Cinnabar Support and Living Ltd

Eden Grange

Inspection report

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Date of inspection visit:
12 December 2017
24 January 2018
26 January 2018

Date of publication:
31 May 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 12 December 2017, 24 and 26 January 2018 and was unannounced.

This was the first inspection of Eden Grange. The home had previously been owned by a different provider, who had failed to meet the legal requirements. Cinnabar Support and Living Limited purchased this service in October 2017 and provided us with an action plan as part of the registration process. The action plan outlined what the new provider would do and when it would be done by in order to make improvements to the service and meet the legal requirements.

Eden Grange 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.

The care home is registered to accommodate up to 33 people, over two floors in one building. The home provides care mainly to older people, some of whom are living with dementia. People living at the home have their own bedroom and access to shared (communal) facilities such as bathrooms, toilets, dining room and lounge areas. At the time of our inspection there were 19 people living at Eden Grange.

The management of the service was shared between several people, although there was a registered manager for the service who was in attendance on the first day of our inspection visit to the home. 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.

The registered manager was not based at Eden Grange as they were also the registered manager for another care home operated by the same provider. At the first inspection visit a new manager had been appointed who stated they intended to apply for registration with the Care Quality Commission. At the time of the last visit to the service the new manager had left their employment. At that time the home was being managed by two senior managers, each covering part of the week.

On the first day of our inspection we identified a number of concerns at the home including the lack of person centred care plans, out of date risk assessments, poor management of some medicines, nutritional needs and governance systems. We were also concerned about the general environmental standards at the home. We wrote to the provider about these concerns, requesting a revised action plan. On 16 January 2018 we also met with the provider's senior management team to discuss our findings and concerns. We asked for information about the actions they would take to make improvements quickly. The provider gave us the information we asked for including timescales for completion. However, on the subsequent inspection visits we noted that some improvements had been made but there were areas that still required attention.

We found that people had access to health and social care professionals when needed, although their advice and instructions were not always recorded in care notes or followed by staff. This was particularly evident with regard to nutritional support and supporting people with their mobility.

Medicines had not always been managed in a safe way, particularly in relation to when required medicines such as pain killers and skin care ointments.

The care plans that we reviewed had been updated and mostly reflected people's needs in a person-centred way.

Staff skills, knowledge and numbers were not always sufficient to meet the needs of the people who lived at Eden Grange. On the days of our inspection visits the staff on duty were continuously busy. We observed that people had to wait for staff to help them. Communal areas were left unattended and the service of the lunchtime meal was disorganised. We were unable to assess whether there were a sufficient number of staff on duty. The provider had not yet introduced a system to calculate how many staff were needed throughout the day and night in order to meet the needs of people using the service. There was a continuous staff recruitment process in place. The recruitment process was mostly operated in a way that helped to protect people from unsuitable staff.

A staff training plan was in the process of being developed to help improve staff skills and knowledge. Most staff had started to receive some training and updates.

We noted that the provider had started to make improvements to some of the bedrooms that were not in use at the home and a new laundry had been installed. However, the general condition of the environment and communal areas such as toilets and bathrooms was poor. There were areas of the home with an unpleasant odour and some of the communal rooms had been used as storage areas for handling equipment.

We asked the provider for a schedule of works to help us understand how, and by when the improvements to the home and the environment would be made. The provider has not given us this information.

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. Policies and systems at the service did not support the requirements relating to consent. The human and legal rights of people who used this service were not protected because staff did not have a good working knowledge of the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

The provider was in the process of developing systems to help identify and manage quality assurance and safety at the service. There were gaps in the governance and performance management at the home and this impacted on the provider's ability to effectively target areas requiring improvements.

We observed that staff treated people with kindness and were mindful of their privacy and dignity. Staff were attentive and worked hard to try and support people in a timely manner. The people who lived at Eden Grange looked cared for and well groomed. No one at the service raised any concerns with us during our visits to the home.

We found that the provider was not meeting the regulations. People did not always receive care and treatment that was person centred or that reflected their needs and preferences. People did not receive safe care and treatment and were not always protected against the risks of harm or abuse. People did not always

receive the support and monitoring they needed to ensure their nutritional needs were met.

Effective quality assurance systems had not been implemented and monitored to help ensure the wellbeing and safety of people who used the service were protected. Although the provider had developed plans to help bring about improvements to the service, they failed to take effective action in a timely fashion.

We found that there were multiple breaches of the regulations, People did not receive safe care and treatment that was person centred or that reflected their needs and preferences. The human and legal rights of people who used this service were not protected because staff did not have a good working knowledge of the principles of the MCA 2005 and DoLS. Quality assurance systems were ineffective and had not fully identified and addressed the impact on the wellbeing and continued safety of people who used the service

You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will normally be kept under review. However, in the case of Eden Grange, during the inspection process the provider made the decision to close the home and applied to the Commission to remove this location from their registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

There was no system in place to assess the required staffing levels based on the needs and dependency of people who used this service.

Medicines were not always managed safely. People did not receive some of their medicines as their doctor had prescribed.

The provider did not have a robust system in place to manage and monitor the prevention and control of infections.

Eden Grange did not provide a pleasant and hygienic environment for the people who lived there. The provider did not have any robust development plans to help address these concerns.

Risk assessments did not consistently include the specialist advice of health care professionals.

Staff recruitment practices were mostly safe but there were some gaps in the pre-employment checking processes.

Is the service effective?

Requires Improvement

The service was not effective.

Care and support did not reflect current evidence based guidance, standards and best practice.

Staff did not have adequate training and support to help them effectively meet the needs of people using this service.

People were not adequately supported with eating and drinking.

Staff at all levels had a lack of understanding and working knowledge of the requirements of the Mental Capacity Act and the specific requirements of the DoLS.

Is the service caring?

Requires Improvement

The service was not always caring.

People who used the service said that the staff were lovely and kind.

Staff appeared to know people very well and were able to speak about people's needs and preferences.

Staff did not always have the time to attend to people's needs at the time support was required. This impacted on people's dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Gaps in care planning placed people who used the service at risk of receiving inappropriate care that did not meet their needs or expectations.

People who used the service had access to social and leisure activities within the home.

The provider had a process in place to help people raise concerns or complaints.

Is the service well-led?

Inadequate

The service was not well-led.

Systems and processes at the home were ineffective. This impacted on the quality of the service and on the health, safety and welfare of people living at the home.

There was a lack of understanding and application of good quality assurance processes. Improvement action plans were not robust. This meant that people using the service had been placed at risk of experiencing poor outcomes.

There was little evidence to support that the service measured and reviewed the standard of care and support provided, against good practice guidelines.

Eden Grange

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.

The inspection was prompted in part by the information we held about the service and notifications of incidents at the service. Information shared with CQC via stakeholders and people working at the service was also taken into account.

The inspection took place on 12 December 2017, 24 and 26 January 2018 and was unannounced.

The inspection was carried out by three adult social care inspectors, a pharmacist inspector (who assessed the safety of medicines management at the home) 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. The expert by experience had expertise of the care of older people and people living with dementia.

Prior to our inspection visit we reviewed the information we held about the service, for example notifications. A notification is information about important events which the service is required to send us by law. In addition we spoke with representatives from the local authority, the clinical commissioning group and the local safeguarding team.

We did not ask the provider to complete a Provider Information Return (PIR) on this occasion as they had given us an action plan during the registration process. The provider had also given us an updated action plan in respect of the service. A PIR 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 planned the inspection days taking into account all of this information.

During the inspection we spoke with two of the people who used the service and four relatives. A high

proportion of the people who lived at Eden Grange were unable to communicate with us. We informally observed staff supporting people with their needs (in communal areas), to help us understand the experience of people who could not talk with us.

We spoke with 15 members of staff including the registered manager, the regional manager, the home manager, deputy manager, carers, cleaners, kitchen staff and maintenance staff.
After the first day of our inspection, we met with the provider, director, operations manager and registered manager to discuss our concerns, give the provider the opportunity to review their action plan and revise this where necessary.

We reviewed the care records of five people and looked at the medicines and medicine records of nine people who used the service. We looked at a sample of the policies, procedures and records that related to the service. We looked at the personnel files of two recently recruited members of staff. We sampled a selection of the staff appraisal records which had been carried out by a manager at the home. We also reviewed the staff training records that were available at the time of our inspection, including the staff training matrix.

During the inspection we asked the registered manager and the operations manager to send us information relating to staff meetings, residents meetings and policies and procedures relating to keeping people safe, complaints and quality assurance reports. These documents were sent to us as requested.

Requires Improvement

Is the service safe?

Our findings

We looked at how risks relating to people's care needs were assessed and managed. One person had a care plan that recorded they were 'at risk of choking and aspiration'. The care plan also stated they required liquidised food and thickened fluids. Although the risks had been identified, there was no risk assessment in place and no information to help staff support this person safely with eating and drinking.

We saw that an occupational therapist had assessed the moving and assisting needs of some of the people who lived at Eden Grange. The occupational therapist had written to the provider and recorded on a professional visitors' record very specific advice about safe moving and assisting practices, including the techniques staff needed to use when supporting those people. However, several weeks later this information had not been written into people's moving and assisting assessments or care plans. The information was not readily available alongside care plans. Some of the staff at the home had only recently been employed and others had been brought in from other homes owned by the provider. This meant that some staff were unfamiliar with people's needs placing them at risk of receiving unsafe support with their mobility.

During our inspection of this service we observed that people were placed at risk of harm or injury from equipment that had not been securely stored. Handling equipment such as hoists and stand aids had been stored in the conservatory and corridors. These items caused potential hazards such as trips and falls. People using this service had free access to these communal areas.

We checked whether the service managed and administered people's medication safely. We looked at the medicine administration records (MARs) for nine of the people who lived at Eden Grange. We found that their records included their photograph, information about their GP and details of any allergies. This information helped to keep people safe.

The administration of people's prescribed oral medicines had been clearly recorded and non-administration codes were used correctly. However, where care staff applied prescribed creams and ointments as part of people's personal care or skin care routines, the guidance for use was incomplete. Additionally, the administration records for this type of medicine were incomplete and showed that staff had not applied some creams at the frequency prescribed. This meant that people were placed at risk of harm or injury due to inappropriate skin care.

Information about medicines prescribed to be given only when needed was not always available and was not person centred. In addition, we found staff did not always record the reasons for administration or the outcome after giving the medicine, so it was not possible to tell whether medicines had had the desired effect.

One of the medicine records we looked at stated that the person should receive their medicines covertly, hidden in food or drink. There was documentation showing this had been agreed as being in their best interest and that their doctor and the pharmacist had been consulted. However, there was no information from the pharmacist to advise the home how to disguise each medicine without reducing its effectiveness.

There was a system in place for recording the site of application for pain relief medicines that staff administered as a patch. The record had not been fully completed for one person whose records we looked at. The gap in this person's records placed them at risk of harm, because the application site needed to be rotated following manufacturers guidance to prevent side effects.

We reviewed the infection control policy and procedures in place at the service. The processes were not robust and had not taken into account the good practice guidance issued by the Department of Health, the Code of Practice for health and adult social care on the prevention and controls of infections. The law says that CQC must take the Code into account when making decisions about the registration of a service.

The provider did not have systems in place to help manage and monitor the prevention and control of infection. There was no one at the home with lead responsibility for infection prevention and control. Records showed that most of the staff at the home had received basic awareness training with regard to infection control and prevention but there was no evidence to support that staff competencies had been checked.

The reception area had an unpleasant odour at all times and the shower room was not fit for purpose due to poor odour from the soil pipe. The manager stated this room was not being used because of the very unpleasant, unhygienic smell and had placed an 'out of order' sign on the door. However, during the inspection we observed this was still being used to shower people. We told the manager about this who stated all staff would be made aware of the importance of keeping this door locked. At our second visit this room was not being locked and was still being used. The operations manager told us that they had been seeking quotes for building work to refurbish the room, which would include remedying the drainage pipes that were causing the malodour. We were told the work would be carried out shortly after the inspection.

The provider had installed a new laundry at the service. On the first day of our inspection there was no hand washing liquid in the laundry and the flooring had not been fitted. We found the provider had addressed these matters on the second day of our visit. However, the laundry was in a disorganised state, with no clear routines for keeping clean and soiled laundry separate. Additionally, there were no paper towels available and protective clothing such as aprons and gloves had been stored on a radiator behind the door in the laundry room.

We observed some poor practices by staff during our visits to the service. We observed one member of staff wearing disposable gloves in one person's bedroom. The staff member did not remove and change the gloves as they went on to carry out other tasks. We did not observe staff routinely washing their hands between supporting people who used the service. When people were taken to the dining room for lunch, we did not see that they were supported to wash their hands prior to eating. We noted that there was a trolley containing bags of soiled linen and soiled disposables left in the main corridor and accessible to people who used the service. On the first day of the inspection we observed, and the deputy manager confirmed, that people did not have their own handling slings or pressure relieving cushions and that these items of equipment were shared. These practices placed people at risk of harm from cross infection and contamination.

During our inspection of Eden Grange, we looked at the premises and the facilities provided at the home. The first-floor accommodation was not being used at this time as it required refurbishment work. On the first day of our inspection those rooms were being used as storage but on the second day workmen were using this accommodation.

The manager described the plans for future improvements to the premises. Work had begun to redecorate

and refurnish some bedrooms. At the time of the inspection it was not clear of the order of the works to be carried out or how this would be managed within a risk assessment framework. However, other parts of the premises were not fit for purpose. People were placed at risk of harm or injury due to poor quality facilities, such as the shower room and unsafe storage of equipment in lounges and corridors.

The provider told us that they were carrying out an audit of the environment and we asked the provider for a schedule of works. We did not receive this information and we were not assured that the environmental improvements would progress.

These matters demonstrate breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, placing the health, safety and welfare of people who use this service at risk.

At the time of this inspection the provider was not using a specific staffing tool to calculate the number of care staffing hours required to meet the needs of the 19 people who lived at Eden Grange. The operations manager told us they were going to implement a dependency tool which would be used to calculate the number of staff needed to support the needs of people who lived there. The operations manager also told us that the minimum staffing levels during the day were one nurse and three care staff. We reviewed the staff rotas. They showed that on some weekdays there were up to five staff on duty and also the deputy manager who was a registered nurse. We found that staffing levels varied from day to day even though the numbers and needs of people using this service remained the same. The lack of a robust dependency system meant that the provider could not be certain that there were a sufficient number of staff on duty to meet the needs of people using this service.

The staff rota showed there was regularly unexpected sickness absence of care staff, particularly at weekends, which was difficult to cover at short notice. We were told this was being addressed with the staff team. The staff rotas for the past month showed that the day staffing did not fall below three care staff and a nurse. The staff handover records also noted these staffing levels. Night staffing levels usually consisted of one nurse and three care workers, but there were occasions where this had dropped to one nurse and two carers. There was only one permanent night nurse employed at the home. For some considerable time the provider had used agency night nurses to cover shifts. The same members of agency night nurses had been used which provided some degree of consistency and continuity of care of the people who lived there. The operations manager explained that there was a continuous recruitment drive for nurses and care staff, and described the challenges of recruiting nurses in the local area.

Two members of staff told us that there were times, especially on the night shift, when there were insufficient numbers of staff on duty. One person said that they had to "juggle things due to the type of service users. There are a lot of people at risk of falling and there are sensor mats in place". Another member of staff said, "Sometimes staffing is low and we have people who are prone to falling or wander at night." On the second day of our inspection, we noted that some of the staff on duty were from one of the provider's other services. The deputy manager told us that this was because of "staff sickness and staff leaving".

During our inspection visits we observed that staff were constantly busy, did not support people to remain as independent as possible and often missed warning signs when people needed assistance. We observed two people became very distressed wanting the toilet but it took some time for staff to respond to the distressed persons. One occasion was due to staff helping people into the dining room at lunch time. The distressed people had to wait for staff to help them.

We looked at the recruitment records of two new care staff members. The recruitment process had included application, interview and health declaration. Before staff started working at the home employment and

character references and Disclosure and Barring Service (DBS) checks had been made. These checks are designed to help ensure only suitable people are employed to work at a care service. However, safe recruitment processes had not always been followed. In one staff file we noted that there was a gap of one year on the applicant's employment history. The interview record did not show whether this gap had been explored with them. Additionally, it was not clear that the provider had explored the reasons for them leaving any previous employment. As a result it was not possible to ascertain their most recent employer; therefore it was not known if their employment reference had been sought from the right organisation or provided accurate information about the prospective member of staff. We spoke to the manager about this and they agreed to look into the matter.

These matters demonstrate breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider could not be sure that there were sufficient numbers of suitably skilled and experienced staff available to meet the needs of people who used this service.

We looked at how medicines were stored. Appropriate checks had taken place on the storage, disposal and receipt of medication. Staff knew the correct procedures for managing controlled drugs. We saw that controlled drugs were appropriately stored and signed for when they were administered. Eye drops, which have a short shelf life once open, were marked with the date of opening. This meant that the home could confirm that they were safe to use.

We checked the information we held about this service. We found the provider had notified us and other agencies appropriately with regards to allegations of harm, abuse and risks to safety. People we spoke with at the service told us the staff were "lovely" and "very kind" and no one raised any concerns with us about their safety during our inspection. All of the people we spoke with told us they, or their relative were safe and secure at the service.

The service had a policy and procedure in place to help them deal appropriately and effectively with any allegations of abuse or discrimination. Information about the local authority safeguarding procedures was available to staff at the home. The staff we spoke to during our inspection of the service understood the processes for keeping people safe. Staff knew about the provider's whistleblowing processes and all the staff we spoke to told us that they would have no hesitation in reporting poor practice to the manager.

A schedule of checks and tests was in place and had been carried out to help ensure the premises and equipment were safely maintained, in line with requirements. For example, gas services, electrical installations tests and six-monthly checks of the passenger lift and hoists had been carried out by external contractors. The provider employed a full-time maintenance member of staff to carry out in-house checks, including safe window restriction, nurse call system, lighting and day to day maintenance of the home. People who used the service had a personal emergency evacuation plan in place. This provided staff and the emergency services with information about the support each person would need in an emergency situation.

Requires Improvement

Is the service effective?

Our findings

We reviewed the way in which people were supported with eating and drinking. We looked at people's nutritional assessments and records and we observed the service of meals and snacks, including the lunchtime meal.

Some people had been identified as being at high risk of malnutrition. We noted the service had obtained advice and help from the dietician and speech and language therapist but advice was not always followed. Some people needed to have the amount of food and drink they had taken, closely monitored and recorded. 'Food diaries' were in place for these people. Although there was good and detailed information recorded with regards to people's dietary needs and the support they required with eating and drinking, the actual monitoring and support was poorly managed. There were instructions for people at high risk to be given nutritional supplements (pro-cal drinks) at least three times per day. We found that staff were unsure of the people who had been identified as being at high risk because there was no records of their names.

We asked the catering staff when people were provided with the pro-cal drinks. They explained that pro-cal was not used but home-made fortified milk drinks, such as milkshakes, were offered to everyone except one person who did not require fortified foods. The food diaries we reviewed made only sporadic reference to milk or fortified drinks. It was not apparent that people were receiving this additional support with their nutritional needs. The information recorded in people's food diaries was poorly maintained. There was nothing to indicate that people had been offered alternative foods or food at different times if they had refused a meal or been asleep at the time of service. There were no drinks or snacks stations that people who used the service could help themselves to if they were hungry or thirsty. There was no guidance about calorie or fluid intake levels to help staff encourage people with their dietary intake. We checked people's monthly or weekly body weight charts. Weight records indicated many people had been losing weight, two of whom had lost over six kilograms over a three-month period. The deputy manager explained that the weighing scales were unreliable which may account for differences in weights.

We observed that food and drink was available at set times, mid-morning and mid-afternoon snacks, breakfast, lunch, tea and supper. On the first day of our inspection, we observed that the lunchtime service took almost two hours. At 12:40 staff began moving people in support chairs through to the dining room. There were not enough wheelchairs for everyone and so staff spent a lot of time transferring people back and forth. One of the people who used the service said, "Oh what a lot of time things take". People already in the dining room began to dismantle the table settings and dropped items on the floor.

It was over an hour before everyone was in the dining room and the four care staff began serving lunch. The mealtime service was disorganised and people were unsettled. Some people struggled to feed themselves and we observed that a lot of meals were only partially eaten.

These matters demonstrate breaches of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have a food and drink strategy that addressed the nutritional needs of people who used the service and we could not be sure that people's nutritional needs

were adequately met.

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 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. 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 authorisation 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. We found that DoLS applications had been made in respect of some people but these had not been in line with legal requirements. There were no mental capacity assessments to show whether the home had considered the capacity of people for whom DoLS applications had been made.

We found that decisions had been made about the use of bedrails for two people. The use of bedrails would restrict their movements in and out of bed. Their care records indicated that those decisions had been made with their relatives and were in the 'best interest' for those people. However, there were no corresponding mental capacity assessments to help demonstrate that the service had considered the capacity of those people to consent to that equipment.

The provider's policies and systems at the service did not support the requirements relating to consent and did not reflect current legislation and best practice guidance. Staff at the home, including managers and senior managers, did not have an understanding and working knowledge of the requirements of the Mental Capacity Act in general, and the specific requirements of the DoLS. However, we were told that training had been arranged for the deputy manager and operations manager.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who used the service were placed at risk of receiving care and treatment that they or the relevant person had not consented to.

During our inspection we looked at the way in which the provider ensured staff had the skills and knowledge to meet the needs of people using this service. We also reviewed the way in which staff were supported and supervised in their work.

New members of permanent staff received an induction where they were provided with information about the home's systems and their practice in supporting people was also observed. We noted that the induction checklists had been signed by a new starter but not by their supervisor. The manager stated that senior staff would take responsibility for signing off the induction of new care workers.

On the first day of our inspection the provider was unable to demonstrate that staff had completed training in several essential health and safety subjects including basic life support and control of substances hazardous to health (COSHH). On the second day of inspection senior managers had put a training matrix in place to help identify the gaps in staff training. A senior manager explained that staff may have achieved this training in the past but their training records had not been made available to the provider when it took over the running of the home. This meant all staff would have to undertake all mandatory training and the new training matrix record was being completed. The provider had arranged for all staff to attend mandatory training over the next two months. So far, the majority of staff members had received in-house training in fire

safety, protection of vulnerable adults, moving and handling, infection control and falls. The service had also signed up to complete the gold standards framework in end of life care. This involved training and best practice assessment of the care provided to people receiving end of life care.

The home provided care for people living with dementia but at the first visit there were no records to demonstrate that staff had received training in dementia care. However, on our second day of the inspection, some staff were attending a short training session on dementia awareness. Some people living at the home exhibited behaviours that challenged, including physical challenges towards staff. There was no record of any training for staff in how to manage challenging behaviours. In recent self-appraisal forms many staff members had identified they had training needs in dementia care, mental health and managing challenging behaviour.

We observed one person becoming very agitated and aggressive with staff. The staff member asked the person not to bite them. Staff struggled to support this person, they tried to distract the distressed person by saying; "Shall we have a drink." The person continued to be distressed, screaming and swearing at the staff member. We asked staff what they did when confronted with distressed and challenging behaviours. They said; "We just stand back and let (Name) rave then we try and distract them with a drink or a chocolate that does the trick or taking them for a cigarette. Then we have to fill out a behaviour chart."

We found that there was no record of the training or competencies of nurses to undertake clinical care tasks such as wound care, catheter care or venepuncture. There were no in-house checks of nurses' competence in administration of medicines.

Agency staff were covering night duties and staff from other services operated by the provider had also been utilised to cover some of the daytime shifts. There were no records of any in-house fire safety training provided to those staff when they started to work at the home. This meant the provider could not be certain that the agency staff and temporary staff were familiar with safe working practices within Eden Grange.

On the first day of our inspection we reviewed the initial appraisal records that had been undertaken with staff by a manager. Although these appraisals had taken place as well as staff meetings, formal staff supervision programme had not been set up at the time of our inspection.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The lack of information regarding the level of staff skills and knowledge and the fact that the provider did not have a system in place to measure people's dependency levels, meant that people using the service were placed at risk of not having their needs met effectively.

Eden Grange provided services for people living with dementia. Some, but not all, corridors and doors to communal rooms had dementia friendly signage to help people orientate themselves around the home. We noticed that some people had memory boxes outside their bedrooms to help them locate their own personal space. However, the environment did not support people to maintain their independence as far as possible.

The care records that we reviewed during our inspection and from the discussions with staff, there was clear demonstration that people who used the service were supported with access to other health care professionals when required. These included occupational therapy, dietician and tissue viability services. There were several people who were cared for in bed, but as a result of the support from staff and external professionals, we were told that there was no one at the home with pressure ulcers.

Requires Improvement

Is the service caring?

Our findings

Although we observed some good practices and interactions between staff and people who used the service, we also observed some practices that could have been improved.

We observed that people were not supported with eating and drinking in a manner that was respectful of their needs. This was partly due to the numbers of staff available and the way in which staff had been deployed. In addition to this, staff were not familiar with the principles of the Mental Capacity Act 2005 or of how to support people with effective communication and decision making.

We also observed that staff were constantly busy, did not support people to remain as independent as possible and often missed warning signs when people needed assistance. We observed two people became very distressed wanting the toilet but it took some time for staff to respond to the distressed persons. One occasion was due to staff helping people into the dining room at lunch time. The distressed people had to wait for staff to help them.

The failure to effectively deploy staff had the potential to impact on people receiving dignified care.

Eden Grange provided services for people living with dementia. Some, but not all, corridors and doors to communal rooms had dementia friendly signage to help people orientate themselves around the home. We noticed that some people had memory boxes outside their bedrooms to help them locate their own personal space. However, the environment did not support people to maintain their independence as far as possible.

During the inspection, we observed staff supporting people in communal areas of the home. We noticed that most of the staff knew people very well. The staff we spoke with could describe people's likes and dislikes and spoke of people with some affection. When staff spoke to people they used their names and spoke in a kind, respectful way.

We observed that there was some friendly banter and jokes between staff and people who used the service. We saw that there were occasions when staff gave people some appropriate hugs. We noticed that people who used the service appeared well groomed and dressed appropriately.

We observed one person using a hoist and being supported by two staff. A senior carer spotted that the person clothes were rucked up exposing their back. The procedure was stopped and the person was taken back to their room so that their clothing could be adjusted in private.

People who used the service and their relatives, had been provided with the opportunity to be involved with the service. A recent meeting had been held at the home. We saw from the minutes of the meeting that managers had used the meeting to introduce themselves and give an overview of the new provider that had taken over the home. It was evident from the meeting minutes that managers were trying to make improvements to the social aspects of life at Eden Grange.

We received comments from some of the people who visited or lived at Eden Grange, as well as from staff working at the home. One relative that we spoke to during the inspection told us; "I come in when I like and I always get offered a coffee." One person who lived at Eden Grange said; "I do like it here, it's very nice. The girls are nice to me." Another person commented; "The girls are lovely."

The deputy manager told us about some of the changes that she had made at the home since her appointment. She said; "I have already made changes to how care is delivered, when I came here half the people were being looked after in bed and I asked why and was told 'we have no chairs'. However, there were chairs available so now everybody who can or wants to get out of bed is helped up. I think that it is improving here. There is still some training that we need to do but we are trying to source that."

Requires Improvement

Is the service responsive?

Our findings

On the first day of our inspection, we found that some work had been carried out with regard to people's individual care plans. However, detailed information about people's individual needs and preferences was not available. The operations manager told us that there was still work to do on these documents to help make sure they were fully person centred and reflective of people's individual expectations.

Health and social care professionals who we spoke to during the inspection told us that they had found care records were not up to date or accurate about people's care needs. However, they also added that they had noticed improvements to these records recently, particularly in the way the records had been organised. One person told us; "Staff are receptive to advice, but the records need to be more personalised and detailed about how to support each person."

We reviewed the care records of five people during our inspection of Eden Grange. We found that care plans lacked details and clear instructions about people's care and support needs, particularly around the management of medicines and supporting people with their mobility. We found that risk assessments had not been routinely reviewed and updated following incidents or accidents.
After the first day of our inspection, we met with the provider to discuss our concerns about these matters. The provider gave us assurances that care planning would improve. They gave us a schedule based on risk assessment, showing how improvements would be achieved.

We reviewed the care plans again on the second day of our inspection. Some aspects of the care planning process had improved. We noted that people with limited verbal communication skills had been supported by their relatives during the updating of their care records. One of the relatives we spoke with said; "I attend my relative's reviews. I've been asked to come into the home for a review on Monday."

We saw evidence to demonstrate that health and social care professionals had provided advice and information about people's care needs. In most cases this information had been included in care plans and risk assessments. Some gaps in information with regards to people's personal care remained. These included, for example the use of creams, people's mobility needs and their nutritional support.

People's care records contained a document that should have been completed with important information about people's basic needs and individual support requirements. The documents were designed to accompany people, should they be ill or have an accident, requiring admission to hospital. The documents had not been completed on the first day of our inspection and remained blank on the second day of the inspection. This meant that when people transferred between services, there was a risk that important information about their personal needs and preferences would not be passed on.

These are breaches of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The lack of information regarding people's care and support needs meant that people using the service were placed at risk of not having their needs met effectively.

We looked at the way people were supported with or had access to social and leisure activities. There was an activities co-ordinator employed at the home but they were due to take some leave. A member of staff told us; "We (staff) try and do things ourselves if people want but it needs to be meaningful just not doing things for the sake of it." One person who lived at the home, told us; "There are things to do if you want, we have music quite a lot, an organist and singers. I also have daily paper which I like to read."

There was an activity room which seemed full of games and items but this was locked and people were unable to access these. We saw that there was a programme of activities organised at the home. Activities included, sensory games, hair and beauty days. Entertainers and people from the local community such as singers, musicians and local schoolchildren visited the home and at the time of our first day of inspection, the Christmas party was imminent. A hairdresser regularly visited the home. In the corridors there were some themed pictures on the walls and a small board with 'fiddle items' such as locks and light switches, though these were set quite high up on the wall. These items were intended to provide tactile objects of interest for people living with dementia.

The provider had a complaints procedure in place. The provider had not received any complaints about the home since they had taken over the running of Eden Grange. We did not receive any concerns or complaints during our visits to the home.

Inadequate

Is the service well-led?

Our findings

As part of the registration process for this service, the provider gave us a plan, outlining the actions that would be taken to improve the quality and safety of the service. On the first day of our inspection, we found that little progress had been made with the implementation of the action plan even though all of the timescales for achievement had passed.

The service had a registered manager, but this person was also registered at another of the provider's services and spent little time at Eden Grange. They were in attendance at the home for part of the first day of our inspection to support a person who had been employed as the manager at the home. The provider's operations manager was also in attendance for part of the day.

We spoke to the operations manager and the home manager (at that time) about the proposed plans for the refurbishment of the building. We requested a copy of the plans but by the third inspection visit the plans had still not been submitted to the Commission. We received no information as to how the provider would ensure the safe operation of the service during any building works.

In January 2018, we received an up-dated action plan about other shortfalls with extended dates for completion.

We wrote to the provider and met with them on 16 January 2018 to discuss our concerns regarding the governance and oversight of the service. The provider had made changes to the day to day management of the home. A further action plan was produced, again extending the dates for completion but not including a schedule of the intended work at the home.

We asked the provider about the governance systems in place at Eden Grange. We were told that that the home would have an individual governance system and that checks were carried out regularly to give an oversight of the situation.

On the first day of our inspection we did not find any evidence of quality and safety audits being undertaken. However, on the second day of our inspection we found a schedule of audits had started to be put in place.

During our initial inspection visit to the home we found that there had been no checks of the hot water temperatures carried out at the washbasins in each room since the provider took over the service. This was because the thermometer had been broken. At our second visit we found the temperature of hot water in bedrooms was now being checked. However, in some bedrooms the hot water was above the safe water temperature of 43°C. There was no record of what action had been taken to address this. The maintenance member of staff stated they would record in future what action was taken to address irregularities in hot water temperatures.

At our first day of inspection we looked at how medicines were monitored and checked to make sure they were being handled properly and that systems were safe. We found that whilst a daily system of medicine

checks was in place the manager was not always notified when discrepancies had been identified. We found poor management of when required medicines, topical creams and ointments. Nurses responsible for the administration of medicines had not had their competencies checked. We discussed this with senior staff at the time of the visits. However, when we returned for our second day these aspects of medicines management had not changed. Although medication audits had been completed these issues had not been identified by the provider or actioned.

We found that there was a lack of adherence to good practice guidance and understanding at the home. We asked the operations manager to send us some of the policies and procedures that were in use at the home. We found that these documents were not specific for Eden Grange. They did not provide staff with sufficient up to date information regarding safe working practices and current best practice guidelines.

At the first inspection visit we requested a copy of the provider's infection control and prevention policies and procedures, which we received. However we found these related to a different care home and made no reference to the relevant Health and Social Care Act 2008 Code of Practice. We raised this with the provider as an area of concern. On 5 January 2018 the provider submitted an improvement plan stating that infection control guidelines and auditing would be updated to embrace all recommendations in the Health and Social Care Act 2008 code of practice. At the final inspection on 26 January 2018 the infection control policy had not been updated and still referred to a different care home.

At the first inspection visit the provider had not carried out an audit of infection control and prevention in the home. At the last inspection visit the quality manager stated an infection control audit had been carried out. We requested a copy of the audit but we did not receive this information.

In December 2017 we wrote to the provider with concerns about the lack of a dependency tool to determine safe staffing levels. On 5 January 2018 the provider submitted an improvement plan stating that the dependency tool for calculating and staffing levels would be addressed by 12 January 2018. At our inspection visits on 24 and 26 January 2018 there was still no dependency tool in place to determine safe staffing levels.

At our inspection visit on 26 January 2018 we asked for a copy of the recent Fire Risk Assessment which had been carried out on 15 December 2017. We did not receive a copy of this document.

During the inspection we saw the manager has carried out some medication audits in November 2017. However these audits had failed to identify the medication issues we found in December 2017, so no corrective measures had been put in place to help bring about improvements.

Although the provider had started to implement some level of governance at the home, the systems in place had not addressed our concerns identified on the first day of our inspection and gaps remained. There were no robust strategies, underpinned by realistic objectives, in place to help ensure improvements to the quality and safety of the service were made.

This demonstrates breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have robust systems in place to effectively monitor and improve the quality and safety of the service nor to monitor and mitigate the risks to the health, safety and welfare of people who used the service.

The organisation's quality assurance manager and the manager of another care home had been spending time at Eden Grange to complete audits and checks. There had been an audit of two people's care files,

three personnel files and four people's medicines records. An audit of the dining experience of people living at the home had also been carried out. The audit format had been adapted from a dementia specialist organisation and was designed to check the mealtime experience for people living with a dementia. The audit identified the positive aspects of the mealtime and also areas where improvements could be made.

The audits had identified gaps and areas that required attention. Action plans had been produced setting out timescales and identifying people responsible for completion. The operations manager told us that they would be re-checking that actions had been taken to address the shortfalls before the action plan was signed as completed. These audits were in the early stages and waiting for review. We were unable to check the effectiveness and whether improvements had been made.

The staff we spoke with were positive about the potential for improvements at the home. One staff member commented, "I'm excited about the planned changes. I've worked here for years and have already started to see changes."

The staff told us generally that they felt that improvements were being made at the home. One member of staff said; "We can access the management team now, especially the deputy manager. (Name) is very good. We can ask for things now such as equipment and tables. It's early days but I am positive about the proposed changes. It's too early to tell how the management support will be." Another staff member told us; "The management are trying to improve things and there are more people about who we can speak to. The deputy manager is here a lot and very accessible. I can speak to them and I think they listen."

Health and social care professionals whom we contacted and spoke to as part of the inspection said that the service generally worked in partnership with them. They commented that they had recently noticed some improvements to the care planning system and records. They identified some areas that could be further improved, particularly around management of behaviours, the use of body maps and more detailed recording about people's needs in order to help inform care reviews. Accidents and incidents were being reported appropriately to the local authority and CQC.

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 9 HSCA RA Regulations 2014 Person-centred care People using the service were placed at risk of not having their care and support needs met in a way that reflected their personal preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People who used the service were placed at risk of receiving care and treatment that they or the relevant person had not consented to.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way. Risks to health and safety had not been adequately assessed and action had not been taken to mitigate the risks. Medicines were not always managed safely for people and administration records were not completed correctly. There were no systems to prevent, detect and control the spread of infections.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not have a food and drink strategy that addressed the nutritional needs of

people who used the service and people's nutritional needs were not adequately met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises were not fit for purpose. People were placed at risk of harm or injury due to poor quality facilities and unsafe storage of equipment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have robust systems in place to effectively monitor and improve the quality and safety of the service nor to monitor and mitigate the risks to the health, safety and welfare of people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider could not be sure that there were sufficient numbers of suitably skilled and experienced staff available to meet the needs of people who used this service. The provider did not have a system in place to measure people's dependency levels and this meant that people using the service were placed at risk of not having their needs met effectively.