Portsmouth City Council

Edinburgh House

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

Summary of findings

Overall summary

This inspection took place on 23 and 25 July 2018 and was unannounced. At our last inspection we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There had been a failure to ensure staff were trained and supported and a failure to ensure a robust process to identify and make improvements. At this inspection we found improvements had been made and there was no longer a breach. However, further work was needed to make the improvements to records and systems which enabled learning. This was being undertaken at the time of our inspection.

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

Edinburgh House can accommodate up to 32 older people in one adapted building. The home has two floors accessed via stairs or a lift, five communal areas and a large garden where people could choose to spend their time. At the time of the inspection 26 people lived in the home.

A registered manager was in post. 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.

Records were not always available to demonstrate people's needs were assessed before they moved into the home, to ensure their needs could be met. In addition, the documents used did not always have a holistic focus. People told us they were always asked for their permission before personal care was provided. Staff adhered to the principles of the Mental Capacity Act, 2005 (MCA) but the records needed improvement. Risks associated with people's needs and measures to reduce these were well known by staff but records did not provide sufficient guidance for staff who may not know the person they were supporting well.

The provider had introduced new governance systems which had identified areas for improvement. These had identified the same issues we found. The work to make these improvements had only just started at the time of our inspection and therefore needed more time for completion and to be fully embedded into practice.

There were sufficient staff to meet people's needs. Staff were safely recruited although the registered manager's records of this needed improvement. Staff understood their responsibility to safeguard people and had received training to do so. Medicines were managed safely. Improvements had been made to staff training and supervision although staff did not always receive training specific to people's needs. We have made a recommendation about this. The home was clean, tidy and staff promoted good infection control management.

Staff knowledge of people was good and they provided person centred care. People were provided with appropriate mental and physical stimulation. People were treated with kindness and compassion. Observations reflected people were comfortable and relaxed in staff's company. People were encouraged to be involved in their care and their independence was supported. People's privacy and dignity was respected. People were supported to ensure they received adequate nutrition and hydration by staff who worked well as a team and supported access to appropriate healthcare services.

There was a process in place to deal with any complaints or concerns if they were raised. People told us they knew how to complain but had not needed to. The registered manager was accessible and operated an open-door policy. Staff were confident to raise concerns and felt listened to.

The provider was aware of the requirement to notify CQC of significant events that occurred in the home and this was happening.

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.

Risks associated with people's needs and measures to reduce these were well known by staff but records did not provide sufficient guidance should this need to be relied upon by staff.

There were sufficient staff to meet people's needs. Staff were recruited safely but the records kept by the registered manager needed improvement to evidence this.

People were protected against abuse by staff who understood their responsibility to safeguard people.

Medicines were managed safely.

The home was clean, tidy and staff promoted good infection control management.

Is the service effective?

Requires Improvement

The service was not always effective.

Improvements had been made to staff training and supervision although staff did not always receive training to meet people's specific needs. We have made a recommendation about this.

Records were not always available to demonstrate people's needs were assessed before they moved into the home, to ensure their needs could be met. In addition, the documents used did not always assess all their needs.

People told us they were always asked for their permission before personal care was provided. Staff adhered to the principles of the Mental Capacity Act, 2005 (MCA) but the records needed improvement.

People were supported to ensure they received adequate nutrition and hydration.

Staff worked well as a team and people were supported to maintain good health and had access to appropriate healthcare

services.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion. Observations reflected people were comfortable and relaxed in staff's company.

People were encouraged to be involved in their care and their independence was supported.

People's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff knowledge of people was good and they provided person centred care but records needed to be improved to ensure guidance was available to staff. People were provided with appropriate mental and physical stimulation.

There was a process in place to deal with any complaints or concerns if they were raised. People told us they knew how to complain but had not needed to.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had introduced new governance systems which had identified areas for improvement. The work to complete and embed these improvements required more time.

The registered manager was accessible and operated an open-door policy. Staff were confident to raise concerns and felt they were listened to.

The provider was aware of their requirement to notify CQC of significant events that occurred in the home and this was happening.

Edinburgh House

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. The inspection was undertaken at this time as the last inspection was rated overall requires improvement. 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.

Prior to the inspection we had received concerns about staffing and a high use of agency, food and the safety of equipment. We looked at these areas as part of our inspection.

This inspection took place on 23 and 25 July2018 and was unannounced.

The inspection team consisted of one inspector and an expert by experience who had experience in caring for older persons. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the service is required to tell us about by law. Prior to the inspection we reviewed information included on the Provider Information Return (PIR). This 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. We used this information to help us decide what areas to focus on during our inspection.

Not all people living at Edinburgh House were able to verbally express their views about the service. Therefore, we spent time observing interactions between staff and people within the communal areas of the home. We spoke with two people who lived at home and four relatives. We also spoke with the registered manager, the nominated individual for the provider, two senior managers and a visiting professional. We spoke with 13 staff, including care staff, ancillary staff, activity staff and agency workers.

We looked at the care plans and associated records of six people, medicines administration records for 14 people, staff duty rotas, four staff recruitment records and eight staff supervision records. We looked at staff

training records, records of complaints, accidents and incidents, policies and procedures, safeguarding and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

While people were not able to say if they felt safe living at the home, our observations found that they appeared relaxed and comfortable in the presence of staff. Relatives said they felt their family members were safe. One told us "I am very impressed; the staff are helpful and accommodating. [Person's name] is well looked after, he is always shaved and clean. It is nice to know that your relative is safe. I rate this care home much higher than those that I visit". Another visitor said, "[Person's name] is content here and looks better than she did at home".

Staff's knowledge of people and the risks associated with their needs and support was good. Staff could tell us about the risks people faced and the support provided to reduce and manage the risks. However, at times records lacked this information and did not provide sufficient guidance for staff who may not know people well. For example, staff told us about the risks one person's behaviour posed towards women. Staff were clear about how this was managed to reduce the risks but the person's care plan provided no information or guidance about the behaviours and support required. The section of the care plan regarding behaviours stated that there were no known behaviours. Staff who may not know this person well did not have access to accurate guidance to enable them to support the person safely.

For one person who was at high risk of falls and had suffered a serious injury previously, the care records lacked information about the management of this risk. For example, staff told us a sensor alarm was in place for one person to alert staff to their movement as they mobilised independently. This was not recorded in the person's care records. The chair sensor alarm was not used on the day of our inspection and staff said that this was not working. As such staff had ensured that they were always present in the lounge area to observe this person and support them if they chose to mobilise, as well as increasing the frequency of checks of this person when they were in their room. The need for this increased level of support was not recorded in the person's care records.

The provider was aware of the need to make improvements to people's care records and had introduced a member of staff to commence work on a new care assessment and planning document for people. The aim was that this would ensure records were accurate and reflected people's needs fully. This had started on the first day of our inspection and would take time to complete. We discussed ways in which the provider and registered manager would ensure staff had information about the risks associated with people's care and how these could be mitigated. They told us they would develop a more comprehensive and detailed handover document for all staff. This had been created and shared with staff by the second day of our inspection visit. This document provided an overview of people's support needs and each member of staff was provided with a copy of this.

A failure to ensure clear, accurate and up to date records for people was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were managed safely. People's medicines were kept in locked cupboards and locked fridges. Staff checked the temperature of the medicines fridge daily to ensure this would not impact on the medicine's

effectiveness, however the temperature of other medicines storage was not monitored. We were told this would commence immediately following our visit. The administration of medicines followed guidance from the Royal Pharmaceutical Society. Staff did not leave the medicines cupboards unlocked when unsupervised. Staff checked the records before administering the medicines and then signed for these once the person had taken them. We looked at the Medicines Administration Records (MARs) and found no gaps in these records. All MARs contained a front sheet with a recent photograph for identification purposes. As required (PRN) medicines had protocols in place to guide staff as to the use of these medicines. Some people had been prescribed creams or lotions and in these cases, there were clear instructions in place for staff to know when and how often these needed to be applied. The stock of medicines was checked each month and a system of checking MARs were signed was carried out daily. Errors were reported and investigated, any learning from these was shared with staff.

Prior to the inspection we had received concerns that equipment was not maintained and functioning which was placing people at risk. During the inspection the registered manager told us that an occupational therapist had recently reviewed all equipment in the home and because of this some recommendations had been made which meant that some equipment was no longer in use. Arrangements were being made to provide further equipment but staff confirmed they still had access to equipment they needed to support people safely. Records reflected equipment was regularly serviced to ensure it was fit for purpose.

Prior to our inspection we had received concerns that staffing did not always meet the needs of people because the provider was using a high number of agency staff. We discussed this at the time of our inspection and the registered manager and representatives for the provider recognised this was a problem for them and had plans in place to address this. The provider had increased staffing levels since our last inspection and now ensured eight care staff were available throughout the day and four overnight. However, due to some permanent staff leaving, this meant that to provide this number of staff agency staff were required. The provider had made arrangements with agencies to try and ensure consistent agency workers were provided. People and staff felt there were enough staff to meet people's needs but some did express that it can be difficult working with agency workers who are unfamiliar with the home. Agency workers we spoke with had worked in the home for a long time and had a good knowledge of people and their needs. They told us they had received an induction and were always paired up to work with experienced staff until they became familiar with the home and with people's needs. Throughout our inspection we observed staff were attentive and responsive to people. The deployment of staff enabled them to spend time with people and be available when people needed them.

People were protected from unsuitable staff because safe recruitment practices had been followed. We were told the provider's recruitment processes ensured applicants completed application forms and attended an interview. We saw e-mails which reflected the provider sought references and Disclosure and Barring Service (DBS) checks before staff were able to start working in the service. The DBS helps providers ensure only suitable people are employed in health and social care services. In addition, applicants were required to provide information about their health so the provider could be confident they were fit to undertake the role. Whilst these checks were undertaken and ensured people were protected from being supported by unsuitable staff, the registered manager was unable to show us these records at the time of our visit, as they had not ensured these were available.

We looked at the information sent by agencies to the provider about the staff they were supplying. We noted this information was relevant and up to date; it included DBS status documentation, evidence of staff qualifications, training and experience, in addition to photographs of staff for identification purposes.

People were protected from abuse because the provider ensured staff received training to give them

knowledge of safeguarding. Staff were able to describe the different types of abuse and the signs that would help them to recognise if this was occurring. Staff were clear that they would report any concerns and would escalate the concerns to others if they felt they were not responded to appropriately. Staff were confident the registered manager would act to address any concerns. Electronic records were kept of any safeguarding concerns reported to the local authority and the investigation of these concerns.

The registered manager told us how they used information to look at patterns and trends and to identify any areas of improvement they could make. They were in the process of investigating an increase in the number of falls at night. The registered manager believed the increase might be due to the staff encouraging a higher level of fluids to prevent dehydration in hot weather which was resulting in people needing to get up more in the night. The registered manager told us staffing levels at night had been increased to enable more monitoring and support.

Throughout our visit we saw the home was clean. We did not detect any malodours. All areas were clean and tidy. There were ample hand hygiene stations throughout the home. All hand basins contained hot running water, soap and disposable towels. Bathrooms and toilets were clean and free of litter or debris. Staff received training in infection control. There was adequate provision of personal protective equipment (PPE) for staff, such as disposable aprons and gloves which we observed were used appropriately.

Requires Improvement

Is the service effective?

Our findings

We received positive feedback about staff working in the home. One relative told us, "The staff are well trained and always 'on the ball', resolving mini crisis' very professionally. I feel there are enough staff and more than enough activities for the residents. [Person's name] can take a quiet day when he wants".

At our last inspection we found the registered person had failed to ensure that staff received appropriate training, professional development and appraisal as was necessary to enable them to carry their role effectively. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the service had improved and this was no longer a breach of this regulation.

The registered manager told us when they first started their priority was to get supervisions up to date and ensure staff had these more frequently. They told us the provider no longer required annual appraisals but instead these discussions featured as part of each supervision. Staff told us they were receiving regular supervisions and records reflected this. Staff said they found these a useful experience and did not feel the need to wait for these to raise issues or concerns.

The registered manager told us that training was also a priority for them when they started. They said they had aimed to ensure staff had a baseline of training which could be further developed. Staff told us training was helpful for them and that there had been an increase since the registered manager had started. We saw staff who administered medicines had received training in this subject. Staff had received training in subjects such as safeguarding, the Mental Capacity Act 2005 (MCA) and equality and diversity. Other areas of training were provided, although we noted significant gaps in the number of staff that had completed these. For example, staff supported a number of people living with dementia who displayed some behaviours which challenged others. Although staff knew them well, we noted that only 16 of 34 direct care staff had completed training in these subject areas. In addition, we also saw that training for people's specific needs such as diabetes was not included on the training records. Staff we spoke with had a good understanding of the potential risks of this condition, how they may notice concerns and what they would do to reduce any risk to people. The registered manager told us bespoke training could be provided if needed and gave an example of plans to do some nutrition based training in the near future with staff.

New staff received an induction and were required to complete the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support.

We recommend that the service seek training for staff on people's specific needs.

Staff monitored people's weights monthly and one member of staff told us if this needed to be done more frequently this would happen. Although people's weights were checked, this did not inform an assessment of their risk of malnutrition. The registered manager and a representative for the provider told us a

nationally recognised tool to assess this risk was being introduced and we did see a blank copy in one person's care folder. The registered manager told us they were waiting for staff to be trained in using this before rolling it out across the home. This was planned for the week of our inspection.

Although staff were monitoring people's weight we could not always see what action was being taken when these records showed they had lost weight. Of the five people whose records we looked at, we found the records for three of them showed they had lost weight. However, we found no review of this to identify any reason or plan of action to address this. The registered manager and an assistant unit manager were unable to provide us with clear explanations as to the reason for the weight loss or the action being taken. Care plans were in place but the guidance to staff was basic and didn't reflect that the weight loss had been recognised or action taken. For example, one person's weight record showed they had lost 4kgs since Feb 2018. Nutritional screening had been done in April 2018 and recorded no weight loss and a low risk. Their care plan dated April 2018 said they needed support to eat and staff were to monitor their food intake but we found no food intake monitoring records. We discussed this with the registered manager and an assistant unit manager and by the second day of our inspection a review of everyone's weight had been undertaken. This showed that for one person our initial findings were due to an error, a second person's weight was beginning to increase and confirmed the unexplained weight loss for a third person. Staff told us this weight loss was due to the person having been unwell. On discussion with staff, we were told the person was eating much better now and that they would temporarily increase the frequency of checking the person's weight to ensure their nutritional status was maintained. Whilst we were assured that action was being taken, we were concerned that this was only due to us identifying the concerns and not because staff had recognised this.

Prior to the inspection we had received concerns that the budget for food had been cut and this meant people were not receiving appropriate food. The registered manager told us that the provider recently introduced a new role across all their services. The person employed, planned menus and visited the homes every week to review these. In addition, they had also decided to change food suppliers. Everyone we spoke to said the food was nice, although one person did express that on occasions they had not liked it. This person also said if they didn't want it they could have something else. The majority of people living at Edinburgh House lived with a cognitive impairment which impacted on their short-term memory. Whilst people were supported to make meal choices, one person told this was done the day before, meaning there was a chance some people may not recall what they had requested. This person told us that if they didn't want their meal they could ask for something different and they received this.

People told us they were asked for their permission from staff before they provided care. Throughout our inspection, we consistently saw staff asking for people's permission before they acted. For example, we saw staff asking people if they could help them when people tried to mobilise, or asking for permission to help if they saw people were struggling with their meals. Consent forms were in people's care plans confirming they and their relatives had been involved in discussing the person's support needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff's knowledge of the MCA and how to apply this to day to day decisions was good. They understood the need to try to support people to make decisions by giving them all the information they needed to do this, and to provide alternative, least restrictive options if the person was not able to understand the risks involved with the decisions.

Records regarding people's capacity required improvement. A decision-making profile was in place in some people's care records which identified areas the person could make their own decisions in, or those which the person could not. We did note where this document recorded they couldn't, we did not find capacity assessments to reflect this had been assessed in line with the two-stage test. For example, one person recorded they did not have capacity to make decisions about 'community contacts and said the person would need to be escorted out. However, there was no recorded capacity assessment.

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 2005. 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 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager had a system in place to track the expiry dates of these and any conditions that were required to be met. There were no conditions imposed with the DoLS that had been authorised and staff understood the DoLS. However, where DoLS had been applied for in relation to accommodation decisions, the registered manager and a representative for the provider told us they relied on a social worker's mental capacity assessment and instructions to apply for DoLS. However, they registered manager did not have records of these mental capacity assessments. Care plans did not record when a DoLS was in place and what this related to. This meant information for staff about any authorised deprivations of a person's liberty was not clear. In addition, as staff in the service had not completed capacity assessments relating to the DoLS, there was no process to ensure the person's capacity was reassessed or reviewed when the DoLS had expired and required another application.

Whilst day to day staff had worked in accordance with the legislative requirements of the MCA, this was not always consistent and therefore is an area in need of improvement.

The registered manager told us that prior to moving into the service most people had a pre-admission assessment where their needs and choices were assessed to ensure staff could provide the care they needed. They said this information was then used to develop people's care plans. However, we did find that this hadn't happened for one person whom the registered manager told us had been an emergency admission and for other people this assessment was not always available. The registered manager was unable to tell us where these were held, saying this was because some of the people living in the home were there before the registered manager started. We could therefore not see how this information was used to develop people's plans of care. They did send us a copy of the preadmission assessment document that was to be used with the rollout of the new care planning system. This identified the areas of support people needed in relation to their physical and social needs. However, we did note that this document did not identify any cultural, sexual, religious of spiritual needs of people. This was important to ensure people's diverse needs were assessed and planned for.

Staff were aware of the need to treat people as individuals and respect their beliefs and lifestyle choices. The provider had policies in place to guide staff on meeting people's human rights and equality and diversity needs. They provided staff with training in equality and diversity to aid staff's understanding. The registered manager and staff were clear that discrimination would not be tolerated and were confident any human rights or equality needs people had would be met.

We observed there was a good working relationship between staff. The organisation of staffing throughout the day and use of volunteers enabled staff to meet people's care and support needs. Regular handover meetings took place to share information on each person to ensure people were provided with appropriate

care that was consistent.

People told us they had access to healthcare. Records demonstrated that people were supported to access appropriate healthcare services. People's records confirmed they had regular appointments with health professionals, such as chiropodists, GPs, mental health nurses, speech and language therapists.

The home was not purpose built but did provide adequate space for people to enjoy time with one another or on their own. People had their own rooms that they had personalised and could choose to spend time in the small lounges or main activities rooms. Most flooring had been replaced to help reduce the risk of falls and further work was planned to do this in all areas of the home. The activities room had an area adapted into an old-style tea room/café and a hairdressing room had been created to provide an authentic hair salon experience. Further work could be done to ensure that the environment would be supportive to those living with dementia. For example, some signage was in place but it was difficult to identify directions from these. Some people might find it difficult to identify their bedrooms as there was no signage to show the room was a bedroom and only written text was used to aid people in recognising it was their room. People with dementia often find contrasting colours helpful in orientating them, however these had not been used.

Good

Is the service caring?

Our findings

Without exception people and relatives told us that staff and management were kind, caring and compassionate. One person said, "They [staff] are kind and they care, they know what help I need, this one's the best [pointing to a member of staff]". A relative said, "The care is brilliant, a life saver. He couldn't have functioned otherwise, he loves it here. I can come at any time and the staff always make me feel welcome". Another relative said "[person] said "It is just like being at a hotel".

People were happy in the presence of staff and willingly accepted support from them when they cheerfully offered assistance. Staff spoke with people with kindness and warmth and engaged positively throughout our visit, laughing and joking with them. We heard good natured banter between people and staff showing they knew people well. People were clearly relaxed and comfortable in the company of staff. We found the atmosphere in the service was warm and friendly with, staff observed to give individual attention to people when needed.

The home was extremely hot throughout our visit due to the weather and staff were very aware of this and took time to encourage people to drink plenty of fluids or have ice lollies to stay hydrated. However, staff were still aware that whilst themselves may have felt hot, people did not always feel this way. As windows were open and fans were on, staff regularly checked people were warm enough by asking them and gently checking their skin temperature. If people said they were cold or staff felt they were cold, they were offered blankets and cardigans.

People were encouraged and able to keep in contact with their family and friends. Visitors were welcomed in the home and were not restricted. Resident meetings reflected that staff encouraged the use of technology such as Skype to enable people to keep in contact with their family and friends.

The service encouraged the use of advocacy services. An advocate is someone who can offer independent support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights. At the time of our inspection we saw that an advocacy service was visiting people living in the home.

The registered manager was aware of the Accessible Information Standard (AIS). The AIS was introduced in August 2016 and applies to people using the service who have information or communication needs relating to a disability, impairment or sensory loss. It covers the needs of people who are blind, deaf, and/or who have a learning disability. Plus, people who have aphasia, autism or a mental health condition which affects their ability to communicate. Whilst care plans and policies were not routinely provided in alternative communication formats, the registered manager said the provider could do this if requested. The registered manager told us how they were supporting one person who was blind and made sure that talking newspapers were available for them and a paid advocate who helped them.

Residents' and relatives' meetings took place to enable people and their relatives to share their ideas and be kept informed of changes at the home. The provider acknowledged that people and relatives might prefer to

share their views and concerns in a different way and had asked some people to share their views by completing questionnaires. Where suggestions were made, these were acted upon. For example, relatives had expressed their feelings about the home needing new bedding and this had been purchased.

People's diversity was respected and people were treated fairly and equally. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. People's independence was promoted and encouraged. People were supported to independently mobilise around the home while staff observed discreetly and technology, such as call bells, were available for people to use if they required assistance from staff. We observed people were provided with the appropriate equipment they needed to eat their meals independently including adapted cutlery and crockery. People could choose how they spent their time, some spending time in the activity areas, whilst others preferred their own space in their rooms or quieter areas of the home.

People were treated with respect and dignity and afforded privacy by staff who took time to explain their actions and involve people in the care that was being provided. Observations showed staff attended to people's needs in a sensitive and discreet manner. People's wishes, with regards to their preferences of male or female care staff, were known and respected. Information held about people was kept confidential. Records were stored in locked cupboards and handover meetings, where staff shared information about people, were held in private rooms to ensure confidentiality was maintained.

Requires Improvement

Is the service responsive?

Our findings

People told us and we observed that staff knew them well. One relative said, "I am impressed with the care. When I arrived, they knew who I was and greeted me. My [relative] has a hairdresser at the home and a chiropractor visits [them] about every two months".

People and their relatives were involved in the development of their care plans. Although it was not always evident in the records how people were involved or contributed to the on-going review of their care, people told us that they were able to talk to staff about anything and felt listened to. They said they felt staff knew them well and how to support them. The provider and registered manager had recognised a need to make improvements to the care records for people and were introducing a new care planning system at the time of our visit. We spoke to the person leading this work who told us they were discussing with each person and staff the specific needs, wishes, preferences of people and gaining the staff's knowledge in order to rewrite these plans. Once they had rewritten these, they planned to review them with everyone involved in the person's life to ensure they were personalised and accurate. This had only just started at the time of our inspection and needed time to fully implement the new system. To ensure that unfamiliar staff such as agency workers developed knowledge of people, they were paired with experienced staff who provided them with guidance.

Some people's care records contained information about their social history, although this was more detailed for some people than others. The new care planning system being introduced included a 'This is me' section and where we saw this had been completed, it contained a lot of information about the person that would help staff understand their background and aid them in engaging with people.

Staff understood people's likes, dislikes and preferences. They had a good knowledge of people and were able to give us detailed descriptions of them. We observed a member of staff ask one person what they would like to drink. The person said, "Coffee" and the member of staff said, "You usually have tea". The person replied, "I have changed my mind to coffee with one sugar". The member of staff brought the coffee and they had a short discussion about people's changing tastes. This demonstrated that staff knew people well, did not make assumptions and offered choice despite knowing people's usual likes.

The registered manager was aware of the need to improve care planning in preparation for the end of people's lives. Although some end of life care plans were in place, they needed more guidance for staff about meeting the person's spiritual, cultural and religious needs. Despite the lack of guidance in care plans, staff were aware of what would be involved and the provider had a policy in place to guide them. This included involving the medical team early and sourcing appropriate medicines and nursing support to ensure they were pain free; ensuring any spiritual, cultural and religious needs were understood and supported as well as involving the person's family if this was the person's choice.

People received appropriate stimulation and activities. Activity staff were employed in the home but in addition to these, volunteers supported activities and links with other organisations had been made to offer further support. For example, one organisation supporting people with learning disabilities provided

support for a coffee morning and ran the tea room/café. A wildflower garden and meadow walk had been created in the garden and plans were in place to create an authentic cinema room. Throughout our inspection, there were a variety of activities going on with people. Some of these were on an individual basis and involved social chats and reading. Some group activities were taking place including the use of interactive technology to engage and entertain people. We observed lots of singing and dancing and people told us about special events and days out.

The provider had a policy and arrangements in place to deal with complaints. They provided information on the action people could take if they were not satisfied with the service being provided. People knew who to and how to make a complaint. One person told us, "I have never needed to complain, if I did I would speak directly to [Registered Managers first name]". Records reflected complaints were investigated.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in November 2017 we found there had been a failure by the registered person to act on feedback from people about the service and a failure to establish robust systems or processes to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had introduced new governance systems which had identified areas for improvement. The work to make these improvements had only just started at the time of our inspection and therefore needed more time for completion and to be fully embedded into practice.

Since the last inspection a new registered manager had started. 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 and relatives we spoke to all knew who the registered manager was and felt they were approachable. There was a clear staff structure in place, with staff being aware of their roles and responsibilities. Staff felt that they could approach the registered manager with any concerns and told us that the management team were supportive and made themselves available. All staff we spoke with during the inspection said they felt listened to by the registered manager. They felt communication had improved and they described the team as working well together.

We spoke in depth with the provider's nominated individual (NI) about the changes made to the governance systems. They told us how the provider had introduced mock inspections and they were undertaking Regulation 17 visits to each of the provider's services. The registered manager told us how these systems were used to identify and make improvements. We saw some improvements had been made as a result of these. For example, the mock inspection had identified the need to provide guidance about the temperatures of the medicines fridge and what to do if this was out of range. We saw this had been implemented and was understood by staff. These visits had also identified a need to improve records for people and ensure a culture of learning from incidents was embedded and communicated. These provider governance systems had identified the issues of concern that we found during this visit, except those relating to the recruitment of staff. Actions were identified to make improvements such as providing clarity around the use of incident forms and developing clear processes to communicate lessons learned.

The provider had undertaken a management team observation over a period of a few days. Following this, the provider had introduced a 'Turnaround Team' to support the management team and to complete the work that was needed to make the necessary improvements in the home. This consisted of several multidisciplinary staff who had allocated roles in the service. An occupational therapist had looked at equipment and was looking at the tracking of incidents such as falls to establish better ways to use the information gathered and make positive changes for people. Another member of this team was focusing on medication processes and the competency of staff. A third member was focusing on the development of clearer, person centred care plans and risk assessments. The aim of this team was to support the

management team to make improvements and embed a culture of continuous quality improvement. This had only just started at the time of our inspection and needed to be completed and fully embedded.

In addition to this work, the NI told us how a multidisciplinary team (MDT) approach would be adopted in the home. The plan was for weekly MDT meetings to take place to discuss any issues of concern and look at proactive care planning. This was due to start in Edinburgh House shortly after our inspection.

People and their relatives were encouraged to give feedback about the service via satisfaction surveys. The results of these were analysed and used to inform actions plans to drive improvement. Recent surveys provided positive feedback with one visitor saying, "I'm extremely happy with the care, he loves his room, he feels safe in there. Food is excellent. They have excellent activities. Since [name] the new manager has been here the improvements are amazing".

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.

We saw good working relationships with the other members of the local authority teams, district nurses, GP and other health professionals. In addition, links with other organisations and volunteers had been established to provide a better service for people.

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 17 HSCA RA Regulations 2014 Good governance A failure to ensure clear, accurate and up to date records for people was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.