Selwyn Care Limited

Edward House

Inspection report

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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
Edward House is a residential care home providing accommodation and personal care for up to 12 people with learning disabilities and autism. At the time of the inspection 12 people were living in the home.

The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes.
The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.
There were deliberately no identifying signs, intercom, cameras, industrial bins or anything else outside to indicate it was a care home. Staff were also discouraged from wearing anything that suggested they were care staff when coming and going with people.

People's experience of using this service and what we found
Risks to people had been assessed and support plans and emergency protocols were in place to guide staff in supporting people safely. However, incident, accident and seizure records had not been reviewed in a timely way to ensure care had been delivered safely and to ensure any new risks could be identified. Improvement was needed to ensure people with epilepsy were always supported safely. This included ensuring people always received their medicines as prescribed.

Other risks to people, including anxiety related behaviours were managed well and people benefited from a spacious homely environment that met their needs. People had enough staff to support them and had opportunities to go out.

Systems in place to monitor and improve the quality and safety of the service had not always been operated effectively to ensure people received a safe service. A lack of consistent strong leadership at Edward House had meant the need to embed provider governance systems, noted at our last inspection, had not been achieved.

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

Rating at last inspection
The last rating for this service was Good (report published 18 February 2020).

Why we inspected
We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about people's epilepsy management. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with the support provided to some people living with epilepsy, so we widened the scope of the inspection to become a focused inspection, which included the key questions of Safe and Well-led.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

Follow up
The service's overall rating has deteriorated to Requires Improvement. We will meet with the provider after this report is published, to discuss how they will make changes to ensure they improve their rating to at least good. We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. 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.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Edward House

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 so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector.

Service and service type
Edward House 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.

The service did not have a manager registered with the Care Quality Commission. The provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. Inspection activity started with visits to the care home on 1 and 5 October 2020 and continued with desk top activity which ended on 12 October 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included feedback from relatives. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we

inspected the service and made the judgements in this report.

During the inspection
We looked around the building and grounds. We spoke with one person who used the service about their experience of the care provided. We observed staff members while they were supporting people. We spoke with eight members of staff including the operations director, locality manager, service manager, registered manager of Matson House (supporting the service), a team leader and three support workers. We reviewed a range of records. This included two people's care records and medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including rotas and incident records were reviewed. We requested documents related to infection control and management of the service from the provider.

After our site visit
We continued to seek clarification from the locality manager and operations director to validate evidence found. We received and reviewed a selection of risk assessments, audits and policies relating to management of the service. We sought feedback from seven healthcare professionals, commissioners and three people's relatives. We received feedback from five healthcare professionals, a social worker and one person's relative.

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 Good. At this inspection this key question has deteriorated to Requires Improvement. 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.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong

- Risks to people had been assessed and support plans were in place to guide staff in how to support people safely. However, we found improvement was needed to ensure risks to people were managed consistently and in a timely manner.
- One person's emergency medicine protocol for tonic-clonic seizures was difficult to follow and had not been checked by health care professionals. Despite the person needing this medicine relatively frequently, our discussions with staff did not assure us that all staff knew when to give this medicine and when to call 999. There was no protocol in place for an emergency medicine prescribed for this person during a different type of seizure. The latter had no impact on the person as records showed they had not required this medicine since living at Edward House.
- Records of people's seizures occurring during August and September 2020 had not been reviewed to ensure staff had followed the guidance in place. While the majority of records we reviewed demonstrated good practice, we found two incidents where it was unclear if one person's emergency protocol had been followed. Not following an approved protocol could place the person at risk of harm. The provider investigated these incidents after our inspection to establish what had happened and to ensure any ongoing risks were addressed.
- One person's dose of epilepsy medicine had been increased during a hospital admission. Following their discharge to Edward House, action had not been taken to ensure the person received their increased dose in a timely manner. This may have placed the person at risk of harm.

The failure to do all that is reasonably practicable to mitigate risks and improper or unsafe management of people's medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Further improvements needed to medicines management had been identified by the provider in their September 2020 medicines audit and an action plan was in place to address these. This included improved consistency in recording use of medicines which required extra security and timely ordering of medicines.
- Medicines administration records (MAR) were audited to ensure they were accurate and complete, and where required had the signature of two staff members.
- People's medicines were stored safely and administered by staff who had been trained and assessed to be competent in medicines administration.
- Other risks, such as in relation to people's anxiety related behaviours, were managed safely. Positive behaviour support plans had been developed with people to manage their anxiety proactively.

● Safety checks on the environment had been completed. Emergency plans were in place and reviewed regularly.

Systems and processes to safeguard people from the risk of abuse;
● Staff were trained in safeguarding and knew how to recognise the signs of abuse. Staff knew how to report incidents and who to report them to. Staff were aware of the whistle blowing policy. This allows staff to raise concerns anonymously when they have concerns about anything they feel is not right.
● Most of the time safeguarding alerts had been raised appropriately and clear records were maintained. However, incident reports had not always been reviewed to determine whether they needed to be reported to external agencies and investigated in accordance with the provider's safeguarding policy.
● Following the inspection, the provider put new processes in place to ensure all new incident and daily records were checked by a manager or senior each day so they could be actioned without delay.

Preventing and controlling infection
● In May 2020 we undertook a review of how Edward House was managing the risks related to the Covid-19 pandemic. They provided us with a range of information which assured us they were managing infection control practices effectively and minimising the risk of infection.
● At this inspection the home was clean and smelled fresh. People were engaging in cleaning their own rooms with the support of staff and demonstrated their understanding of why good hygiene was important.
● Staff followed national guidance in relation to the Covid-19 pandemic such as wearing personal protective equipment (PPE) appropriately and maintaining enhanced cleaning routines.
● Information, in easy to read formats, was readily available for people about how to stay safe during the pandemic and general good hygiene practice.

Staffing and recruitment
● There were enough staff on duty to meet people's needs and wishes.
● People were supported by staff with the appropriate skills and experience. Staffing levels were provided in line with the support hours commissioned for people. Day-to-day staffing numbers were managed flexibly to respond to risks and facilitate planned events.
● Records showed staff had been recruited in a safe way and in line with the provider's policies and procedures.

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 has 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

- There had not been a registered manager at Edward House since November 2019. A registered manager from one of the provider's neighbouring services had been overseeing the service until the new manager started on 20 July 2020. The new manager was in their probationary period and had not applied to register with CQC. Their employment at Edward House ended after this inspection.
- The provider's quality assurance systems were not always operated effectively to ensure improvements needed to maintain safety of the service were actioned in a timely way. A provider audit on 7 July 2020 identified improvements were needed in some areas of medicines management and in the reporting, recording and review of incidents. The deadline for completion of improvement actions needed was set by the provider for 30 August 2020. However, this work had not been completed when we visited on 1 October 2020. This meant opportunities to immediately reduce risks to people, to identify trends and to learn from previous incidents had been missed.
- Information of concern had not always been used effectively to support the monitoring of risks and quality in the service. Despite concerns having been raised about the support one person received to manage their seizures, not all shortfalls we found in relation to epilepsy management had been identified by the provider. When the issues we found were brought to the provider's attention, immediate action was taken by them to mitigate risks to people.
- In the two-to-three weeks before our inspection, the provider had identified that the new manager had not completed all actions expected of them. Daily monitoring by senior management was carried out and an additional action plan was put in place. Managers from the provider's other local services were working to address a backlog of audits and incident reviews when we arrived to inspect. Time was needed before we could judge whether these actions would be effective in monitoring and improving the service people received.
- Staff told us they lacked confidence in the new manager's leadership and understanding of people's needs. Feedback to CQC from two external professionals echoed this. One professional said there had been no improvement in the service further to feedback on issues they had raised to the new manager.

The systems in place to monitor and improve the quality of the service had not always been operated effectively to maintain safety of the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Further to our feedback, immediate action was taken by the provider to ensure the systems in place to support people were safe. This included investigating two incidents where it was unclear if staff had followed an emergency protocol correctly, two potential safeguarding incidents and amendments to hospital passports to ensure known risks to people were clearly communicated.
● The previous inspection rating was displayed in the home and on the providers website, in line with our requirements.
● The service had notified CQC of significant incidents which is their legal responsibility. CQC monitors whether appropriate action has been taken to keep people safe through the notifications sent to us by providers.

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
● The provider understood their responsibilities to be open and transparent with people and their representatives when things go wrong.
● The provider had contacted relatives earlier in 2020 to inform them of a Covid-19 related incident and how this was being managed.

Working in partnership with others
● Staff worked openly with health and social care professionals including the community learning disability team, GP and social workers.
● The provider had worked with other agencies to ensure staff understood Covid-19 and what they needed to do to keep people stay safe.

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 12 HSCA RA Regulations 2014 Safe care and treatment The service had not done all that was reasonably practicable to mitigate risks to people and people's medicines had not always been managed safely. Regulation 12(1)(2)(b)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems to monitor and improve the safety of the service and to mitigate the risks relating to people's health had not always been operated effectively. Regulation 17(1)(2)(a)(b)