Edge Hill Limited

# Edge Hill Rest Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| Is the service safe? | **Inadequate** |
| 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

This was an unannounced inspection of Edge Hill Residential Care Home carried out on 24 and 25 November 2016. We last inspected the service in July 2015. At that inspection, we found the service was meeting all the regulations that we reviewed.

Edge Hill Residential Care Home provides care and support for up to 36 people. It is a detached building situated approximately one mile from Oldham Town Centre and is surrounded by a large garden. There is a small car park to the rear of the property. At the time of our inspection Oldham Metropolitan Borough Council (OMBC) had put in place a temporary suspension on new admissions to the home, following a number of concerns raised by different health and social care professionals about aspects of the care provided. These included concerns about poor moving and handling practices, lack of meaningful activities, out-of-date support plans and poor staffing levels.

The service had 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 and associated Regulations about how the service is run.

We found five breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014, which were in relation to unsafe moving and handling practices, poor infection control, poor food hygiene practices, inadequate staffing levels, poor training, failure to work within the principles of the Mental Capacity Act 2005, poor record keeping, failure to handle complaints correctly and poor governance. We made three recommendations. These were in relation to dignity and privacy, activities and staff handover meetings. You can see what action we told the provider to take at the back of the full version of the report. We are currently considering our options in relation to enforcement and will update the section at the end of this report once any action has concluded.

During our inspection we observed some staff using incorrect and unsafe methods for moving and repositioning people despite receiving training in this topic. We found that moving and handling risk assessments and care plans were not up-to-date.

Infection prevention and control measures were not fully implemented in order to protect people from the risk of infection, although the registered manager had taken steps towards rectifying this by purchasing handwashing posters and foot operated waste bins to install in the bathrooms and toilets.

Food hygiene practices were not thorough as we found opened, uncovered and undated food had been left in the fridge, and fridge and freezer temperatures in the kitchen had not always been monitored. This meant there was a risk that contaminated food could be given to people who used the service.

There were not always sufficient staff to provide prompt care and support to people who used the service.

On one occasion we saw that a person had to wait for forty minutes before there were staff available to assist them to change their position.

The management of medicines was carried out in a safe way and those staff with the responsibility to administer medicines had been trained to do so.

Arrangements were in place to safeguard people from harm and abuse. Recruitment processes were robust and protected people who used the service from the risk of unsuitable staff being employed to provide care and support to vulnerable people.

Staff had received training in a variety of subjects which enabled them to carry out their roles. However, although staff had received training in moving and handling we observed some staff supporting people to move in an unsafe way.

One member of staff who was in their induction period and should have been working under supervision told us that they had assisted a person with their meal without the appropriate training.

There was a 'fob' system in place which prevented people who relied on assistance from staff to mobilise, from leaving the communal areas. This meant that the home was not working within the principles of the Mental Capacity Act (2005). Following a discussion with the registered manager and owner, the system was permanently deactivated.

We observed that staff were kind and caring in their interactions with people who used the service and the majority of comments about the staff were positive. However, we saw one example where a member of staff did not interact in a thoughtful manner with a person who used the service.

One person who was lying in bed was visible to us from outside their bedroom window. We have made a recommendation in relation to dignity and privacy.

Care and support records were not always up-to-date and therefore did not reflect people's current needs. The registered manager had started the process of thoroughly reviewing and reorganising care files.

Although a number of outside entertainers visited the home, there were not sufficient meaningful activities available to provide people using the service with stimulation and opportunities to socialise.

There were systems in place to enable people to make a complaint about the service. However, the complaints policy had not been followed when a complaint had been received.

We received positive comments about the registered manager and during our inspection we found her helpful and receptive to suggestions we made to improve the service.

Some governance systems were in place to monitor the quality and safety of the service. However governance systems had not identified the issues raised by Commissioners prior to our inspection or the issues we found during this inspection.

People using the service, their families and staff were provided with opportunities to express an opinion about how the service was managed and the quality of service being delivered through surveys.

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.

## 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 always safe.

Some staff were using incorrect and unsafe methods for moving and repositioning people who used the service.

Infection prevention and control measures were not fully implemented in order to protect people from the risk of infection.

Food hygiene practices were not thorough which meant there was a risk that peoples' food could become contaminated.

There were not always sufficient staff to provide prompt care and support to people who used the service.

The management of medicines was carried out in a safe way.

Arrangements were in place to safeguard people from harm and abuse.

Recruitment processes were robust and protected people who used the service from the risk of unsuitable staff being employed.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff had received training in a variety of subjects which enabled them to carry out their roles. However, we found that although staff had received training in moving and handling some staff were still assisting people to move in an unsafe way.

The use of a 'fob' system to prevent some people from leaving the communal areas and incorrect documentation in relation to covert medication meant that the home was not working within the principles of the Mental Capacity Act (2005).

People who used the service received the appropriate support from staff to ensure their health and nutritional needs were met.

## Is the service caring?

Requires Improvement

The service was not consistently caring.

The majority of comments about the staff were positive.

We observed that staff were kind and caring in their interactions with people who used the service. However, we saw one example where a member of staff did not interact in a thoughtful manner with a person.

Although people looked clean and well-groomed we saw that attention had not been paid to the finer details of their appearance, such as the wearing of footwear, or spectacles.

## Is the service responsive?

Requires Improvement

The service was not always responsive.

Care and support records were not always up-to-date therefore did not reflect people's current needs.

There were not sufficient meaningful activities to provide people using the service with stimulation and opportunities to socialise.

There were systems in place to enable people to make a complaint about the service. However, when a complaint had been made it had not been responded to in line with the provider's complaints policy.

## Is the service well-led?

Inadequate

The service was not always well led.

Some governance systems were in place to monitor the quality and safety of the service. However these had not identified the issues we found during our inspection, in relation to food hygiene, infection control, care documentation and moving and handling.

We received positive comments about the registered manager.

People using the service, their families and staff were provided with opportunities to express an opinion about how the service was managed and the quality of service being delivered through the use of surveys.

# Edge Hill Rest Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

This was an unannounced inspection and took place on 24 and 25 November 2016. The inspection team consisted of two adult social care inspectors.

The inspection was carried out in response to concerns that had been raised by different health and social care professionals about aspects of the care provided at Edge Hill Residential Care Home. In particular there were concerns around unsafe moving and handling techniques used by staff to assist and move people who lived at the home.

Prior to the inspection we reviewed the information we held about the service, including the previous inspection report and the Provider Information Return (PIR). This asks them to give key information about the service, what the service does well and what improvements they plan to make. We also reviewed the statutory notifications received. A statutory notification is information about important events and incidents which the service is required to send us by law. We also contacted Healthwatch Oldham to ask them if they had any concerns about the service at this time, which they did not. Healthwatch is an independent consumer champion that gathers and represents the view of the public about health and social care services in England.

Some of the people living at the home were unable to give their verbal opinion about the care and support they received. Therefore we examined peoples' care records and observed the care and support provided to them in the communal areas to capture their experiences.

During our inspection we spoke with two people who used the service, three relatives, the registered provider (owners), the registered manager, two care staff and the cook for the day.

We looked around the building, observed how staff cared for and supported people, reviewed records and looked at other information which helped us assess how peoples' care needs were met. We observed a lunchtime meal and watched the administration of medicine to check that this was done safely.

As part of the inspection we reviewed the care records of five people living at the home. The records included their care plans and risk assessments. We looked at three staff files to check that the recruitment process had been carried out correctly. We also reviewed other information about the service, such as the training programme, quality assurance process, policies, complaints and compliments.

Inadequate

# Is the service safe?

## Our findings

We carried out this inspection in response to concerns raised by health and social care professionals about some aspects of the care provided at Edge Hill. One of the concerns identified was in relation to poor moving and handling practices being carried out. During our inspection we observed that some staff were not moving people safely and were not using correct techniques or equipment to support them to do this. This meant people were at risk of being moved incorrectly and unsafely.

During the first day of our inspection we observed two members of care staff reposition a person in bed using a 'drag' lift. A drag lift is a way of handling the patient in which the handler places a hand or an arm under the person's axilla (armpit), whether the patient is being moved up the bed, sat up in the bed, being assisted from sitting to standing, or being assisted to change from one seated position to another. This technique is considered unsafe and should not be used as it can cause injury to both the person being moved and the handler. When we spoke to the staff about this they told us they were aware they should use a slide sheet to move the person, but they did not have one readily available in the room. This meant they risked injuring the person through not using the correct equipment. Slide sheets are designed for sliding transfers and repositioning. They are made of very low friction material, which when placed on top of one another become slippery. Placed underneath a person they enable them to be moved or transferred easily and with minimal risk of damage to the person or to the people carrying out the movement.

On the first day of our inspection we saw a member of staff and a relative assist a person to stand from their chair by placing their arms under the person's armpits. They then moved the person back into their chair. As stated above, moving a person in this manner risks causing damage to the person's arms and shoulders. We brought this to the attention of the Registered Manager.

On the second day of our inspection we saw on two occasions that people were brought into the communal lounge in wheelchairs that did not have foot rests attached; their feet therefore touched the floor as they were moved. People who are moved using a wheelchair should have their feet supported by foot rests to ensure good posture and to minimise the risk of their feet or legs becoming trapped or damaged. We told the staff that they should use foot rests when moving people in wheelchairs and brought this to the attention of the registered manager.

We looked at the arrangements the home had in place for the prevention and control of infection. We saw that in several toilets there were no paper towels available, no handwashing posters on display showing the correct handwashing procedure and no foot operated waste bins. At the end of our inspection the registered manager informed us that handwashing posters and foot operated bins had recently been purchased and these had just been delivered. She assured us that they would be put in place immediately. We saw a comment from the November 2016 relatives survey which said ''often paper towels are not available''. Alcohol hand gel was provided at both entrances for visitors to use when entering and leaving the building in order to de-contaminate their hands and prevent the risk of infection. We observed staff using personal protective equipment (PPE), including disposable vinyl gloves and aprons. However we saw that two members of staff wore a watch while delivering care to people who used the service. Jewellery can harbour

microorganisms, can reduce compliance with good hand hygiene and may cause damage to the frail skin of people who use the service. We brought this to the attention of the registered manager.

We inspected the kitchen to check on food storage and cleanliness. A 'Food Standards Agency' inspection had been carried out in November 2015 and the home had been awarded a rating of 5, the highest rating available. During our inspection, although we saw that the kitchen was clean, we found that the daily cleaning schedules had not always been completed. For example we saw that on 8, 10, 23 and 24 November 2016, the kitchen cleaning schedule had not been completed. This meant we could not be sure that the kitchen had been cleaned on those days. We checked the recording of the kitchen fridge temperature and found that on 7,8,13 and 14 November 2016 the fridge temperature had not been checked. During our inspection we found that food was not always being stored safely. For example in the fridge we saw an opened packet of cooked meat without a 'date opened' label on it. We saw a bottle of salad cream that said 'use by 23/11/16' was still in the fridge on 25/11/2016 and we saw a covered bowl of rice pudding that did not have a label on in to show how long it had been stored in the fridge. This meant there was a risk that contaminated food could be given to people who used the service.

During our tour of the building we saw that one person's bedroom was used to store a wheelchair that was not theirs. This cluttered up their room. We asked for the wheel chair to be removed.

We talked to the registered manager about staffing levels. She told us that she did not use agency staff, as the majority of regular carers were able to work extra shifts to cover for staff absence. She was in the process of recruiting staff to work night shifts and an apprentice from Oldham College was shortly to start working at the home. The registered manager told us that she was in the process of introducing a dependency tool which would be used to indicate the level of dependency in relation to a range of areas such as nutrition, personal care, moving and handling for each person who lived at the home. This tool would be used to assist in planning the staff rota.

We reviewed staffing levels to check that there were enough staff available to provide care and support to people. During our inspection we found that there were not always enough staff available to respond to peoples' needs promptly. On the first day of our inspection, before the day staff had arrived, we heard one person in the communal lounge requesting a blanket as they were cold. They were told by a carer that they would be unable to get them a blanket as that would mean leaving other people unattended. We heard one person calling out repeatedly for their breakfast. They received this half an hour after their initial request. Whilst we were talking with a person who used the service they told us they were uncomfortable and needed to change their position. We pressed the nurse call bell to summon help. A carer responded promptly, but told us that she would require assistance to move the person. It was not until forty minutes after our initial request for help that two care staff were available to provide assistance. During the first day of our inspection we saw that one person who was sitting in the communal lounge had to call out five times to summon assistance to be taken to the toilet. Lack of a timely staff response to people's request for support and assistance at such times compromises their dignity.

During the first day of our inspection we were told by a carer that they had fed a person who was lying in bed without raising them to a sitting position. This member of staff was working their first shift as part of their induction, and should not have carried out any care unsupervised. They told us they had not been shown how to raise the electric bed or to assist people with eating. This put the person at risk of choking. The two care staff working the shift with this member of staff were busy attending to other people at the time.

One person who lived at the home told us ''Last night they (staff) were rushed off their feet''. One member of staff had commented in the February 2016 staff survey ''I think we need more staff on each shift as the

residents are getting harder''. In the November 2016 relatives' survey we saw several comments about staffing levels. These included '' Ensure there is always a member of staff available on the floor at all times'' and ''Split the staff smoke/meal breaks so there's always someone on the main floor''.

The above examples of unsafe moving and handling practices, poor infection control, poor food hygiene practices and inadequate staffing levels demonstrate multiple breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We inspected the systems in place for the storage and management of medicines. Medicines were stored in a treatment room which was clean and tidy and contained a locked medicines trolley which was secured to the wall. The treatment room also contained the controlled drug cupboard. Some prescription medicines are controlled under the Misuse of Drugs legislation e.g. morphine, which means that stricter controls need to be applied to prevent them from being misused, obtained illegally and causing harm. We saw that controlled drugs were appropriately and securely stored. We checked that fluid thickeners were stored out of reach of people who used the service and found that they were stored safely. Fluid thickening powder should be stored securely to minimise the risk of it being accidentally swallowed, as this can cause choking.

The temperature of the treatment room and medicine fridge were checked daily to ensure that medicine was stored at the correct temperature, and our observations of recent temperature recording sheets confirmed this. A fan was available for use if the room temperature rose above the maximum limit.

We observed the lunchtime administration of medicine and saw that it was carried out safely. Staff who were administering medicines wore tabards to indicate that they should not be disturbed during the medicine round. This helped to minimise the risk that they might be distracted and inadvertently make a drug error. We looked at three Medication Administration Sheets (MARs) and saw that they had been completed correctly. Each MARs contained a photograph of the person and information about any allergies, and the MARs file contained a staff signature list for all staff signing for the administration of medication.

Staff employed by the service had been through a thorough recruitment process. We inspected three staff personnel files and found that they contained all the relevant documentation, including two appropriate references and confirmation of identification. All staff had Disclosure and Barring Service (DBS) criminal record checks in place. These help the service provider make an informed decision about the person's suitability to work with vulnerable people, as they identify if a person has had any criminal convictions or cautions.

We undertook a tour of the premises to check that the building and equipment were safe and that the environment was clean. The home was generally well maintained and was free from any unpleasant odours. The entrance hallway and stairs and the small lounge had recently been decorated. However, the paint work on some bedroom doors and walls upstairs looked scuffed and would benefit from re-painting. The home was surrounded by a large garden which contained lawns and shrubs and there was an area to the rear of the property where people could sit out and was accessible to wheel chairs. However, the garden was in need of maintenance, as one of the fences was broken. At the time of our inspection the regular maintenance person was on sick leave. All maintenance problems were being dealt with by a temporary employee who worked for the service two days per week.

Maintenance checks on equipment, such as the gas, passenger lift and emergency lighting were up-to-date which helped to ensure that the safety of people living, working and visiting the home was maintained.

There were systems in place to protect staff and people who used the service from the risk of fire. We

inspected the home's 'fire log' and saw that regular checks on the fire extinguishers, fire alarms and fire escapes were up-to-date. A fire drill had been held in February 2016.

People who used the service had a personal evacuation escape plan (PEEP) in place which explained how they would be evacuated from the building in the event of an emergency, and contained information about their mobility and any communication problems. A copy of the PEEP was contained in each person's care file and a further copy stored in a plastic file in the registered manager's office, so that it was easily accessible in the event of an emergency. We saw three of the people who used the service did not have a PEEP in the office file, although there was a copy in their care file. This meant that vital information needed in the event of an emergency was not easily available. We asked the registered manager to rectify this immediately, which she did.

There was an up-to-date 'business continuity management plan' to follow in the event of a major incident, such as a power failure, loss of heating or gas leak. Edge Hill had an arrangement with another local provider who could act as a temporary base for people who used the service, if they needed to be evacuated.

From our review of the training records we saw that staff had received training in safeguarding vulnerable adults and staff we spoke with were able to tell us how they would identify and report signs of abuse or neglect . One carer told us ''I'd go straight to the manager''.

Requires Improvement

# Is the service effective?

## Our findings

Staff undertook a variety of face-to-face training which enabled them to acquire the skills to carry out their roles. This included infection control, moving and handling, dementia awareness, safeguarding vulnerable adults, mental capacity act and food hygiene. All care staff were trained in medicines administration. One staff member said ''I love learning''.

A recent report by the local authority moving and handling coordinator, written following concerns about staff using incorrect moving and handling techniques, had suggested that the home should have trained moving and handling facilitators in place. This would enable them to advise and demonstrate to staff safe moving and handling techniques and use of appropriate equipment. The registered manager told us that one person was scheduled to attend this training in January 2017.

The registered manager told us that all newly recruited staff worked for a probationary period of three months before they were given a permanent contract. If they were successful in completing their probationary period they were supported to undertake the Care Certificate, a professional qualification which aims to equip health and social care staff with the knowledge and skills needed to provide safe and compassionate care. At the start of their employment all staff undertook an induction programme which included completing mandatory training on topics such as moving and handling, safeguarding vulnerable adults and infection control and undertaking 'shadowing', where they worked alongside other carers in order to gain experience of caring for people. The registered manager told us that the length of time spent 'shadowing' was dependent on how much experience of 'caring' each individual person had.

On the first day of our inspection we spoke with a new member of staff who had completed their first shift at the home, which was a night shift. They told us they were shadowing another carer and should not work unsupervised. However, during their shift they had assisted a person to eat their breakfast. They had done this without supervision. The person they assisted was lying in bed and should have been raised to a sitting position to eat their meal. The new member of staff told us that they did not know how to raise the electric bed and had not yet been shown how to support someone with eating. This put the person at risk of choking. We reported this to the registered manager who told us she would ensure that people on induction did not work unsupervised.

During our inspection, as detailed in the 'safe' domain of this report, we saw that staff carried out unsafe moving and handling of people who used the service. We looked at the staff training matrix and saw that all staff had been trained in moving and handling. Despite this training, staff continued to use unsafe methods for moving people.

Supervision of staff was carried out twice a year and staff we spoke with told us that they found it helpful. The registered manager told us she carried out additional supervision sessions with staff following periods of sickness or lateness, in case any adjustments to their employment needed to be made. An annual appraisal is a formal opportunity to analyse a persons performance at work, and to offer them a chance to discuss their development needs. No staff had received an appraisal during 2016. The registered manager

told us she planned to undertake an appraisal for all staff in January 2017, in order to review how they had responded to her first year in post. Supervision and appraisals are important as they provide opportunities for staff to review their performance and identify any support they need.

The above examples of poor training and lack of appraisals demonstrate a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked to see if people were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met. One relative we spoke with told us ''The food is ok''. We were shown the menu plans which had been devised following consultation with people who used the service and saw that people were offered a choice of two main meals at lunch time with a lighter meal offered at tea time. Tea and biscuits were offered between meals. No fresh fruit was available as a snack, although the registered manager told us it was sometimes offered as a dessert. One relative we spoke with told us ''I've never seen fruit''. We brought this to the attention of the registered manager who told us she would consider offering fresh fruit as an alternative snack between meals. Jugs of juice were available in the communal area and we saw that staff provided people with drinks which helped reduced the risk of dehydration. We saw that people's weight was monitored either weekly or monthly, depending on the person's level of need. Where people were losing weight we saw that they had been appropriately referred to a dietician. We checked the weight monitoring for everyone living at the home at the time of our inspection and saw that everyone's weight was stable.

The registered manager told us that she had recently recruited a new cook and was waiting for her pre-employment checks to be completed to enable her to start working. In the meantime two other members of staff were undertaking cooking duties. On the first day of our inspection we spoke with the member of staff who was cooking meals for the day. She did not have any cooking qualifications. We asked her how she would prepare food for people who had swallowing difficulties and required their food to be pureed. The Social Care Institute for Excellence (SCIE) suggests that different pureed foods are kept separate to enhance the quality of the eating experience. She was unaware of this practice as she told us that she would puree the different elements of the meal together. This meant that the person who required their food to be pureed received an unappetising meal.

On the first day of our inspection we saw that the menu was written on a board in the dining room which was currently out of use, due to repairs to the heating system. This meant that people who used the service could not see the day's menu choice.

The Mental Capacity Act (MCA) (2005) 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 a particular decision, any made on their behalf must be in their best interests and as least restrictive as possible. We saw that the majority of staff had undertaken training in the MCA and Deprivation of Liberty Safeguards (DoLS). During our inspection we saw that staff sought consent from people before carrying out any care and that they offered choice to people, for example asking them what choice of meal or drink they would like.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The Care Quality Commission (CQC) is required by law to monitor the operation of the DoLS and to report on what we find. At the time of our inspection those people who required a DoLS had the appropriate authorisation in place.

On the first day of our inspection we saw that access to communal areas, corridors and bedrooms was restricted by the use of a security system which was deactivated by staff through the use of a 'fob'. One person who used the service who was independently mobile had their own fob, so that they were able to move freely throughout the home. We asked a member of staff why people were unable to leave and she told us ''Can't let them roam out. Can't leave because they've got dementia. Everyone in here has got dementia''. However, the owner told us that the system had been put in place a number of years ago to help minimise the number of 'falls' occurring at the home. We read a comment made in the November 2016 relatives' survey which said ''Visitors are left in the main room trying to get out''. We discussed with the owner and registered manager that the system gave the impression to people who lived at the home and to visitors that they were being locked in and that its use constituted a form of restraint. This meant they were not working according to the Mental Capacity Act (2005). They told us they would review its use. On the second day of the inspection we found that it had been deactivated, apart from in a small area of the home where it prevented access to the kitchen area, in order to protect the safety of people who used the service. The registered manager and owner told us that, on reflection, they did not feel it was necessary to have the system in place.

On examination of the care records we saw that one person was receiving medication covertly. This means giving medicines in a disguised form, for example in food or drink, when a person refuses the prescribed medication treatment necessary to maintain their physical or mental health. We saw that there was a letter dated 2012 from the person's doctor authorising staff to give the medicines covertly. However there was no evidence that a 'best interests' meeting had been conducted, as is best practice. The registered manager told us that she would contact the person's doctor to seek clarity on this issue.

A judgement by the Court of Protection in July 2016 clarified the steps required in relation to the administration of covert medicines. This judgement indicated that covert medicines can be considered in exceptional circumstances, but that a best interests meeting should be held prior to providing medicines covertly. A record of the decision making should be contained in the person's care records and should be easily accessible. There was no recorded capacity assessment or formally recorded best interest decision in relation to the decision to administer medicines covertly in the medicines file of the peoples' care files.

These issues show processes at the home were not operated effectively to ensure staff were working within the requirements of the MCA 2005. This was a breach of Regulation 13 (1) (2) (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People living at Edge Hill had access to a range of health care professionals, such as district nurses and dieticians. Visitors we spoke with told us that they were kept informed about changes to their relative's health.

Requires Improvement

# Is the service caring?

## Our findings

The majority of comments received about staff were positive. One visiting professional told us ''The staff are friendly'' and a relative said ''Some of the staff are lovely''. One relative told us ''The staff have a laugh with her '', and another person commented ''I'm happy with all the care my mother is currently receiving''. We looked at the service user survey from February 2016 and saw that there were both positive and negative comments about the staff. One person had commented' 'I don't ask for much but when I do the staff provide it''. Another person had commented ''Some staff are OK but some are not''. In response to the question ''How do you rate the care provided by staff?'' 11 out of the 13 responses were either good or excellent.

We saw that people in the home generally looked cared for; their clothes and appearance were clean. One visitor told us their relative ''Always looks well… doesn't look unkempt''. However, during the first day of our inspection we saw two people sitting in the communal area without any socks or tights and shoes on. We were told that one of the people repeatedly tried to remove their footwear. However no reason was given for the second person being without socks and footwear. One person's communication assessment said '' (person) to wear glasses''. However, on the first day of our inspection we saw that this person was not wearing their glasses. This meant their communication needs were not being fully met.

During both days of the inspection we saw that, while sitting in the communal lounge, people had blankets over their knees and they looked comfortable.

During our inspection we observed how staff interacted with people and saw that they were caring and kind. One person told us ''They're always nice to me. Always nice and gentle'' and a comment we saw from the November 2016 relatives survey said ''The staff treat (the person) in a very friendly manner with kindness and respect''. We watched one person being supported to eat their meal and saw that the carer chatted to the person in a reassuring manner and asked them if they liked their food. One carer we spoke with told us ''I love these residents to bits''. However we saw an example where a member of staff did not respond in a thoughtful way. One person who was eating their dessert accidently tipped the contents of the bowl onto their lap. Although the carer immediately cleaned their clothes they did not offer the person another dessert.

On the first day of our inspection we saw that it was possible to see one person lying in bed, through their bedroom window. We asked the person if they minded this and they told us they did. This showed that the home had not fully considered this person's dignity and privacy. We altered their blinds so that they could not be seen from outside the building and brought this to the attention of the registered manager.

We recommend the provider take steps to review best practice on promoting dignity and privacy within a care home setting.

Staff told us that people's cultural and religious needs were respected. For those people who wanted to continue practising their faith a communion service was held every Sunday. At the time of our inspection there was no one from another faith living at the home, but the registered manager told us that support for

people with other faiths could be sought from the local community.

The district nursing service provided support for staff caring for those approaching the end of their life and we saw from records that some staff had received training in end of life care.

Requires Improvement

# Is the service responsive?

## Our findings

Prior to a prospective service user moving into Edge Hill the registered manager carried out a pre-admission assessment of the person's needs to ensure that the home was able to provide the care and support they required.

During our inspection we reviewed the care records of five people who used the service. We saw that records contained a range of information including risk assessments, support plans, mental capacity assessments, hospital passport, daily reports, MUST and Waterlow scores. MUST and Waterlow scores were up-to-date. The Malnutrition Universal screening tool (MUST) is used to identify adults who are malnourished, at risk of malnutrition or obese. The Waterlow score gives an estimated risk for the development of a pressure sore and is used as part of a prevention strategy.

Some of the information in the records was out-of-date and it was difficult to see what information was current and relevant. For example we saw a document which showed the morning and evening routine for a person was dated August 2015. It described how they needed to be assisted to the bathroom by one member of staff. However, this was not correct as the person was now permanently in bed. Some of the support plans and assessments we reviewed were not dated, so it was impossible to see when they were originally written and if they were still relevant. For example we saw that both the continence and oral care assessments for one person were not dated and another person had a moving and handling assessment that was not dated. Body maps used to record wounds for one person were not dated and hospital passports for two people were dated 2014.

We saw that some support plans had been reviewed on a monthly basis. In some instances however, people's needs had changed significantly since the original care plan had been written, which in some cases was around two years previously. Although the person's current support needs were recorded in the monthly reviews, the original support plan was still contained in the file. This would increase the risk that staff who were not familiar with people's needs would not be aware of the level of care that should be provided.

The above examples of poor record keeping demonstrate a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 Regulated Activities Regulations 2014.

The registered manager was in the process of undertaking a full review of the care records of everyone living in the home in order to ensure that they were up-to-date and was revising the format of the care files to make them easier to read. She showed us copies of a new hospital passport form which she had devised which would ensure that when people were admitted to hospital from the home all the information about their care needs was relevant and current.

We were told that 'handover' meetings between staff were undertaken on every shift and that information was recorded in a handover book which was available for staff to read. Having a handover ensures information about changes to the health or care needs of people living at the home are discussed and that

any alterations in their care are communicated promptly. We observed the handover meeting between the night and day staff on the first day of our inspection and saw that it was very brief and that only information about two people was discussed. The care and support needs of the remaining people were not mentioned. This meant there was a risk that vital information about a person might be missed. During the first day of our inspection we saw that information regarding a person's request for pain-relief was not handed over from the night to the day staff. This meant that the person had to wait an hour before they received medication to relieve their pain.

We recommend the provider reviews their procedures in relation to 'handover' meetings to ensure that they are thorough.

The registered manager was in the process of trying to recruit an activities coordinator, as the previous activities coordinator had left the service several months previously. Since then the role of organising activities had been undertaken by two different carers. There was a list of activities on display in the home; however this was out of date. One relative we spoke with told us ''there's not been much going on since the activities coordinator has gone'' and comments made in the service user survey conducted in February 2016 indicated a level of dissatisfaction with the activities provided at the home. One comment said ''Nothing to do at all''. One member of staff we spoke with told us ''the residents are bored'' and a comment made by a staff member in the February 2016 staff survey said ''more activities are needed for residents''.

During the first day of our inspection we saw that there were no activities to occupy people sitting in the communal area, for the majority of the day, other than the television, which most people appeared to ignore. At 4pm two visiting entertainers provided a 'sing-a-long' which some people seemed to enjoy. The registered manager informed us this was a weekly event. We were told that a visiting company undertook 'armchair exercises' with people. During the second day of our inspection the owner and one member of the care team sat with two people who used the service and helped them with a 'colouring activity'. Other than this there were no activities provided during our second day of inspection. The registered manager told us that a member of staff had taken over responsibility for organising activities and she planned to ask people what activities they would like, with a view to organising a programme of events. Lack of appropriate and meaningful activities taking place on a regular basis can result in people who use the service becoming isolated and withdrawn.

We recommend the provider reviews their procedures in relation to the provision of activities.

We looked at the method the home had for recording and responding to complaints. A provider is required to operate effectively an accessible system for identifying, receiving, recording, handling, and responding to complaints. We were shown a complaints file containing the complaints procedure which explained that all complaints would be responded to, in writing, within 28 days of having been received. We saw that one complaint had been received in June 2016, but there was no written evidence to show how it had been dealt with or if it had been responded to within the appropriate timescale.

This was a breach of Regulation 16 (1) (2) of the Health and Social Care Act 2008 Regulated Activities Regulations 2014. Receiving and acting on complaints.

From talking to the registered manager we saw that the complaint had been handled appropriately.

Inadequate

# Is the service well-led?

## Our findings

At the time of our inspection the home had a registered manager who had been in post since November 2015. We received positive comments about her from people we spoke with. One person told us that they felt the home had ''improved generally '' since she was in post and another person said ''I find her approachable''. During our inspection we found the registered manager cooperative and helpful and open to suggestions we made about changes and improvements that were needed to the service.

The registered manager told us she had a very good relationship with the home owners and that she was in daily contact with them by email to keep them informed about all issues relating to the running of the home. In addition, the owner made a weekly visit to the home in order to review any concerns and to monitor standards.

People who used the service, relatives and staff had the opportunity to comment on the standard of care through surveys. The most recent survey, for relatives, had been conducted in November 2016, just prior to our inspection and the results had not yet been fully analysed. We looked at some of the returned survey forms and saw that several of the comments people had made related to issues we identified during our inspection. For example, we saw that one person had commented that her relative's room was sometimes used as storage space and during our inspection we saw that someone else's wheelchair was stored in this person's room. We also saw comments about lack of paper towels in the toilets and lack of interaction between staff and people who used the service, both of which we identified during our inspection.

We saw that staff had made positive comments about the registered manager in the February 2016 staff survey. One person had commented '' Since (name) has come there is a great improvement''. Staff we spoke with told us they felt supported by the registered manager. One carer told us ''It's really good team work. We help each other out''.

We talked to the registered manager about improvement plans for the home. She told us that this year they had replaced the roof, redecorated ten of the bedrooms and the entrance hall and updated the heating system so that the temperature of individual radiators could be adjusted. Security cameras were due to be installed to monitor the exterior of the building.

We saw evidence that staff meetings were held on a regular basis, which enabled important information about the service to be communicated to staff. However, we saw that where decisions were made at meetings they were not always put into practice. For example, at the managers meeting held in January 2016 a decision had been made to display up-to-date pictures of all the staff working at the home. This would enable visitors and people who used the service to familiarise themselves with staff. We did not see evidence that this had been carried out.

We looked at how the service recorded and monitored accidents and incidents and saw that these were recorded in a log book which detailed the type of accident, the person to whom it related and the date and time it occurred. However, there was no system in place to monitor trends of accidents or identify actions to

be taken to minimise the risk of a reoccurrence in the future. We discussed this with the registered manager who told us she was happy to implement this.

As discussed in the 'responsive' section of this report, the registered manager had not followed the provider's complaints policy correctly in relation to responding to a complaint they had received in June 2016.

Following the concerns raised about the home in relation to poor moving and handling practice the registered manager was asked to implement a number of changes, including the purchase of hoist slings and glide sheets and the improvement of moving and handling guidance and documentation, such as risk assessments and moving and handling care plans. During our inspection we saw that steps had been taken to implement some of the changes, such as the purchase of equipment. However, we saw that up-dated risk assessments and care plans for all people who required the use of a hoist had not been completed, as was requested by the local authority moving and handling coordinator. During a visit to the home on 25 October 2016 by the local authority moving and handling coordinator, staff had been shown how to correctly move people using the hoist. However, despite this additional training, during our inspection we saw incorrect moving and handling practices, as detailed in the 'safe' and 'effective' domains of this report.

The registered manager routinely carried out a number of checks and audits, for example in relation to medicines administration and the maintenance and safety of the home. These help to maintain the quality of service delivery and monitor its standards. We saw that where a problem had been identified, for example identification of a medicines error, steps had been taken to rectify it. The registered manager had recently introduced a regular check of the condition of pressure relieving cushions and mattresses to ensure they were in good condition. The registered manager and owner told us that they carried out 'spot checks' during the night to monitor the standard of care provided by night staff.

Although there were a number of quality assurance processes in place they were not robust and effective enough to fully assess and monitor the quality of the service provision and ensure service improvement.

This was a breach of Regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider was not working within the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.<br><br>Regulation 13(1)(2)(5) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>Systems were not in place to ensure complaints received were appropriately logged, investigated and responded to.<br><br>Regulation 16 (1) (2) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider had not ensured that staff received the appropriate training, support and appraisals to enable staff to carry out their roles.<br><br>Regulation 18 (2) (a) |

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>We found poor infection control and food hygiene practices. Staff were moving people in an unsafe way. Staffing levels were not sufficient to provide prompt care |

**The enforcement action we took:**

warning notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Although there were a number of quality assurance processes in place they were not robust and effective enough to fully assess and monitor the quality of the service provision and ensure service improvement. |

**The enforcement action we took:**

warning notice.