Edenplace Limited

Eden Place Mental Health Nursing Home

Inspection report

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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?	Requires Improvement

Summary of findings

Overall summary

A comprehensive inspection visit took place on 20 August 2018 which was unannounced. We returned announced on 22 August 2018 so we could review the provider's quality assurance systems and to speak with more staff about what it was like to care for people living at Eden Place.

Eden Place is a mental health nursing home, which provides care for up to 34 people over three floors. At the time of our inspection there were 32 people living at Eden Place. People had their own bedroom and some bedrooms had en-suite facilities whilst others shared communal bathrooms. Eden Place had a secured outdoor area and was monitored externally by CCTV, with the entrance to the home accessed by an electronic gate.

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

A requirement of the service's registration is that they have a registered manager. 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 the associated Regulations about how the service is run. At the time of our inspection visit there was a registered manager, however they were away from the home on maternity leave. An interim manager had been appointed to cover this absence from 6 August 2018.

At our last comprehensive inspection in September 2017, we rated the service 'Requires Improvement' overall. At this inspection we found the evidence continued to support the rating of Requires Improvement. This was because there remained limited understanding of working within the principles of the Mental Capacity Act 2005. The provider's quality assurance systems required greater improvement and because there continued to be limited improvement, we found this was a continued breach of the regulations. Some improvements since the last inspection had been addressed, for example, medicines management and the provider had submitted statutory notifications to us when notifiable incidents had occurred.

Care plans required more personal and individualised information for staff to provide care to people in a more person-centred way. For people who had recently moved to Eden Place, a lack of detailed care plan information meant staff did not have the knowledge they needed to know about that individual. For people assessed as being at risk, risk assessments needed more information so staff could manage risks to people safely.

Staff protected people from risks of abuse. All staff understood what actions they needed to take if they had any concerns for people's wellbeing or safety. Staff felt confident to raise concerns to the management and provider.

Staff received regular refresher training to meet people's needs, and effectively used their skills and experience to support people. People's care and support was provided by a caring and consistent staff team and there were enough staff to provide care when people needed it.

Staff did not always work within the principles of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Where people lacked capacity, staff's knowledge was not always consistent to ensure people received the right level of support. Care records did not always include the support people needed to make specific decisions where they lacked capacity.

Staff were caring in their approach and interactions with people. However, the lack of investment in keeping the environment safe and risk free showed the provider had not always considered how their actions impacted on those in their care.

There was limited stimulation for people to be involved in leisure interests to keep them active and to have fulfilling lives. People and staff were working together to help promote their social and lifestyle skills.

Staff supported people to ensure they maintained a balanced diet and people had choice of what they wanted to eat and drink.

People received support from other healthcare professionals to ensure their overall mental health and physical wellbeing was met. Regular checks and monitoring ensured medicines continued to be given safely by trained and competent staff. Time critical and patch medicines were given safely in line with their prescription.

Health and safety checks and environmental checks were not always identified and rectified to protect people from unnecessary risks. Some risks within the home such as water temperature checks, fire safety risks and risks associated with leaving cleaning liquids unattended, where not always realised which put people at unnecessary risks.

Examples of audits and checks were completed but further improvements to audits and checks had been recognised by the manager following our visit. Some checks had been completed with limited understanding of what was correct and there remained limited records to show what actions had been taken. The manager told us they planned to improve the service and wanted people's experiences to be positive and what they deserved. The manager gave us a commitment that actions would be taken following our visit.

We found a continued breach and an additional breach of the Health and Social Care Regulations. You can see what action we told the provider to take at the back of the full version of the report.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

At the last inspection we found medicines were not managed safely and given in line with the prescriber's instructions. At this inspection, we found medicines were given safely by trained staff and in accordance with safe administration. Staff understood their responsibilities to keep people protected from unsafe practice. Safe staffing levels ensured people were supported by experienced staff. Health and safety checks and individual risk assessments were not always identified to protect people from unnecessary risks.

Is the service effective?

Requires Improvement

The service was not always effective.

At the last inspection we found where people lacked capacity, assessments and care records did not support what decisions people needed support with and some people had unnecessary restrictions placed on their freedoms. At this inspection we found best interest decisions and assessments had been completed, especially in cases where a Deprivation of Liberty Safeguard had been applied. Staff received regular training and people received support from other healthcare professionals when needed. The environment within the home required updating and improved maintenance to ensure it remained safe and suitable for people.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff treated people with compassion, and were kind and caring about those in their care. However, the lack of attention to detail in people's care plans, risks assessments and within the environment they lived, meant we could not be confident people felt valued.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care planning and people's involvement in their care delivery required improving and people needed more input to motivate and stimulate their interests. People knew how to complain.

Is the service well-led?

Requires Improvement

The service was not always well led.

At the last inspection this home was rated as 'requires improvement' in this area, because audit systems were not effective and actions were not always taken. We continued to find the governance and quality assurance systems needed further improvement because they failed to identify the issues we found to ensure people received good outcomes. Where checks were delegated to others, there needed to be greater scrutiny that actions were taken to improve the delivery of service.

Eden Place Mental Health Nursing Home

Detailed findings

Background to this inspection

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

This comprehensive inspection visit took place on 20 August 2018 and was unannounced. The inspection team consisted of one inspector, one inspection manager and a specialist advisor. The specialist advisor was a mental health nurse. One inspector returned announced on 22 August 2018 to review more records and to look at the provider's quality assurance systems.

We reviewed the information we held about the service. Prior to this inspection visit we received information suggesting a person had been at risk of potential harm. We looked at this concern during the inspection. Following this inspection, we continued to work with other agencies such as the local authority safeguarding team. This was to assure ourselves the provider was aware of the known risks and they had taken the necessary interventions to mitigate potential risk to people at the home.

We looked at any information shared with us by the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. We looked at the statutory notifications the provider had sent us. A statutory notification is information about important events which the provider is required to send to us by law.

To help us understand people's experiences of the service, we spent time during the inspection visit talking with people in the communal areas of the home. This was to see how people spent their time, how staff involved them in making decisions about their care, how staff provided their care and what they thought about the service they received.

We spoke with three people who lived at Eden Place. Some of those people did not want to have a full conversation with us, but were happy to share some of their experiences of living at the home. We spoke with a director of the provider company and the home manager. We also spoke with three nursing staff, three care staff, a housekeeper and two maintenance staff.

We looked at five people's care records and other records including individual risk assessments, quality assurance checks, daily notes for people, medicines and health and safety records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in September 2017 we found staff did not always protect people from known risks within their care and support and risks people faced from their environment. At this inspection we found improvements had not been made. The safety of the service continues to be rated as Requires Improvement.

No one told us they felt unsafe. One person said they felt safe because the care staff and nurses were nice to them. People told us the staff who supported them were approachable and they had no concerns asking any staff member for assistance.

Risk assessments required improvement so staff had the right information to protect and support people from known risks. For example, one person's care plan stated they could present behaviour that could be shown through verbal or physical aggression. However, there was no information to show strategies to support the person to manage these behaviours were known, recorded or shared for consistency. To manage risks associated with diabetes, some people needed their blood pressure and blood sugars to be checked frequently. Risk assessments did not say how often these checks should be carried out to ensure the appropriate support if safe levels were not maintained. Another person was identified as having short term memory loss and their risk assessment stated they needed, 'lots of prompting'. There was no information to show what they needed prompting with or how to communicate this to the person so they understood. The manager accepted work was required to improve the risk assessments and was planning to review all the care plans and risk assessments.

We found some unsafe practices within the home that had potential to put people at unnecessary risk. For example, maintenance within the home was not always identified or if it was, took too long to improve. At the last inspection we found a bathroom was out of action because of a water leak. The bathroom had been repaired, however at this inspection, we found a downstairs toilet was out of action because a leak from a shower room above, had made the area too wet for safe use. An infection control audit dated March 2018 identified one bathroom as having, 'no plug in the basin and paint flaking off the ceiling' which had potential to pose a risk. We checked at this inspection visit and found these issues had still not been rectified.

Water temperatures were checked regularly by the maintenance staff to ensure water from taps, baths, and showers were at a safe temperature to prevent the risks of scalding, however the checks were always in the same few rooms meaning some rooms remained unchecked. Health and Safety Executive guidance states temperatures should not exceed 44 degrees Celsius from bedroom taps, however records showed some temperatures exceeded 58 degrees Celsius. Shower heads were recorded as dispensing water at over 60 degrees Celsius. The maintenance staff were unware of the safe limits, even though they continued to test temperatures regularly, and had not considered that some rooms were never checked and could be unsafe.

Infection control measures consisted of staff using personal protective equipment to reduce cross contamination and we saw staff used this correctly. During our inspection visit, we saw cleaning liquids that could be harmful if ingested, were left unattended and a storage cupboard containing cleaning materials

was left unlocked, with the door open. The provider's own infection control audits had identified improvements were required to maintain good hygiene and limit the risks of cross infection, but there were limited records to show what action had been taken to improve. This included bathrooms that had not been repaired and flooring that still required replacing.

Gas safety checks had been completed yearly and records showed that in October 2017 and March 2018 the gas utility company had served 'at risk' notices regarding ventilation and low valve pressure in the basement area where some staff worked. Similar issues had been identified in October 2014, but there were no records to show what safety improvements had been made. The manager and maintenance staff said because the 'at risk' notices were not followed up by Gas Safety, no action was taken by staff and the provider. Following our inspection visit we contacted the manager and asked what actions they had taken to ensure water temperatures and gas safety risks had been reduced. The manager said the gas utility company was replacing relevant gas pipe work but they were satisfied safety was maintained. Thermostatic valves were being fitted to hot water outlets. All this work was planned to be completed by end September 2018.

At this inspection it was clear to see that the environment would benefit from redecoration and a lack of effective oversight had potential to put people at unnecessary risk. On the second inspection visit we saw a fire escape on the 3rd floor was unsupervised which meant people could access this without being seen. We also saw an unlocked cupboard that housed a 'live' fuse box. The maintenance staff said they were told to leave this 'open' but did not understand the risks this this posed to people. They had arranged for a padlock to be put on this as a temporary safety measure whilst we were there, however this too could present a delay if they needed to isolate the power quickly. These examples showed us there was a lack of care and consideration into how some people may have viewed their surroundings as well as the potential risks they faced. The manager recognised there were improvements needed to provide people with an environment where they felt valued.

The provider did not have effective arrangements in place to keep the environment safe and free from potential risks. This was a breach in Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, medicines management was not always safe and there was a breach of the regulations. At this inspection we found improvements had been made. People received their medicines as prescribed, from trained and competent staff. Systems ensured medicines were ordered, stored and administered safely. Medicines Administration Records (MARs) were used to record when people had taken their medicines and daily counts by trained staff made sure medicines were given as prescribed. MARs were completed correctly and for some people who had medicines on an 'as and when' basis, guidelines included when to administer the medicines, the reasons for doing so, and safe dosage limits. Time critical medicines were given at the correct times and medicines were stored within safe temperature ranges. Medicines that required stricter controls were managed, stored and recorded correctly. Topical creams and some patch medicines were applied safely by staff who recorded their application on the correct charts.

Staff had safeguarding training and they understood the signs that could indicate a person was at risk of harm or abuse. Staff had confidence to challenge poor practice and to share any concerns with the manager, CQC or the police if needed. Where a safeguarding concern or incident had been identified, the manager had acted to report this to the relevant organisations who have responsibility for investigating safeguarding issues. At the time of our inspection visit, we were told about one potential safeguarding incident. Following our visit, we continued to work with the safeguarding team to ensure appropriate actions and measures were taken to keep people protected. Safe systems ensured people's money was kept safe and secure. Staff told us regular checks were made to ensure people's money was correct and safely

locked away.

There were sufficient experienced staff to meet people's needs. No one living at the home said they did not receive help when needed. A nurse managed the shift which consisted of five care staff for 12 hours of the day, reducing late evenings. Staff said on occasions if unplanned absence occurred, this presented challenges, but one staff member said, "We cope, it's not all the time and we have agency staff." The manager said they used agency staff where required and they were consistent agency staff so they knew those they supported. Housekeepers, maintenance and driving staff complemented the staff team. We were told on occasions a driver was not always available which limited opportunities for people to go out which they enjoyed. The manager was confident staffing ratios were correct to meet people's needs.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection, we found a breach of the regulations because staff did not always work within the principles of the Mental Capacity Act 2005 (MCA). People who lacked capacity to make specific decisions were not always assessed and records of best interest decisions were not always recorded. Following the inspection, the provider sent us an action plan telling us how they would ensure people's rights and freedoms would be upheld in line with their ability to consent to decisions.

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 so that they can 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. At the time of our inspection, six people had an approved DoLS in place.

At this inspection, whilst staff promoted choice and sought consent, managers and senior staff needed to be more consistent in the application of the Mental Capacity Act 2005 to determine what decisions people lacked capacity to make and how this affected their care delivery. We recognised some improvements had been made and they were no longer in breach of the regulations. This was because there was evidence that showed both 'best interests' decisions and mental capacity assessments were being completed as part of the pathway to seeking a DoLS application. We checked records for people who lacked capacity to take their medicines. In this case, people's medicines were disguised (in food or crushed) and records showed best interests decisions had been made and why it was beneficial to administer their medicines covertly.

Where people had an approved DoLS, records explained why this was, for example 'lacks the capacity to make an informed decision about their residence, care or treatment'. However, speaking with the manager, they needed a clearer understanding to determine whether deprivations needed to be considered for supervision when taking people out of the home on trips, or whether it was about managing risks to allow people's freedom with staff support. The manager told us they would review all the records for people who lacked capacity and ensure, assessments were decision specific. They also told us they would look at ways to enable people, where possible, to take the least restrictive options whilst maximising their choice and independence. They also agreed to review guidance around applying MCA principles and best practice.

Staff told us they felt confident in their roles because they received regular training that kept their skills and knowledge up to date. Staff received training from a variety of sources including, on line training and learning from peers and senior staff. The manager kept a training schedule that informed them when refresher training was due so staff skills reflected current best practice in providing care.

Staff said they had supervision meetings and this provided opportunities to request further training or development. Staff meetings also gave an opportunity to discuss issues with their peers and raise concerns or share ideas.

No one living at the home said they did not like the food, and one person told us, "The food is very edible." We saw people were given two choices and the cook said alternatives could be prepared if people wanted something that was not on the menu. The cook knew about people's dietary requirements, such as vegetarian, cultural foods or diets that were soft or fortified with additional calories, and prepared those meals accordingly. The manager was planning to improve the social experience at meal times because they wanted it to be more pleasurable rather than task focussed. They had purchased new condiments, plates, cups and tablecloths and planned to introduce these as soon as possible.

People's healthcare needs were met by staff and any concerns were supported by the nursing staff, or other healthcare professionals were requested when needed. People's records showed they had seen doctors, district nurses, dentists and mental health support workers. One person told us they had seen a doctor and a dentist.

The home was an older building which was not purpose built and the layout of the corridors presented some challenges, such as upper floor areas that made it difficult to observe people. Bedrooms were arranged over three floors, most of which were accessible by stairs, a passenger lift or stair lift. The decoration and a lack of tactile objects and pictures made the home feel clinical rather than homely. The provider planned to replace flooring in the communal hall which was torn and unsightly. A number of leaks in communal bathrooms meant some bathrooms or toilets were temporarily out of use or had not been redecorated once the main issues had been repaired, so looked unappealing. The manager acknowledged the challenges of the home environment and plans were in place to redecorate and smarten up the home for the benefit of the people who lived there.

Requires Improvement

Is the service caring?

Our findings

At this inspection, we found people continued to be supported by a caring staff team who helped promote people's independence as much as possible. However, despite the staff's commitment to supporting people, the provider needed to make improvements to people's overall experiences living at Eden Place. The rating has changed from good to requires improvement.

No one told us they did not feel valued or cared for by staff. One person was complimentary of their care, saying they were, "Well treated" by staff and they enjoyed living at Eden Place. They said they could go out and staff helped them to do the things they wanted to do.

During our inspection visit we saw staff treated people with kindness and gave them the emotional support they needed. We observed staff treated people with respect and compassion and staff gave people enough time to respond and think what they wanted to say and do, at their own pace. Staff told us they treated people as individuals and enjoyed working at Eden Place. Staff said recent morale issues aside, they wanted to provide good care to people and said Eden Place was a good home. Staff understood the importance of promoting people's independence because they did not want to de-skill or remove people's choice to do things that they could do themselves. One person said staff encouraged them to make their own bed and change their bedding which they were happy to do. They told us staff chose their clothes at their request, because they did not want to.

Staff said they respected people's privacy and dignity. Staff said if people wanted to spend time on their own, that was fine and people were supported to do this. Staff said whenever people needed support with personal care, this was done discreetly behind closed doors. During our visit people had support from staff with showering. One staff member said they made sure they took all people's personal toiletries and towels into the bathroom before supporting them with personal care, to limit the possibility of the person being left in a bathroom on their own. They told us they made sure doors were locked to prevent unwanted intrusion.

However, improvements from the provider were required to make sure people received a consistent and caring service in an environment that promoted positive wellbeing. People's care plans required more detail to ensure staff continued to provide consistent care.

People's confidential information was kept secure. This helped ensure people's confidentiality was maintained. However, we were informed about a recent incident that had potential to put people's and staff's, confidential information at risk which we discussed with the provider. Following this inspection, we maintained contact with the safeguarding team to ensure important information was safeguarded by the provider.

Requires Improvement

Is the service responsive?

Our findings

At this inspection, we found care planning and care reviews needed more scrutiny to ensure people's care plans reflected the support they needed. People were able to pursue some interests, however more was needed to ensure people did the things they wanted to do, when they wanted to do them. The rating has changed from good to requires improvement.

Care was not always person centred. There was limited information to show people were involved in making and reviewing their care decisions. Individual preferences, interests and aspirations were not always known by staff. Records did not record what people liked, disliked and what worked well to promote good care outcomes for people's mental and physical wellbeing. Staff told us they knew people well enough, but said the care plans could be more detailed so they could be more proactive in knowing how people's health needs differed, and what worked well to support them. For example, one person had an alcohol related brain injury. Staff understood the potential causes, but did not always understand how they could tailor their approach as the only guidance for staff in the person's care plan was, 'Be positive, encourage the person to keep to structure and daily routines'. The manager started at this service in August 2018 and had identified care plans required improving. They said, "Care plans are under review – they are not person centred….more run of the mill." To improve this, they said, "I have gone back to other care plans that are more inclusive and not task orientated."

Staff told us there were times when staffing levels did not allow for people to do the things they wanted. For example, one staff member said staffing levels at weekends and evenings, had on occasions dropped below expected and assessed levels. They said this made it difficult to provide the 'extras' that improved people's day, but said they were able to complete their tasks. One person said they enjoyed going out but did not do this as often as they wanted. They told us there had been a shortage of drivers. Other staff confirmed this. On the day of our visit, the manager told us a driver was not present because they had to attend a personal appointment. On occasions, other staff could cover, but this had potential to leave them short of a staff member to support people within the home.

Some people did activities and pursued leisure interests they enjoyed. Some people went to the local shops with staff support to help them be safe. Some people liked to go shopping, or to the hairdressers. One person said staff painted their nails which they liked. However, during our visit, we saw little stimulation for people. People sat in different areas of the home, but there were limited opportunities to get people involved or interested in activities that were meaningful to them. The manager had identified this as an area for improvement and was planning to get people more involved in the things they wanted to do. Meetings were being held to get people's feedback.

No one told us they had made a complaint. One person said they wanted to go out more and had told staff this although they could not tell us when they last out. Information about how to make a complaint was displayed in the communal corridor and included, expected timescales for responding to the complaint and what to do if people were unhappy with the provider's response. We did not see any records of complaints made since our last inspection visit.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in September 2017 we found the provider was not meeting all the legal requirements and was rated as 'Requires Improvement' under the key question of 'Is the service well led?' This was because we found the systems that monitored and managed risk were not entirely effective and had failed to provide opportunities for reflective practice. There were limited systems in place to ensure people's rights had been upheld in line with the Mental Capacity Act 2005. Assessments of capacity and best interest meetings had either not been considered or not completed. The provider's own audits had failed to identify the issues we found. This meant the service was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. The provider submitted an action plan that detailed the improvements required to meet their legal obligations. At this inspection we found some improvements had been made, however further improvements were still required and we found the provider continued to be in breach of the regulations.

Quality assurance systems did not identify and evidence improvements. Some completed audits had not identified the issues we saw. For example, health and safety checks for safe water temperatures were completed. Staff who completed those checks, did not know safe temperature ranges and continued to record high temperatures that exceeded safe limits. This had not been identified by the provider or manager. At risk notices issues by gas utility companies were not acted upon which continued to put people at potential risk.

Environmental and infection control audits identified improvements, but no action had been taken. There was no follow up or responsibility taken to make those improvements. Some improvements that had been identified four months ago, showed no action had been taken. Care plans, risks assessments and mental capacity assessments were not routinely checked, updated and reviewed to ensure they provided staff with up to date and accurate information.

Following a fire authority visit, internal walls had been removed, however this presented additional risks and exposure to electrical equipment which was otherwise restricted. No thought had been given to this or ways to cover this equipment to limit the risks to people. During the second day of our visit, on the third floor, we saw a fire door was left open and unsupervised. People could have left the home via the fire stairwell and made their way into the garden area, and have left via an unsecured gate. Improved risk awareness and management would help keep people protected, especially as some people could not leave the home without staff support for their safety. The unsecured gate had not been identified as a potential risk in the provider's own audit of the environment. This had not been identified during regular checks of the environment.

The manager, a director and staff explained how poor staff morale and recent difficulties within aspects of the staff team had contributed to create an uncomfortable working atmosphere that stifled progress and improvement. A director told us they knew there were issues but they had not tackled them sufficiently and in a timely way, which escalated potential poor practices. The director told us they visited regularly but it was more of a social call and not used in a formal way to record and consider quality issues.

Providers should be aiming to achieve and sustain a rating of 'Good' or 'Outstanding'. Good care is the minimum that people receiving services should expect and deserve to receive. The provider is expected to have established systems and processes that operate effectively to ensure compliance with the regulations. The provider did not have effective arrangements in place to monitor, improve and evaluate feedback about the quality, safety and welfare of people using the service. This was a continued breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The interim manager had been in post since August 2018, she was an experienced mental health nurse and had worked for the provider at their other service. She showed us an improvement plan they were working to which had been given to them by the local authority. This action plan identified some of the issues we found at this visit. The manager told us they were capable of making the improvements and they said they had the support of the provider. During both inspection days the manager outlined to us how they planned to improve the overall experiences for those people and staff, at Eden Place. The manager said, "It is not homely." They had recognised that care plans required updating and the risk assessments, "Which only tell you what the risk is, not how to manage it." They planned to improve the mealtime experience for people and had purchased new tablecloths and pictures and they had approached the provider for additional funds to make those changes happen which had been agreed. They planned to improve activities as they felt people were not always stimulated and interested in pursuing hobbies. They also planned to 'Promote the safety of residents' by improving the bathrooms as a priority.

The manager welcomed the inspection and was committed to making the improvements. They told us they were determined to make sure people received a quality of care that they were proud of. The manager told us some staff practice was "institutionalised" and the provider's philosophy was, "We want to provide a home – not an institution." The manager told us with recent staff and nurse appointments, they were confident they had the right team to deliver a good standard of care. Changes within the staff team had improved the atmosphere and culture within the home and staff told us they all shared the same objectives in supporting those people in their care.

It is a legal requirement for the provider to display a 'ratings poster'. The regulation says that providers must 'conspicuously' and 'legibly' display their CQC rating at their premises. A copy of the report showing the ratings was displayed in the home and a copy was also displayed on the provider's website.

People's personal and sensitive information was managed appropriately. Records were kept securely in the staff office, so that only those staff who needed it could access those records. During this inspection we discussed a possible breach of confidentiality with the provider who told us they were investigating this to ensure lessons learnt would be taken into safeguarding important information. This meant people could be assured their records were kept confidential.

At the last inspection the provider was in breach of the regulations because they failed to tell us about notifiable incidents. Following the last inspection, the provider told us about important events that we needed to be notified of such as expected deaths, safeguarding incidents and approved DoLS. The manager knew when to notify us of such events and we found they were no longer in breach of the regulations.

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 15 HSCA RA Regulations 2014 Premises and equipment The provider did not take responsibility to ensure the premises and equipment were safe, maintained and fit for use. Regulation 15(1)(2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes continued not to be robust, established and operated effectively to ensure risks to people were reduced and to provide a good quality service to people. Regulation 17 (1)(2)(a)(b)(e).