Edgehill Care Home Limited

Edgehill Care Home

Inspection report

Buttermere
Liden
Swindon
Wiltshire
SN3 6LF

Tel: 08000121247
Website: www.agincare.com/care-homes/wiltshire/edgehill-care-home-swindon

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Edgehill Care Home is a residential care home providing personal and nursing care to 53 people aged 65 and over at the time of the inspection.

Edgehill Care Home can accommodate up to 60 people in one building which is on one floor. The service supports people living with dementia.

People's experience of using this service and what we found
Care records were not always fully completed. Risks to people were not always assessed and managed. Medicines were not always managed in line with good practice guidance and the provider's medicine policy.

Whilst some improvements had been made since the last inspection in relation to governance and oversight, systems were still not always effective in identifying and addressing quality concerns.

People were positive about living at Edgehill Care Home and told us they felt safe. They were supported by sufficient staff who were knowledgeable about their needs and had time to spend with them.

There were effective infection prevention and control systems in place to ensure the risk of infection was managed.

Everyone we spoke with was positive about the new home manager and complimentary in how hard the home manager and staff had worked during the COVID-19 pandemic to keep people and staff safe.

Relatives told us they had regular contact with the service throughout the COVID-19 pandemic and they felt confident to raise any concerns.

There was an open culture and staff were complimentary about the improved staff morale that had been achieved with the support of the home manager.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 1 January 2020) and there were multiple breaches of regulation. We issued warning notices asking the provider to ensure they met the regulations by a specified date. This service has been rated requires improvement for two consecutive inspections and was rated inadequate at the inspection carried out in March 2019.

Why we inspected

We undertook this focused inspection to check whether the Warning Notice we previously served in relation to Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. This report only covers our findings in relation to the key questions Safe and Well-led which contained the previous breaches.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained the same as the last inspection, requires improvement. This includes the findings at this inspection.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the safe management of medicines and the effectiveness of systems to monitor the quality and safety of the service at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. We will work with the local authority to monitor progress. If we receive any concerning information we may inspect sooner.

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 always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Edgehill Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted as part of our Thematic Review of infection control and prevention in care homes.

This was a focused inspection to check whether the provider had met the requirements of the Warning Notices in relation to Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inspection team
The inspection activity was completed by three inspectors, a pharmacist specialist advisor and an Expert by Experience (ExE). An EXE is a person who has personal experience of using or caring for someone who uses this type of care service.

Edgehill is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
We gave the home manager one days' notice of the inspection as we needed to check if anyone at the service had Covid-19 symptoms. The management confirmed there was no one at the service with symptoms or a positive test result for Covid-19. The site visit took place on 12 August 2020.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We spoke with the provider and

requested a range of documentation relating to the management of the service. We looked at six people's care records. The ExE spoke with six relatives by telephone and an inspector spoke with 10 staff, which included members of the care team, a medicines officer, a member of the housekeeping team and the maintenance person.

During the inspection
We spoke with four people who used the service about their experience of the care provided and a visiting health professional. We spoke with the home manager, a care manager and two medicine officers.

We reviewed a range of records. This included two staff files and medicines records. Some records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the home manager to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely; Assessing risk, safety monitoring and management.

At our last inspection, the provider had failed to ensure that medicines were managed safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice.

At this inspection we found that whilst some improvements had been made the provider had not met all the requirements of the warning notice issued following the last inspection and were still in breach of regulation 12.

- The provider did not ensure medicines were managed safely. One person was prescribed a medicine to be administered in an emergency situation. This medicine was out of date.
- Risks to people were not always assessed and managed. One person was diagnosed with a specific condition. There was no risk assessment to determine how the condition would be managed and staff were not clear of the action to take in relation to the person's condition.

We found no evidence that people had been harmed, however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed to ensure there were systems in place to ensure risks to people were effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvements had not been made and the provider is still in breach of Regulation 17

- Medicine records were not always fully and accurately completed in line with national guidance and the provider's medicine policy. Handwritten entries on medicine administration records (MAR) did not always contain accurate information and were not always signed by two staff as required.
- Information relating to people's allergies was not always consistent on all records.
- People's care plans did not always contain consistent information in relation to how risks were managed. One person was at risk of pressure damage. The care plan gave staff conflicting information relating to the

support the person needed to manage this risk.
● Information was not always available to staff and care plans were not always completed. One person who had recently moved into the service did not have a fully completed care plan in place. The person had several diagnosed conditions. There were no risk assessments or care plans identifying how those risks should be managed. This was not in line with the provider's admission policy.

We found no evidence that people had been harmed, however, systems were either not in place or robust enough to ensure risks were effectively assessed, monitored and mitigated. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People and relatives told us people were safe in the service. One person said, "I am very safe and well looked after. A relative told us, "I believe (person) and all the residents are safe, I have no concerns at all. We couldn't be happier for (person), very settled and well looked after".
● The provider had systems and processes in place to ensure all concerns were reported and investigated.
● Staff had completed training and had a clear understanding of the action to take in the event of any safeguarding concerns.

Staffing and recruitment
● The provider had safe recruitment processes in place to ensure they recruited appropriate staff to work in the service.
● People told us there were enough staff. One person said, "Plenty of staff. They always answer the bells". People gave examples of staff having time to take them out and organise a range of activities to keep them engaged.
● Throughout the inspection staff were attentive and had time to speak with people.

Preventing and controlling infection
● Staff and management had a clear understanding of the required COVID-19 infection control precautions and followed current guidance.
● There was enough personal protective equipment (PPE) in stock. Staff wore PPE in line with current guidance.
● Staff had access to guidance and training on infection control to ensure safe working practices.
● The service was clean and free from malodours. There were cleaning schedules in place to ensure all areas of the service were kept clean.

Learning lessons when things go wrong
● The provider had systems in place to monitor accidents and incidents and look for ways to improve the service and reduce the risk of further occurrences.
● An audit of all accidents and incidents identified areas for improvement and actions needed as a result of the audit.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection, the provider had failed to ensure there were effective systems in place to assess, monitor and improve the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection sufficient improvement had not been made and the provider was still in breach of Regulation 17.

● Audits carried out had identified some issues found during the inspection. However, action had not been taken in a timely manner to address these issues. A medicines audit completed by an external agency had identified some out of date medicine and an action recommended to address this concern. This action had not been completed.
● Internal medicines audits had not been completed against the providers medicine policy and had not identified other issues found.
● Care plan audits had not identified the issues found relating to the completeness and accuracy of risk assessments and care plans.
● Where audits had identified issues action plans did not always identify when actions needed to be completed and who was responsible for the completion of actions.

We found no evidence that people had been harmed, however, systems were either not in place or robust enough to ensure effective assessment, monitoring and improvement of the quality and safety of the service. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong.
● A new home manager had been appointed since the last inspection and they had applied to become the registered manager with CQC. The home manager promoted a person-centred culture that put people at the centre of all the service did. It was clear, throughout the inspection, that the home manager was known by everyone and was approachable.

● People and relatives were extremely positive about the home manager and the positive impact they had on the service. A relative told us "(Home manager) is smashing, so helpful and so kind, when (person) first went to live there I was quite upset, and (home manager) was very supportive at helping me and (relative) adjust. I think she is very intuitive and caring".
● Relatives told us the home manager was open and honest and always contacted them if there were concerns. One relative told us, "(Person) has had a couple of falls which is to be expected as balance isn't too good. The home have contacted me straight away and looked after (person) appropriately.
● Staff were equally confident in the home manager. One member of staff told us, "(Home manager) is lovely and this is a big job. She is very approachable. Things get done now more quickly if there's a problem".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were engaged in the service. There were many examples of changes made following suggestions made by people. One person told us how a gardening club had been started after they had shown an interest in the garden.
● Relatives told us they had regular contact with the home manager and prior to the Covid-19 pandemic they had regular meetings with directors where they had the opportunity to share ideas and voice concerns.

● The provider had ensured regular engagement with staff throughout the pandemic. This included visits to the service (outside) and regular video and email messages. Staff told us they felt valued and listened to. One member of staff said, "Yes, I do feel involved in the running of this service".

Working in partnership with others
● The service worked closely with commissioners and health professionals supporting people living at the service. One visiting health professional told us the service referred people appropriately and felt the service was well-run.

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 The provider had failed to implement effective systems to ensure the safety of people using the service.

The enforcement action we took:

We served a notice of proposal requiring the provider to submit monthly reports relating to the monitoring of medicines and care plans.