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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 21 September 2017 and was unannounced.

Eden Place Mental Health Nursing Home is registered for a maximum of 33 people offering accommodation for people who require nursing or personal care and requiring treatment for substance misuse. At the time of our inspection there were 31 people living at the service. People using the service were being supported with their mental health needs and no one was requiring treatment for substance misuse. Eden Place was last inspected by us in July 2015, and we rated the home as Good.

The home had 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 2008 and associated Regulations about how the service is run.

People's medicines were not always administered as prescribed, and medicines records did not always demonstrate that medicines were administered consistently. Some prescribed creams were being administered by care staff who had not been trained to do so. Audits designed to check medicines practice was safe and in line with best practice had not identified some of the issues we found.

Action had not always been taken to keep people safe in response to incidents that took place within the home.

Where people did not have capacity to make their own decisions, this had not always been assessed and documented. It was not always clear who was authorised to make decisions in people's best interests, and applications to deprive people of their liberty had not always been made as required.

Systems in place to check the quality of the service provided were not effective, as they had not identified the concerns we found during our inspection. The provider had not always notified us of incidents that occurred in the home which is their legal requirement to do.

People told us they felt safe with the staff who supported them, and we saw people were comfortable with staff. Staff received training in how to safeguard people and understood what action they should take in order to protect people from abuse. The provider ensured staff followed safeguarding policies and procedures.

There were enough staff to meet people's needs effectively. The provider conducted pre-employment checks prior to staff starting work, to ensure their suitability to support people. Staff told us they had not been able to work until these checks had been completed.

People were asked for their consent before staff supported them. People had access to health professionals

when needed and care records showed support provided was in line with what had been recommended.

People were offered a choice of meals and drinks that met their dietary needs, and where they were at risk, their food and fluid intake was recorded and action taken where required.

People and relatives told us staff were respectful and treated people with dignity. We observed this in interactions between people, and records confirmed how people's privacy and dignity was maintained. People were supported to make choices about their day to day lives. For example, they were supported to maintain any activities, interests and relationships that were important to them.

People's care records were written in a way which helped staff to deliver personalised care and gave staff information about people's communication needs, their likes, dislikes and preferences. People were involved in how their care and support was delivered.

People and relatives told us they felt able to raise any concerns with the registered manager. They felt these would be listened to and responded to effectively and in a timely way. People and staff told us the management team were approachable and responsive to their ideas and suggestions.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

Medicines were not always administered safely and as prescribed. Medicine audits were not effective because they had not identified the concerns we found. Incidents which put people at risk had not always been acted on quickly and effectively. Staff knew what action to take to safeguard people from the risk of abuse, and the provider had measures in place to ensure they recruited people who were suitable to work in the home. There were enough staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Where people lacked capacity to make day to day decisions, this had not always been assessed and documented. DoLS applications had not always been made as required, and it was not always clear who was authorised to make decisions in people's best interests. Staff understood the need to obtain consent from people in relation to how their needs should be met.
People were supported by staff that were competent and trained to meet their needs effectively. People were offered a choice of meals and drinks that met their dietary needs, and where they were at risk, their food and fluid intake was recorded and action taken where required. People received timely support from appropriate health care professionals.

Is the service caring?

Good

The service was caring.

People were treated as individuals and were supported with kindness, dignity and respect. Staff were patient and attentive to people's individual needs and preferences, and showed respect for people's privacy. People were supported to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support which had been planned with their involvement and which was regularly reviewed. Staff responded to people quickly and effectively on a day to day basis, and as people's needs changed. People were supported to maintain hobbies, activities and interests. People knew how to raise complaints and were supported to do so.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems to check the quality of the service provided were not effective, as the issues we identified during our inspection had not been picked up. The provider had not always notified us of incidents that took place in the home as they were legally required to do.
People and staff felt able to approach the management team and felt they were listened to when they did so. Staff felt well supported in their roles and there was a culture of openness.

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.

The inspection took place on 21 September 2017 and was unannounced. The inspection was conducted by two inspectors.

We reviewed the information we held about the service. We looked at information received from local authority commissioners. Commissioners are people who work to find appropriate care and support services for people and fund the care provided. We also looked at statutory notifications sent to us by the service. A statutory notification is information about important events which the provider is required to send to us by law.

We reviewed the provider information return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection visit, we spent time observing interactions between people and staff. We spoke with five people who lived in the home, and with one visiting relative. We also spoke with the registered manager, the clinical lead nurse, a second nurse, a maintenance worker, a domestic worker and three care staff.

We reviewed five people's care records, to see how their care and support was planned and delivered. We looked at other records related to people's care and how the service operated to check how the provider gathered information to improve the service. This included medicine records, staff recruitment records, the provider's quality assurance audits and records of complaints.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in July 2015, we rated 'safe' as Good. At this inspection, we found improvements were required to ensure people were kept safe.

People's medicines were managed and administered only by staff who were trained and assessed as competent to do so. Medicines such as tablets and injections were administered by two members of staff, who checked each other's work, to minimise the risk of any errors. However, care staff administered cream to people during personal care, and sometimes worked alone. Care staff explained they administered prescribed creams, and recorded they had done so in people's care daily notes. However, the medicines administration record (MAR) was completed by a member of nursing staff. One care worker said, "If I apply prescribed cream for example, I would record it in the care plan then tell the nurse. They would not be there while I did it [applied cream] though." We were concerned this meant nursing staff could not be sure prescribed creams had been applied safely.

Some people required medicine, such as pain relief, in the form of patches on their skin. We found staff had not completed body maps or patch position records to make sure the correct amount of patches had been applied in the right places. This was confirmed verbally by the clinical lead nurse. There were no records in place to record when patches were removed from people's skin, to ensure people did not wear more than the prescribed dose of patch medicine. This put people at risk of receiving too much medicine, or skin irritation from patches being applied in the same place.

Some people required medicines to be administered on an "as required" basis, for example in response to pain, or when they became agitated and anxious. There was no clear guidance in place for the administration of these types of medicines to make sure they were given safely and consistently by staff.

The doctor had prescribed one person medicines, and had instructed staff to administer the medicines covertly (without the person being aware they were taking medicine) if they refused to take their medicines each day. The doctor had agreed this on 15 October 2014. Records showed this arrangement had not been reviewed since November 2015. As some medicines were not effective when crushed, and may cause side effects, each medicine that was crushed needed to be checked with the pharmacy or medicines specialist, to understand whether it was safe to administer. We found no records were in place to record whether medicines remained safe and effective when crushed.

We found the person was prescribed a medicine which should have been given with a full glass of water. No instructions were provided for staff to follow to ensure this medicine was given in line with pharmacist advice. In addition recommended manufacturer's guidance for the medicine stated, 'do not split or crush the tablets before taking them as this may destroy or alter the effects of their contents' Not following this guidance had potential for the person to be harmed if their medicines were not effective.

We found people had the medicines they were currently prescribed, recorded on their medicines administration record (MAR). MARs also listed medicines that were not being administered to people at the

time of our inspection visit. We asked the clinical lead nurse why MARs showed medicines that were not being given to people. They told us that some MARs were out of date and listed medicines that were no longer prescribed. The provider had not put in place medicines care plans and risk assessment for each person who received medicines from staff. However, the clinical lead nurse had put in place some medicines care plans, and told us they were working towards all people having a plan in their care records Therefore MAR's could not be checked against a current and up to date list of prescribed medicines for everyone living in the home, which had potential for people to receive medicines no longer prescribed to them.

We checked to see whether medicines had been disposed of when they were stopped, in accordance with recommended guidance. We found one person had one of the medicines they were no longer prescribed, still in stock. The medicine was dated April 2017, and had not been given to the person since April 2017. This however meant there were insufficient auditing procedures in place to identify when stocks of medicine had not been disposed of to minimise the risk of giving medicines unnecessarily.

Each person's MAR included their photograph, the name of each medicine prescribed to them, and the frequency and time of day it should be taken. MARs were signed by staff when medicines were administered, to confirm people received their regular medicines. Daily and monthly checks were in place, conducted by medicines trained staff, to ensure medicines were managed safely and people received them as prescribed. However, these checks on the administration of medicines did not highlight the issues we found during our inspection visit which continued to place people at risk of receiving medicines not in accordance with their prescriber.

We found this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection visit, the registered manager sent us information which showed new systems had now been introduced to ensure medicines were administered safely and as prescribed. For example, the provider had taken steps to ensure prescribed creams were administered as directed, and that this was clearly recorded. They had also ensured this was the case for people who took medicines in the form of 'patches.'

With the exception of medicines, the registered manager had identified potential risks relating to each person who used the service, and care plans had been written with the person, to instruct staff how to manage and reduce those risks. Most of the risk assessments we looked at were reviewed regularly to ensure they were up to date. For example, where people were at risk of harming themselves or others due to their complex care needs and behaviours, risk assessments detailed what the triggers might be for such behaviours. They also guided staff on how they could minimise triggers, how staff should react at the first signs the person might be becoming anxious, and what techniques staff might use to distract the person and change their behaviours to become more positive.

However, we reviewed one person's 'falls' risk assessment to determine whether the risks of them falling were being safely managed. The person was identified as being at high risk of falls, and the care records showed the person had bed rails in place to prevent them from falling out of bed during the night. The person lacked the capacity to make decisions around this risk, as they did not understand the impact to their health of them falling. We found the person had been taken into hospital several days before our inspection visit with a suspected dislocated shoulder joint. We asked the clinical lead nurse how the injury had occurred. They were unable to explain the injury, yet we established that staff did not use bed rails for the person, as per their care plan because they became distressed when these were used.

There was no risk assessment in place to show whether an alarm mat was required, to alert staff when the person might fall in their room. This meant the person's risk assessments were not up to date and did not clearly show how risks to them falling could be minimised by staff.

Other risks, such as those linked to the premises, or activities that took place at the home were assessed and actions agreed to minimise those risks were in place. Routine safety checks were completed for the premises, these included gas checks and checks on electrical items. The provider ensured equipment was safe for people to use. For example, we checked records of maintenance of hoisting equipment, and found this was up to date.

However, we found one of the downstairs bathrooms was not in good repair. The roof leaked water, and water was dripping onto the bathroom floor through a light fitting on the ceiling. The bathroom ceiling was showing signs of water damage. We asked the maintenance person whether the bathroom was due to be repaired. They explained an electrician had been called in the week before our inspection visit and had advised the provider the light fitting was safe with the water ingress. However, there was no written risk assessment in place to assess and record any actions that had been taken to minimise risks to people at the home. There were ample toilet and bathroom facilities at the home, so the bathroom could have been closed whilst repair work was undertaken, without putting people at an unnecessary and avoidable risk. Following our inspection, the registered manager assured us the leak had been fixed and the ceiling repaired. They also sent us evidence that the bathroom had been closed following our inspection visit to ensure people were safe.

People told us they felt safe living in the home. Comments included, "Yes, I feel safe. There is nothing not to feel safe about", "I feel safe. I've got my walker (walking frame) to help me."

People were supported by staff who knew how to protect them from the risk of abuse. Staff attended safeguarding training regularly which included information about how to raise issues with the provider and other agencies if they were concerned about the risk of abuse. Staff told us this training assisted them in identifying different types of abuse and they would not hesitate to inform the manager if they had any concerns. One staff member said, "I would look out for changes in personality, maybe people becoming withdrawn, unexplained bruises or injuries, that kind of thing. I would go straight to the senior, the deputy or the manager." However, we found two safeguarding incidents that, whilst action had been taken by the provider to ensure people were protected, had not been reported to the local authority or CQC. We raised this with the registered manager, who explained these were not determined to need a safeguarding referral at the time as they were as a result of people's ongoing behaviour, which was well known and managed by staff. However, they acknowledged such incidents needed to be discussed with the local authority safeguarding team, and assured us they would do so.

The provider's recruitment process ensured risks to people's safety were minimised because checks were made to ensure staff who worked at the home were of suitable character. Disclosure and Barring Service (DBS) checks and references were in place before any staff started work. The DBS helps employers to make safe recruitment decisions by providing information about a person's criminal record and whether they were barred from working with people who use health and social care services.

The provider had taken steps to minimise the impact of unexpected events such as fire. The provider had undertaken work to ensure the premise was safe in the event of a fire following a notice issued by the fire service. The fire service was due to return to the home shortly after our inspection to check the work undertaken. People who lived at the home had an up to date personal emergency evacuation plan (PEEP) to instruct staff and the fire service about how they should be supported when evacuating the building.

People and their relatives told us there were usually enough staff to meet people's needs safely. One relative commented, "Sometimes they seem to be down to the minimum, but it varies day to day. But I think personally there are enough staff. Staff also told us there were enough staff to care for people safely, though they felt lunch times could be very busy. One staff member explained, "I think there are enough staff for the workload. Lunch time can be a bit manic."

We observed there were enough care staff at the home to care for people safely. Staff were available in the communal areas to respond to people's support needs straight away. The registered manager told us staffing levels were determined by the number of people living at the home, and their specific support needs.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in July 2015, we rated 'effective' as Good. At this inspection, we found improvements were required to ensure people were supported effectively.

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager and deputy manager understood the basic principles of the MCA and DoLs. Records showed most people had mental capacity assessments undertaken when a need was identified. However, we found one person did not have a mental capacity assessment, even though the registered manager had applied to restrict their freedom under a DoLS. We brought this to the attention of the registered manager during our inspection visit. They explained this was an oversight. Although a capacity assessment had been completed by the local authority when assessing for the DoLS authorisation, the registered manager agreed they would complete their own capacity assessment so staff were clear which decisions the person could make for themselves.

Some decisions made in people's best interests were recorded, for example, where people did not have the capacity to manage their finances. However, this was not always the case for other decisions. The registered manager reviewed people's care needs to assess whether they were being deprived of their liberties. We found one person who lacked the capacity to make all of their own decisions, and who had restrictions placed on them, that did not have a DoLS application. Whilst some applications for DoLs had been made appropriately, the registered manager had failed to consider if the other people living in the homw who lacked capacity, or had variable capacity to consent to their care and treatment and were not free to leave the home unsupervised also required an application to made to authorise their deprivation of liberty. In addition, where people's DoLs had expired, the registered manager had not made further applications to ensure their liberty was deprived in a lawful way.

Speaking with the manager, we found they did not always know what action to take where people lacked capacity. For example, one person, who lacked the capacity to make all of their own decisions, was being supported by staff at the home and health professionals, to make important decisions. These were being recorded as best interest decisions. However, the person did not have any family members or representatives to support them, and speak for them, regarding their care decisions. We asked the manager whether the person had an appointed advocate to help with making decisions, and to act in the person's best interests. The manager and deputy manager were unable to confirm whether an advocate was appointed, or had been consulted when decisions were made. There was no evidence to suggest they were consulting anyone independently to act in the person's best interests.

We found this was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff understood the importance of supporting people to make their own decisions when they were able to, but told us they would escalate any concerns they had that people might not have capacity to understand decisions they were making where this put them at risk. One staff member explained, "Capacity is about whether or not someone can make decisions for themselves. If not, you might need to intervene and get outside help. I would raise it with the manager first."

Care staff understood the importance of ensuring people made choices and ensured they checked people were in agreement before they supported them. We observed a number of interactions between people and staff where consent was sought before people were supported.

Care staff were aware some people living in the home had DoLS authorisations in place. One staff member explained, "A lot of the people living here have a DoLS in place. You can never force anyone to do anything. If someone refuses support you have to respect that, unless it has been assessed as being in their best interests."

Systems to monitor fluid intake were not consistently completed and reviewed, to ensure people remained hydrated. We checked one person's fluids which staff monitored so they knew if the person was drinking enough, as they were at risk of developing a urine infection. There was no target amount recorded on the person's risk assessment or care record to alert staff to the minimum recommended fluid the person should drink before staff raised this with the clinical lead nurse. There was no evidence to show that fluid amounts were reviewed to highlight when the fluid intake could place the person at risk. We reviewed the person's records for three days at the end of August 2017. It showed for one day the person consumed 600ml of fluids, and another day they consumed 800mls. We asked a nurse whether any action had been taken to increase the person's fluid intake. The nurse told us staff were told to encourage the person to drink. However, the person had developed a urine infection during this time period. This meant that staff were not always recognising and managing the risks to people's health.

Other people's fluid monitoring records were not always fully completed, and it was not always clear what a healthy fluid intake would be for people. The clinical lead explained staff knew people very well and, where fluids were monitored, this was not always in response to any identified risk, but was a safeguard should people's fluid intake drop for any reason. However, we were concerned inconsistent records meant people's fluid intake could not be effectively managed and any potential issues may not be noticed quickly enough. The registered manager acknowledged it would be more effective to focus on fluid intake for people who had been assessed as being at high risk. Following our inspection visit, the registered manager sent us information which showed new food and fluid balance care plans had been put in place, to ensure risk of dehydration and malnutrition was effectively managed.

We saw people had access to drinks and that staff replenished people's drinks where they had finished them. Over lunchtime, people were offered a choice of drinks and staff ensured these were available and topped up as required. We also observed staff supported people to eat where they needed this.

People told us they enjoyed the food on offer, and that they had choices about what they wanted to eat and when. We saw examples of staff offering choice during our inspection visit. For example, one person said, "I don't like rice pudding." A care staff member responded, "What would you like instead, would you like a yoghurt?" The person said they would prefer a yoghurt, and they were offered a range of flavours to choose from.

Everyone we spoke with told us staff had the skills needed to support them effectively and safely. One person commented, "Oh yes, they [care and nursing staff] know what they are doing."

Staff told us they received an induction when they started work which included working alongside an experienced member of staff and training courses tailored to meet the needs of people who lived at the home. The induction training included specialist training in how to support people with mental health conditions and challenging behaviours. The induction training also supported staff to receive a recognised 'Care Certificate'. The Care Certificate assesses staff against a specific set of standards. Staff have to demonstrate they have the skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support.

We observed staff used their skills effectively to assist people at the home. For example, care staff were observant and proactive in minimising anxiety when people appeared worried. Staff removed others from the environment that may be causing other people distress, and spoke quietly with people to help reassure them.

The manager told us, and records confirmed, they maintained a record of staff training and their performance, so they could identify when staff needed to refresh their skills. The manager told us the provider also invested in staff's personal development, and they were supported to achieve nationally recognised qualifications.

The provider worked in partnership with other health and social care professionals to support people's needs. Care records included a section to record when people were seen or attended visits with healthcare professionals and any advice given was recorded for staff to follow. Records confirmed people had seen health professionals when a need had been identified, which included their GP and mental health professionals.

Good

Is the service caring?

Our findings

At this inspection, we found people were as happy living at the home as they had been during our previous inspection, because they felt staff cared about them. The rating continues to be Good.

People told us staff continued to be considerate, kind and caring, and that the home offered them a 'homely' family-type atmosphere. One person said, "They [staff] are nice to you. They look after you." A relative commented, "Oh yes, I do think they are caring. One hundred percent so."

Throughout our inspection visit we observed staff spoke with and about people in a caring and respectful manner, and people responded positively when staff interacted with them. We asked care staff what delivering a 'caring' service meant to them. One staff member responded, "It is about looking after people how you or your family would want to be cared for." Another staff member talked about how important it was to help people feel secure. They said, "If someone is feeling threatened or anxious, you sit and talk to people and make sure they are okay."

People were supported to be as independent as possible. Care plans included personalised information for staff on how they could help people achieve things for themselves, and plans were in place to help people achieve their aims. Staff understood how important it was to help people be as independent as possible, and used these opportunities to promote people's self-esteem. One staff member said, "We make sure people keep their independence as much as possible, but we are there for them if they need us."

We observed staff ensured people's privacy and dignity was respected, by taking people to private areas of the home if they needed help with personal care for example. People were supported to dress according to their preferences and individual styles. Several of the ladies living in the home had matching jewellery and clothes for example, some had their nails painted. One gentleman was wearing a suit, with a coloured handkerchief in their jacket pocket. The gentleman enjoyed compliments he received from other people and staff on his smart appearance.

Good

Is the service responsive?

Our findings

At this inspection, we found people continued to receive care that was personalised and responsive to any changes in their needs. The rating continues to be Good.

People told us staff were on hand to respond to their needs. One person explained, "Whenever anyone needs some help, they [staff] are there straight away." We observed one staff member come into the communal lounge and tell people they were going to the shops later. One person asked the staff member to buy them a notepad and pen, another asked for sweets, while another requested some biscuits and some crackers.

We observed one person made their way back to their room, telling staff they had left their walking stick in another part of the home. The person was at risk when mobilising independently, but insisted they wanted to go and fetch their stick. Staff were on hand immediately, and supported the person to find their stick to ensure they were safe, without attempting to get the person to sit and wait.

People's care plans were personalised to their needs, and were undergoing review at the time of our inspection visit. People's care records, risk assessments and staff knowledge about people's care needs were not always consistent. For example, some risk assessments were not fully completed, and fluid monitoring was not always consistently completed. The provider recognised this and has sent us information following our inspection visit on how they are dealing with this. Care plans contained personalised information to help staff respond to people's needs as effectively as possible. People told us they knew about their care plans, and were involved in ensuring they remained accurate. A relative told us they were also involved in care planning where appropriate.

There was a handover meeting at the start of each shift attended by nursing staff where any changes to people's health or behaviour was discussed. Information was written down in a handover log, so each member of staff could review the information when they started their shift.

People told us they could maintain hobbies or interests they wanted to, and had the opportunity to go out. They told us there were activities on offer in the home they could join in with if they wanted to. One person told us, "I like to nip out to the shops, that kind of thing." They added, "Sometimes people come in [to the home] and play music. I come in and listen when they do that."
The provider explained there were no longer staff dedicated to arranging and providing activities, and that this was something they wanted all staff to be involved with.

People and a relative told us they had not needed to complain, but they would be confident in doing so. In the complaints log, previous concerns, feedback and complaints had been fully investigated and responded to in a timely way. The provider had taken action to ensure the home learned from complaints made and could improve practice as a result.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in July 2015, we rated 'well led' as Good. At this inspection, we found improvements were required to ensure the home was well led.

We looked at the statutory notifications that had been sent to us by the registered manager and provider. A statutory notification is information about important events which the provider is required to send us by law. We found we had not received statutory notifications regarding safeguarding concerns where these were required. For example, one person was at risk of harming staff and other people at the home. We found two occasions recorded in the provider's incident and accident records, the person had thrown items such as cups of tea at staff and people, or had physically interacted with people at the home. This had only been recorded internally and not referred to us or other agencies.

We asked whether the incident where the person had dislocated their shoulder had been reported to the appropriate authorities and CQC, and whether any safeguarding investigation had been undertaken, to establish whether the person had fallen or the injury had occurred in another way. The provider told us they had not notified CQC, or conducted a safeguarding investigation or referral regarding the incident. No incident or accident had been recorded in the home's accident and incident register for the injury.

This was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

Whilst checks and audits were in place to help identify where the home could improve, these had not been effective in identifying some of the issues we uncovered during our inspection. For example, the registered manager showed us an audit that had been completed by one of the directors in March 2017. This had not identified any of the issues we found.

We reviewed one medicines audit, which had not identified potential risks and discrepancies in the way medicines were administered. We did not see evidence of any other medicines audits as part of our inspection. Checks of care records had not identified where people should have had their capacity assessed and required a DoLS application to be made. Neither had they identified where food and fluid monitoring was not being completed as required to keep people safe. The health and safety risks we identified in relation to one of the bathrooms had also not been managed, and the provider had continued to allow the bathroom to be used, putting people at risk. Incidents had not always been investigated and action taken to keep people safe. The failure to do so had not been identified by the management team or the provider.

This was a breach of Regulation 17(1)(2) (a)(b)(c)(e) HSCA (RA) Regulations 2014. Good governance.

The provider had displayed the previous rating in a communal area of the home, as they were legally required to do.

Following our inspection visit, we received notifications relating to these incidents, and evidence that they were being investigated with support from other agencies. We also received information from the registered

manager which showed how they were addressing the concerns we had raised in relation to medicines management, capacity assessments and DoLS applications for example. This assured us action was being taken quickly by the provider.

The registered manager was also responsible for managing another, smaller home for the provider. They told us they spent four out of five working days a week at Eden Place. They acknowledged they needed to spend more time on improving the service provided at Eden Place, and would work with the clinical lead to achieve this, and sent us information after the inspection which demonstrated a range of actions had been taken to improve the service.

People and a relative were positive about the home, and told us they felt this was down to how well it was managed. A relative commented, "I think it [Eden Place] is very well run. The staff are wonderful. No problem at all."

Staff told us they felt well supported by the senior management team. Comments included, "We get lots of support. They [management] are approachable. I feel I can go to them with any problem", "We have really good support. We have seniors we go to first, then we can go to the deputy or the manager." Staff added they felt the home was well run. One staff member explained, "We are a very good team, morale is good. We all know what we are doing so we just get stuck in and get on with it."

Staff told us they had the opportunity to meet individually and as a staff team to share and develop good practice, and so they could be kept informed of changes within the home. Staff confirmed these meetings happened regularly throughout the year and helped them feel confident and included in the running of the home.

The provider also met people living in the home regularly so people had the opportunity to share their views on how the home was run. Records of these 'residents' meetings included a 'you said, we did' section where action taken in response to suggestions or requests made by people was recorded. For example, people had made specific requests for outings they wanted to go on, these requests had been met by the provider.

The provider used other methods to gather feedback from people, staff and relatives to help the home to improve. The registered manager explained questionnaires were due to go out in December 2017. Once these were returned, they told us the results would be analysed by a senior member of staff from the provider group, who would report on the headline results and develop an action plan in response, where necessary.

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 Accommodation for persons who require treatment for substance misuse Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not always notified us of incidents that took place in the home as they were legally required to do.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people lacked capacity to make day to day decisions, this had not always been assessed and documented. DoLS applications had not always been made as required, and it was not always clear who was authorised to make decisions in people's best interests.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured medicines were always administered safely and as prescribed. Medicine audits were not effective because they had not identified the concerns we found.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to check the quality of the service

substance misuse

Diagnostic and screening procedures

Treatment of disease, disorder or injury

provided were not effective, as the issues we identified during our inspection had not been picked up.