respect for each other." A visiting health professional commented, "[Registered manager] provides excellent leadership and it is obvious that the other staff respect and like him. I would recommend it to friends and family."

The registered manager told us they aimed to provide a homely environment where people felt they were part of the family. This approach was valued by people living at the home and their relatives. A relative told us, "This is a family run business it makes a difference they are very caring." Another relative said, "They are really helpful I just think I am so glad my relative is here and nowhere else." Staff were committed to the vision of providing a 'home from home' service. One member of staff told us, "I love it here. It's so homely, like family. It's so much more than a job." Another staff member commented, "It is just like one big family."

People living at the home, their relatives and staff were given opportunities to provide feedback on the home and influence development. The trainee manager told meetings for staff and people living at the home were held every six months, but added that many more conversations were had informally with people to enable them to have a say about how the home was run. Weekly meetings also took place to plan menus for the week ahead. The registered manager was also planning to conduct a satisfaction survey to give people opportunity to share their views.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their most recent rating in the home. The provider did not have a website.

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 11 HSCA RA Regulations 2014 Need for consent People's rights under the Mental Capacity Act 2005 were not respected. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The environment and equipment was not sufficiently clean. Regulation 15 (1)

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 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service were not protected from the risks associated with their care. Environmental risks were not consistently identified or mitigated. Medicines were not stored safely. Regulation 12 (1) (2)

The enforcement action we took:

We issued a warning notice telling the provider to take action to address the issued identified at our inspection.

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 Appropriate action was not taken to ensure that people were protected from abuse and improper treatment. Regulation 13 (1)

The enforcement action we took:

We issued a warning notice telling the provider to take action to address the issued identified at our inspection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor and improve the quality and safety of the service were not effective. Action was not taken in response to known concerns.

Systems were not in place to record and investigate incidents which posed a risk to the health and wellbeing of people who used the service.

There were no systems in place to keep up to date with good practice.

17 (1)

The enforcement action we took:

We issued a warning notice telling the provider to take action to address the issued identified at our inspection.