Edge View Homes Limited

Edgeview Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection visit took place on the 28 March 2018 and was unannounced.

Edgeview is a nursing home. People in care homes receive accommodation and 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. Edgeview is registered to accommodate 24 people in three buildings. At the time of our inspection 24 people were using the service. Edgeview accommodates people in three buildings. The main building has three floors, two communal living rooms and a large communal dining area. There is a separate building which is an activities room. There is also a bungalow where three people live and a stable for a further three people. All areas are accessible from the main building. Some of the people living at Edgeview have learning disabilities or mental health needs. The care service has not been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. This was as the service was created a number of years before this guidance was published. These values should include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service are not always supported or to live as ordinary a life as any citizen. Registering the Right Support CQC policy.

There is a registered manager in place. 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.

Following the last inspection, we asked the provider to make improvements to how people's dignity was upheld, to consider how people made choices and to ensure that action was taken to protect people from potential harm. We found the provider had not made the necessary improvements.

Risks to people were not fully considered and when incidents occurred action was not always taken. When people had behaviours that may challenge themselves and others all areas of risk had not been considered for these people. People were not safe as poor moving and handling was observed and the information in people's care plans was not always followed. People did not receive their planned care hours and we could not always be assured there were staff available for people.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice. When people had DoLS authorisations in place the conditions of these were not being met. Staff received training however we could not be assured this enabled people to receive the support they needed. Although there were procedures in place and staff demonstrated an understanding we could not be sure all incidents were appropriately investigated or considered as safeguarding.

We found people were not always supported in a dignified way. People's choices were not considered and

they were not always encouraged to be independent. Staff did not always positively interact with people and they were unsure how to support some people. People did not always receive care that was responsive to their needs. Staff did not always have the most relevant up to date information available to offer support.

The systems the provider had in place were not always effective in identifying areas of concern. Records were not always stored securely and annual feedback had not been obtained from people and relatives. There was a lack of leadership within the home.

There was an activity room and people could access this, people were also offered the opportunity to go out. There were infection control procedures in place and these were followed. When people needed support from other health professional referrals were made. People enjoyed the food. Medicines were stored in a safe way. Staff felt listened to and knew who the registered manager was. We were notified as required about significant events within the home.

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.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

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.
Risks to people were not always considered or action taken when needed. Staff were not always available and we could not be assured people always received their assessed levels of support. Staff knew what constituted abuse however we could not be sure all incidents were considered. There were infection control procedures in the home and these were followed. Medicines were stored in a safe way. There were systems in place to ensure staffs suitability to work within the home.

Is the service effective?

Requires Improvement

The service was not always effective.
When needed people's capacity had not been assessed and decisions made in their best interests. Conditions of DoLS were not being met. We could not be sure the training staff received enabled them to support people as needed. People enjoyed the food and referrals were made to health professionals when needed.

Is the service caring?

Inadequate

The service was not caring.
People were not always treated in a dignified way. When people made choices this was not always recognised. People were not always encouraged to be independent. Staff did not always interact with people. People were encouraged to maintain relationships that were important to them.

Is the service responsive?

Inadequate

The service was not responsive.
People did not receive individualised care that was responsive to their needs. People's preferences were not always considered and people were not in control of their lives. Some people had the opportunity to participate in activities they enjoyed for others more stimulation was required. Complaints were responded to in line with the provider procedure and no one was receiving end of life care.

Is the service well-led?

Inadequate

The service was not well led.
The systems in place were not always effective in driving improvements within the service. The provider had not completed their annual survey so we were unable to review this. Records were not always stored securely. There was not always effective leadership within the home. Staff felt listened to and the registered manager understood their responsibility around registration with us.

Edgeview Nursing 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, and to provide a rating for the service under the Care Act 2014.

This inspection visit took place on the 28 March 2018 and was unannounced. The inspection visit was carried out by two inspectors.

The inspection was informed by feedback from members of the public and whistle blowing information we had received. They pointed out some concerns about the care people received within the home and the staffing levels.

We also checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service. We reviewed the last quality monitoring report completed by the local authority. We used information the provider sent us in the 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. We used all of this information to formulate our inspection plan.

After the inspection we requested a list of people's contracted hours and which local authority they received funding from, this was provided to us. The provider also sent us some additional information, including rotas and care plans that they requested we reviewed following our feedback. We reviewed this information prior to issuing the draft report.

We spent time observing care and support in the communal areas. We observed how staff interacted with people who used the service. We spoke with five people who used the service. We also spoke with seven members of care staff, a senior member of staff, a student nurse and the registered nurse. We spoke with a member of the kitchen staff, the operations manager and the registered manager. We did this to gain people's views about the care and to check that standards of care were being met. The provider attended the meeting at the end of our inspection where we offered high level feedback.

We looked at the care records for nine people. We checked that the care they received matched the information in their records. We also looked at records relating to the management of the service, including audits carried out within the home, staff rosters and actions plan that were in place. We also looked at staff files so we were able to review the provider's recruitment process.

Inadequate

Is the service safe?

Our findings

When people had behaviours that may challenge themselves and others there was not always guidance for staff to follow. For some people all 'risk behaviours' had not been considered. For example, we saw documented that a person had demonstrated a potential act of violence towards a staff member. Although the provider had recorded why this may have occurred, there was no risk assessment in place identifying this was a potential risk or any action taken to reduce the risk of this reoccurring. This meant action was not always taken to ensure staff were safe, and were aware of potential risks they may be exposed to. We spoke with the registered manager who confirmed this was not in place they told us that they had considered the risk of harm and this was reduced by the person receiving one to one support. They also told us this behaviour was not something the person usually did. This demonstrated that risk or potential risk had not always been fully considered.

For another person we saw they appeared unkempt. Staff told us and records confirmed that this person would often refuse support with personal care from staff. One staff member said, "It's their choice not to". Furthermore, during our inspection the person remained half undressed and half in their night clothes. For long periods of our inspection they were outside. A staff member said, "It's usual for this person to wear their night clothes all day". We spoke with the registered manager who told us, "It is their choice; they sit outside all weathers including snow or rain. We have provided them with a door bell to ring when they want to come back in". There was insufficient guidance for staff to follow to offer support during these instances. We spoke with the person about this who told us, "I haven't settled in I can't see why I am here. I am constantly in the nude my clothes go missing". After our inspection we raised our concerns with the local authority safeguarding team for them to consider.

We saw that another person was transferred between their wheelchair to the sofa on six separate times. One staff did this by holding the person by both of their hands, standing in front of them and pulling them up to a standing position. This practice was unsafe and does not meet the guidance from the health and safety executive for moving and handling in care homes. We looked at records for this person and the mobility care plan stated, 'two staff are to be present and stand either side of me'. We spoke with staff about this. The staff member who we had observed transferring the person told us, "That is how I was shown to do it and how other staff do it. I hold [person's] hands and pull them up I don't lift them, it only takes one staff member". Another member of staff said, "I think it has to be two staff, we tried to hoist them and they didn't like it so it's better with two". On one occasion when we observed the person being transferred, another staff member commented, "They shouldn't be doing it like that they have a transfer board". We did not see this during our inspection. The care plan had not been reviewed since July 2017. The registered manager confirmed to us this person needed two staff to transfer safely. This meant this person was not transferred in a safe way in line with their care plan.

Risks to people were not always managed in a safe way. We saw documented that two people had a history of developing sore skin. For one person it was documented they had a pressure sore in February 2018. During our inspection although this person was seated on a pressure cushion we did not see they were offered a change of position as required and they slept for long periods of time. We asked staff how they

offered support to this person they told us, "They had one pressure sore but it's cleared up now. When the sores are bad we try and encourage them to stand". We checked records for this person. There were no individual detailed plans in relation to pressure care in place. We saw documented in the 'keeping well' support plan; 'Staff to stand me every hour to relieve pressure from my bottom'. This had not been reviewed since the person last had a pressure area. We observed this did not take place and staff confirmed this to us. The documentation we reviewed and that the provider sent to us after our inspection confirmed that the person had a change of position, when offered personal care. This happened at 09:45, 14:00 and 19:19 during the day of our inspection. This meant this person did not receive pressure relief as required and were placed at an increased risk of developing sore skin. For the second person we did not see any guidance in place. This meant staff did not always have the information available to offer support to people when they were at risk of developing sore skin.

When people were prescribed creams we could not be sure how these were administered or recorded. A staff member told us, "We fetch the cream; they are kept in the nurses office. We collect them for personal care in the morning. There is a body map in place where the cream is administered". The staff member and records confirmed they did not sign when this cream had been administered. The nurse confirmed they signed for it. Therefore the nurse had signed for the creams even though they had not seen it being administered.

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

During the morning of our inspection we observed that an incident occurred. A staff member who was allocated to work on a one to one with a person left them independently in their room for over 15 minutes to offer support to another person who had 'shared hours'. We were unsure who should be offering support to this person and if being on a one to one meant this person could be left independently. There was no information in people's records confirming this. A member of staff told us, "We can leave them, they will be okay by themselves for a few minutes". However, another staff member said, "When people are on one to ones we must remain with them all the times due to the risks". Both staff we spoke with were unsure why this person was receiving one to one support. This meant we could not be sure staff offered a consistent approach and people received their support as needed. After the incident we discussed this with the registered manager. They told us that the person was at risk of falls if left alone. They said, "If you leave them alone they will try and stand and start fidgeting that's why we have to have someone with them all the time". As this person had been left independently so the staff could offer support to another person, they were therefore placed at risk. Following this information we could not be sure there were enough staff to offer support to people.

Prior to our inspection we had received information of concern from whistle blowers about staffing levels within the home. During our inspection we spoke with staff about this. One staff member said, "As there are quite a few people on one to one support we need a lot of staff. I don't think there are enough staff for the people who don't have a one to one. At times those people also need one to one support, so for example at mealtimes they need individual support and this isn't taken into account, they have to wait". Another staff member said, "Staff get moved quite a bit and it leaves us short. It doesn't happen all the time but enough to cause us problems. We need more staff".

We were told and the rota confirmed that 17 care staff were needed to deliver people's assessed care hours. This included both one to one and two to one support and other people needed a ratio of one staff to three people. During the afternoon two care staff were sent to another home to offer support. Another member of care staff on the rota had recently started working within the home and was completing their induction.

After lunch two people who did not receive one to one support were supported out of the home on a one to one basis. That meant that there were 14 care staff available within the home, out of these care staff 12 were allocated to offer one to one support to people. This meant there were ten people in the home who had two care staff available to offer them support. These ten people were all allocated a ratio of one staff to three people. As there were only two staff available for this ten people this meant they did not receive the agreed level of support. Furthermore one of the care staff who was available to offer support to these people was also allocated to deliver one to one support to a person between 2:30pm-4:00pm, meaning only one care staff was available during this time. We discussed this with the registered manager who told us that the two nurses and the student nurse were also available and had been allocated to offer support to these people. However we observed that the nurses were completing other tasks. For example, one nurse remained in the office during this time along with the student nurse. This meant there were not enough staff available to offer support to people in line with the providers assessed ratios for providing safe care.

Furthermore we observed that the activity coordinator was supporting someone who was on a one to one. We spoke with the member of staff who told us, "I am supporting the person on one to one as well as leading the activities for the other people which isn't ideal. Sometimes I am supporting someone on one to one basis plus two or three non-one to one people. It happened on Monday". We asked them who was providing the one to one support they said, "Me but I also have to coordinate in here".

This is a breach of Regulation 18(1) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Staff knew what constituted abuse and what to do if they suspected someone was being abused. A member of staff said, "It's keeping all clients safe and reporting any kind of abuse". The staff member went on to confirm they had received recent training and they knew how to report any concerns. Procedures were in place to ensure any concerns about people's safety were reported appropriately to the local authority. We saw that the provider had raised some safeguarding concern's however we could not be assured all concerns were internally investigated or considered as safeguarding's. For example we saw body maps in people's files stating that bruising and injuries had occurred. We checked records and although the nurse had checked some of the injuries to see if further intervention was required, there was no follow up or action taken to find out how these had occurred. Some of these were recorded as unwitnessed. This meant we could be sure all incidents had been investigated and considered as possible safeguarding concerns.

We saw an incident occur during our inspection. The incident was not documented in any notes or handover that we reviewed. When we spoke with some staff about this they were unaware this incident had occurred. The registered manager could not provide an explanation as to why this information hadn't been shared with the staff team. This meant we could not be sure that all incidents were recorded and shared with staff so that they could monitor the situation and take action if necessary. When incidents occurred or things went wrong within the home there were no current systems in place to demonstrate improvements could be made and lessons learnt. We spoke with the registered manager and asked them to provide any evidence of this to us; we did not receive this during or after our inspection.

We saw staff administering medicines to people. The staff spent time with people explaining what the medicine was for. When people had medicines that were on an 'as required' basis we saw this was offered to them first. We saw there was guidance known as PRN protocols available for staff to ensure people had these medicines when needed. There were effective systems in place to store medicines to ensure people were safe from the risks associated to them.

We saw there were infection control procedures in place and followed within the home. Staff told us and we

saw protective equipment including aprons and gloves were used within the home. One staff member said, "We have enough available". We also saw the provider had been rated as five stars by the food standards agency and the cook confirmed to us they had received the relevant training needed to work within the kitchen environment. The food standards agency is responsible for protecting public health in relation to food.

We looked at six recruitment files and saw pre-employment checks were completed before staff could start working in the home. We saw there were systems in place to ensure nurses had the correct registration and this was up to date. This demonstrated the provider completed checks to ensure the staff were suitable to work with people in their homes.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so or 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. 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 to see if the principles of the MCA were followed. We saw when needed capacity assessments were not in place. We looked at four files for people who staff told us lacked capacity and no assessments had been completed. There was also no evidence that decisions were made in people's best interests. Both staff and the registered manager did not demonstrate an understanding of this. The registered manager told said, "We wouldn't do capacity assessments as we don't know how to do these, we have asked the community team". This meant the principles of MCA were not followed.

People were not supported in the least restricted way. For example, one person received one to one support for 13 hours per day. During our inspection we observed that this person was in their bedroom watching television. The staff member providing this one to one support was also in the person's bedroom sitting on a chair observing this person. The person was relaxed and calm. On the four times we went into this person's room no interactions were taking place between the staff member and the person. We asked the staff member what they were observing they told us, "To make sure the person was safe". They could not provide any more detail. We checked the records for this person and there was no clear guidance in place for staff to follow. We asked the registered manager why this person needed one to one support they told us it was due to their history of behaviours and risk of falls. We checked this person's records and could not see when they had last fallen or displayed a behaviour that may challenge. We asked if the staff member needed to be in the room observing the person the whole time and they said this wasn't something they had considered. They confirmed that other lesser restrictive options, such as sensor mats had not been considered. For other people who were on one to one support we found the same concerns. We observed for another person every time they stood up the staff member followed them. Again we asked staff why this was and they told us, "It's because they are on a one to one".

We also found that all the bedroom doors had sensor alarms on; it was unclear why these were in place. We were told that when people were in their rooms these were switched on. There were no capacity assessments or best interest decisions in place relating to this and it was unclear when people had capacity if they had consented to these. This meant that their freedom to leave their room was potentially restricted.

When people had DoLS approvals in place the conditions of these were not met. For one person a DoLS had been approved in November 2017. A condition on this was that eight individual capacity assessments were completed for this person. We saw and the registered manager confirmed these had not been completed meaning this condition had not been met. When other people had restrictions placed upon them such as

constant supervision or restricted access to areas of their home these had not been considered and applications had not been made.

This is a breach of Regulation 11 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Staff received an induction and training to fulfil their role. Although staff told us the training they received helped them support people, we could not be assured how effective the training was. For example, staff told us they had MCA and DoLS training however some staff did not demonstrate to us an understanding in this area. One staff member said, "I know what DoLS stands for but I don't know who has one and what it means for people". Staff also told us they had received moving and handling training however we observed unsafe practices during our inspection. A further staff member was completing their induction, although they told us they had received training they were unable to tell us about risks to people meaning they did not have all the information available to offer support to people. We spoke with the operations manager who told us since our last inspection staff had undertaken a lot of training in relation to concerns we found with how people were treated, they provided us with evidence of this training. As at this inspection we found the same concerns we could not be sure this training had been effective. This meant we could not be sure the training staff received enabled them to support people as needed or if staff had the knowledge and were competent to deliver the necessary support to people.

As people could not always access areas of their home there was limited space for people to use, this had not been considered by the provider. Communal areas were all decorated with bare white walls and all doors were identical. There were some paintings in the communal dining area but we could not be assured people had not been able to personalise communal spaces. People's bedrooms had been adapted with their own belongings and people confirmed they were happy with this.

People enjoyed the food. One person said, "I liked that, I enjoy my roast dinners". Another person said, "I go out for fish and chips later, that's my favourite but I still enjoy my dinner before I go". We saw that people were offered drinks throughout the day. When people needed their food prepared for them in a certain way for example, liquidised, we saw this was provided for them. People's dietary requirements were documented in their care files.

We saw when needed people had access to healthcare professionals. For example, we saw referrals had been made to a range of professionals including speech and language therapists and occupational therapists. When recommendations had been made by these professionals we saw people were supported in line with these. This demonstrated when needed people had access to healthcare professionals.

Inadequate

Is the service caring?

Our findings

At our last inspection we found people were not always supported in a dignified way and staff were interacting with each other rather than people they were supporting. Choices people made were not always considered. At this inspection we found that improvements had not been made.

We saw a staff member in the communal area feel a person's trousers to check if they required support with personal care. We heard them say to another staff member, "[Person] needs changing where shall I do it". We then observed a staff member say to another staff member who was across the room from them, "Shall we check [person] before we go out". The staff then assisted the person to the bathroom, to offer support with personal care. We also saw that a staff member brought soiled clothes into the dining room as they were offering support to the person they put them on the floor. The clothes were protected in the correct bags. However the staff member called out to another staff member to remove them. This meant people were not always treated in a dignified way.

People's independence was not promoted in the main building. At meals times we saw pre-prepared meals were passed to people through a hatch from the kitchen. We saw gravy was put on meals for people; toast was buttered when people had requested this and milk had been put on cereals for people. People were not encouraged or supported to do this for themselves. People did not have access to the kitchen and the door was locked. Staff confirmed to us people were not involved with preparing their own meals or able to access their kitchen independently. One person told us, "When I want a drink I have to go to the hatch or ask the staff." During mealtimes a trolley and bowl had been brought into the dining area so that people could scrape their plates when they had finished. Some people were able to do this independently whereas for other people staff did this for them while they remained at the table. This demonstrated that people were not always encouraged or empowered to complete tasks for themselves.

This is a breach of Regulation 10 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

When people made choices these were not always recognised or considered by staff. Some people living at Edgeview did not verbally communicate; they made choices by using body language and the actions they displayed. We saw that a staff member tried to stand a person to transfer them from their wheelchair to the sofa. We saw that the person pushed them away. The staff member then went and got a different member of staff who transferred this person. Both staff had not considered the action the person had displayed or the choices they made. The person was transferred back to their wheelchair shortly after this as they were unsettled.

Staff did not always interact with people. When people were supported on a one to one basis it was often unclear which staff member was supporting them as they did not interact verbally or physically with the person. We saw that one person was being supported on a one to one and this staff member was changed every hour. During one of these periods we did not see any interactions between the person and member of staff. We saw that staff sat with people in their bedrooms and other areas of the home and offered no

interaction with the person they were supporting.

We received mixed views about the staff that supported people. One person said, "Some of the carers are lazy and rude". Another person told us, "I like the staff". Other people were unable to tell us their views. We saw some positive interactions between some staff and people. For example, one person lay on the sofa and staff stroked the person's head to help them to relax. People were encouraged to maintain relationships that were important to them and we saw some people had met up with families in their homes or local places such as cafes.

Inadequate

Is the service responsive?

Our findings

People's individual preferences were not always considered and they were not empowered to be in control of their lives. People were not always involved with daily routines and were not offered the opportunity to develop their skills. One person told us, "I can't see why I am here; We all sit around all day doing nothing. I don't see what the future plan is or what I am doing here". Another person told us they had special dietary requirements. They told us that although their diet was catered for this was often limited and they were offered the same meals. Staff and records confirmed this to us. We spoke with the registered manager about this who said, "They don't believe that the meals we have prepared are suitable for them". Nothing had been put in place to ensure the person was reassured by this. The person was not given the opportunity to be involved with the preparing of their meals and not offered any reassurances over this. Furthermore the person records did not reflect their current dietary needs, they appeared to be losing weight and no monitoring of this was taking place.

When people chose to smoke some people's cigarettes were stored in communal areas and locked away from the person. One person's care plan stated 'I smoke cigarettes and collect 12 from the office each morning'. Other people's cigarettes were also stored in the office. We spoke with staff about this. One staff member said, "I don't know why we do this we always have". Another staff member said, "We can't let people have cigarettes as they may burn themselves and some would want to smoke all day". There were no capacity or risks assessments in place relating to this. We asked one person how they felt about this they said, "I don't know the staff have always looked after them, I like smoking". When we discussed this with the registered manager they told us that some of the people's cigarettes were no longer stored in the office and it was due to risks to people and for insurance purposes. They confirmed this had not been discussed with people and that no risk assessments were in place.

During our inspection we saw that when people were not in their bedrooms the doors in the main building were locked. We also observed that the kitchen and bathrooms were locked too. The registered manager told us people had keys to their room if they chose to. We looked at one person records which stated, 'I have a key to my room'. We discussed this with the person who said, "I don't have a key, I asked for a key which hasn't come". The registered manager told us it was as they were unable to use a key; they had not considered any alternatives for this person.

People's care was not always reviewed to reflect their current needs. We saw documented that one person required a minimum amount of fluid per day due to a health concern. We checked records and saw no recording of the amount of fluid they have was being completed. Staff confirmed this. We spoke with the registered manager who told us this person no longer required their fluid intake to be monitored and confirmed the care plan needed updating. We did not see any evidence in the person's file to support that they no longer needed their fluids monitored. We found the same concerns for other people. When people had behaviour management plans and physical restraint procedures in place although these had been reviewed people's current needs were not always fully considered. For example, some people who required physical restraint had not displayed the 'risk behaviours' for many years and other people's mobility had changed and this had not been reflected. There was no clear guidance as to when staff would physically

restrain people and the plan stated, 'only as a last resort'. This meant we could not be assured all information was accurate and up to date and that restraint would not be used inappropriately.

For a person who received one to one support the staff changed on an hourly basis. The registered manager told us this was partly as the person liked a variety of staff and due to the intense support this person may need. It was not considered how this may impact on other people. For example, one person ate their lunch with a member of staff who they were receiving one to one support from. Shortly after this there was a change of staff for this person. As the staff member had not eaten their lunch this person then had to sit with the other staff member and observe them eating their lunch. We also observed that during the morning the same person had requested to go out for a drink. They had not been able to go as their one to one support staff had changed before they had time to go. This meant that this person did not have care that was planned to meet their needs.

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

People who were living with dementia or did not verbally communicate were not always provided with the support they required. For example, people were asked what they would like to eat before the mealtime but there were no pictures or prompts used to support these people to make their choices. Staff confirmed they did not use pictures or prompts at mealtimes. The registered manager confirmed they were aware of accessible information standards (AIS) however we could not see how this was used within the home. AIS were introduced by the government in 2016, it is a legal requirement for all providers of NHS and publically funded care provision to make sure that people with a disability of sensory loss are given information in a way they can understand. Communication care plans were in place for some people detailing how to use photographs or pictures to offer support to people. During our inspection we did not see these communication aids were used. This meant people were not always enabled to communicate in their preferred format.

People were not always supported with relationships. We saw documented for one person, 'I get anxious over wanting a relationship. Staff have spoken to me about this as I don't know what a proper relationship is'. The person talked to us about this. However, there was no follow up or evidence as to how the person had been supported with this.

Some people were given the opportunity to participate in activities they enjoyed. One person said, "I like going to the shops". There was an activity coordinator working at the home and an activity room where people could go. We saw a variety of activities taking place during our inspection and some people had the opportunity to go out. In the activity room we saw displayed pictures of activities people had participated in and art work they had completed. There was an activity planner in place which gave details about what was going on in the home for people to participate in. This showed us people had the opportunity to participate in activities they enjoyed. When people did not access the activity room there was limited activities available for people. When people did receive one to one support staff did not always engage with the person and there were not always plans in place about how this time should be spent. We saw some people completed puzzles and listened to music in communal areas, however for other people they slept for long periods. We reviewed activity records documentation included, 'I have spent time this morning playing with my top' and 'I have spent the morning moving from the table to the sofa'. This meant for some people the stimulation they received was limited.

The provider had a procedure in place to manage complaints. When complaints had been made the provider had responded to these in line with their procedures, asking the complainant if they were happy

with the outcome.

At this time the provider was not supporting people with end of life care, therefore we have not reported on this at this time.

Inadequate

Is the service well-led?

Our findings

At our last inspection the provider had an on going safeguarding concern and had not taken the necessary action to ensure people were protected from potential harm. At this inspection we found improvements had been made however further concerns were identified.

There were some systems in place to identify when improvements were needed within the home. For example we saw that the provider was completing an audit on health and safety and infection control. When areas of improvement were needed action was taken. However for other areas we could be not assured the systems in place were effective. The registered manager and provider told us they completed a medicines audit when we reviewed this we saw this was stock check of the amount of tablets people had in the home. No other areas were being considered. When we saw medicines had not been signed for there was no effective system in place to identify this. For example, the error had been identified as a member of staff had seen this and reported it to the manager. Therefore the systems in place to manage medicines were not robust to ensure concerns would always be identified. For other areas of concern we identified during our inspection for example, care plans being out of date and not reflecting people's needs there were no systems or monitoring in place to identify this. The provider also completed a monthly Regulation 17 audit. This was an audit that was completed by the provider to cover areas of how the home was governed. This identified training staff needed, staff supervisions, staffing levels and incident and accident reporting. Where areas of improvement had been identified there was no action plan in place and we could not see how the provider was using this information to drive improvements. For example, only 59% of staff had received moving and handling training and only 21 staff had received supervision during 2018. The provider told us they would send us this action plan after the inspection; however at the time of writing this draft report we have not received this.

As noted in 'Safe', when incidents had occurred we did not see action was taken to mitigate further risks. For example, the provider completed critical incident forms. When these had occurred we could not always see what action the provider had taken to reduce the risk of reoccurrence, care plans and risks assessments were not always reviewed to identify these concerns and changes. The information had been collated together in a graph to show the amount of incidents that occurred however we could not see how the provider was using this information to make changes to the home or to the care people received. This demonstrated that when action was needed to reduce future risks this was not always taken.

An annual survey was completed by people and relatives. We saw the 2016 survey had been completed however the 2017 should have been sent out at the end of 2017. The operations manager confirmed this as yet had not been completed therefore we could not review this information.

We could not be sure records were stored securely. People's care files were stored on a shelf on a desk that was in the communal dining room. There were periods of time when no staff were present and people's personal information was accessible. This meant people's rights to confidentiality were not always maintained.

This is a breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

There is a registered manager in post. Although staff felt listened to and supported by the registered manager we could not be assured there was effective leadership in the home. Following a previous safeguarding concern and our last inspection we were told and saw that a desk area had been put into the communal area so observations could take place. We were told by the registered manager on arrival that the nurse and senior were in charge of managing the shift. During our inspection concerns we saw with people not being treated in a dignified way and poor moving and handling techniques all took place in the communal area. During this time the nurse or senior did not identify the concern we saw or take action. As there was only one nurse on duty during the morning of our inspection they were often completing other tasks and unavailable within communal areas to deliver effective leadership. It was also allocated on the rota that two staff were needed to work at a different home on the afternoon of our inspection, no one had considered how this had impacted on the people living at Edgeview and that there would not be enough staff available for people.

Staff told us they felt supported by registered manager one staff member said, "We have team meetings and the opportunity to raise concerns. I think she listens to us our concerns, with staffing concerns that is out of their hands". Another staff member told us, "The manager is approachable we all get on well". We saw that one to one supervisions and yearly appraisals for staff were taking place. Staff knew about the whistle blowing process. Whistle blowing is the process for raising concerns about poor practices. One member of staff said, "We have revisited this, I know what I would have to do". We saw there was a whistle blowing procedure in place. This showed us that staff were happy to raise concerns if needed.

The manager understood their responsibility around registration with us and notified us of significant events within the home. The provider was displaying their previous rating within the home in line with our requirements. The home worked alongside other agencies, we saw that a student nurse was completing a placement in the home and was being mentored by the registered nurse.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive individualised care that was responsive to their needs. People's preferences were not always considered and people were not in control of their lives.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated in a dignified way. People were not always encouraged to be independent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent When needed people's capacity had not been assessed and decisions made in their best interests. Conditions of DoLS were not being met. And people were not always supported in the least restrictive way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always considered or action taken when needed.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place were not always effective in driving improvements within the service. The provider had not completed their annual survey so we were unable to review this. Records were not always stored securely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not always available and we could not be assured people always received their assessed levels of support.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent When needed people's capacity had not been assessed and decisions made in their best interests. Conditions of DoLS were not being met. And people were not always supported in the least restrictive way.

The enforcement action we took:

We imposed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always considered or action taken when needed

The enforcement action we took:

We imposed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place were not always effective in driving improvements within the service. The provider had not completed their annual survey so we were unable to review this. Records were not always stored securely.

The enforcement action we took:

We imposed conditions on the providers registration.