County Healthcare Limited

Courtenay House Care Home

Inspection report

Fakenham Road
Tittleshall
Kings Lynn
Norfolk
PE32 2PF

Tel: 01328700646
Website: www.fshc.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 6 and 8 February 2017 and was unannounced.

Courtenay House provides accommodation and personal and nursing care for a maximum of 46 older people, some of whom may be living with dementia. At the time of our inspection there were 37 people living in the home.

At this inspection, there were five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was also a breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report.

There was a registered manager in place who has been registered with the Care Quality Commission (CQC) since March 2016. 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.

Assessments of risks to people's safety had been completed. However, staff did not always provide support or monitoring of people's safety as identified in these plans. Medicines were not always stored safely. People were at risk of not receiving their medicines as the prescriber intended.

People who were at risk of not eating and drinking enough were not supported to ensure that they did. Records to monitor this were not always completed by staff. Changes in peoples support needs were not always updated in all of the records provided for staff to use.

Staff did not always respect and maintain people's privacy and dignity. People received personal care which could be observed by other people because doors were not closed. Staff could be overheard discussing peoples support needs and personal information.

People's expressed preferences were not always met. Although staff knew what people liked, they did not always offer people choices. Staff at times were task orientated and did not focus on people receiving care.

There were issues regarding the governance and quality monitoring of the home. The provider's quality monitoring did not always identify shortfalls in the provision of care to people. The registered manager's audits and checks were not effective in identifying issues around the home. The registered manager did not have a full understanding of their responsibilities and had not always taken the required actions to notify the CQC of certain events.

There were sufficient numbers of suitably qualified staff employed at the service. The provider's recruitment process ensured they only employed staff deemed suitable to work with people in a care setting.

Safeguarding adults' procedures were in place and staff understood how to protect people from the risk of abuse. There was a whistle-blowing procedure available and staff said they would use it if they needed to.

Staff had completed an induction programme when they started work and they were up to date with the provider's mandatory training.

Staff sought consent from people in line with the relevant legislation. The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The registered manager was knowledgeable about when a request for a DoLS application would be required. Although applications had been submitted appropriately to the relevant local authority, the CQC had not been notified as is required, when an application had been authorised.

The registered manager ensured that people had access to appropriate healthcare. People were able to see a GP when they needed to and access support from community healthcare professionals.

People and their relatives were involved in making decisions about their care as much as they wished to be. People were supported by staff to maintain their independence.

The service had a complaints procedure available for people and their relatives to use and staff were aware of the procedure. The registered manager took action to address people's concerns and prevent any potential for recurrence.

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 managed in a way that promoted peoples' safety and welfare.

Identified risks to people were not always managed with actions taken to reduce them.

There were enough staff available to support people in a timely way.

Is the service effective?

Requires Improvement

The service was not always effective.

People who were at risk of not eating and drinking enough were not supported to ensure that they did. Records to monitor this were not always completed

Staff received regular training and supervision.

People were able to see health professionals when they needed to.

Is the service caring?

Requires Improvement

The service was not always caring.

Most staff interactions were kind and caring but there were times when care was task orientated and lacked individualised care.

People's privacy and dignity was not always maintained by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care that met their needs and preferences. Records detailing the care people received were not always completed.

People and their relatives knew how to complain. The provider monitored people's complaints and took action in a timely way to address these.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems for monitoring, assessing and improving the quality and safety of the service were not operating effectively.

Statutory notifications to the Care Quality Commission were not always made.

Staff were motivated and enjoyed working at the home.

Courtenay House Care Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 6 and 8 February 2017 and was carried out by two inspectors, a specialist advisor in nursing practices and an expert by experience. An expert by experience is someone who has experience of using or supporting someone who uses this type of service.

Before our inspection, we looked at information we held about the service including notifications. A notification is information about important events which the provider is required to tell us about by law. We spoke with professionals from the local authority and clinical commissioning groups who had regular contact with the home.

During the inspection, we spoke with seven people living in the home and three relatives. We also spoke with the registered manager, the activities' coordinator, seven members of care staff and one member of nursing staff. We also spoke with the provider's regional operations manager. We observed how people were supported.

We looked at nine people's care records, quality assurance surveys, staff meeting minutes and medication administration records and audits. We checked records in relation to the management of the service such as health and safety audits and staff training records.

After the inspection visit we asked the registered manager to send us some further information in relation to people's care and staff training. This was received promptly.

Requires Improvement

Is the service safe?

Our findings

People living in the home had a detailed plan that identified how to keep them safe and reduce the potential impact of any risks of harm. However, we saw that staff did not always adhere to this plan and provide safe care and treatment. For example, we observed on a number of occasions that people's walking frames were not left in reach so that they could use them to mobilise safely.

On one occasion, we observed a person who needed to use a walking frame for safety, walk from the dining room to their bedroom, without it. The person walked along the main corridor, past several members of care staff who did not intervene to support the person. The person we observed was living with dementia, they required prompting by staff and reminding to use their walking frame. We had previously observed this person to be sleeping in the dining room for the majority of the morning, and at no point was their walking frame in the room. We later observed the same person seated in the communal lounge, and saw staff place their walking frame out of reach, against a wall. This meant that the person was unable to use their frame to get up from their chair and to mobilise safely. We also observed this to be the case for two other people who were sitting in the lounge.

We reviewed a recent action plan put in place following a quality audit conducted by the West Norfolk clinical commissioning group. We noted that the registered manager had stated in the plan that, " We ensure residents have their calls bells close to hand, providing pendant alarms for residents who cannot reach call bells in the lounge due to mobility issues." During our observations, we saw that several people did not have their call bells close to hand. The registered manager explained that some of the people we had observed did not have the capacity or ability to use their call bell so they were not provided with one. We saw this identified in people's care plans for the majority, but not all of the people we had seen without access to a call bell. We also found that staffs understanding of who was able to use a call bell was inconsistent. This was because some people, assessed as not being able to use a call bell, still had a call bell placed in their bed or on their chair with them.

We observed that of the 14 people sitting in the lounge area, only one person had access to a pendant alarm. We saw that most people in the room had reduced or very limited mobility, and were unable to call for assistance. We observed that for a period of 15 minutes, no staff members were present in the room to check that people were safe or required assistance. Some staff members had walked through the lounge on their way to another part of the home, but did not stop to check people.

We saw that a prescribed powder agent to thicken liquids used to help people who cannot swallow safely was left unsecured in a person's room. It is important that this is safely stored as it presents a risk to people in the home living with dementia who may ingest it. We also saw that the prescription label had been removed. This presented a risk to the person because the prescription label contains the directions for its safe use. It also identifies who the product is prescribed for

This meant that some identified risks to people, and the planned actions to help mitigate them, were not adhered to or adequately monitored by staff. Equipment identified to help reduced risks to people's safety

was not always available to them. We concluded that systems for managing and minimising risks did not properly contribute to people receiving safe care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We assessed if medicines were safely stored and managed. We found that some people's prescribed nutritional supplements and ointments were not stored safely and that the original prescription labels had been removed or altered.

We saw that one person had with them on their bedside table, a tub of prescribed cream used for skin ailments. We saw that the prescription label on this tub was damaged, so should not be used. However, we could see that the name on the tub was that of a different person using the cream. We brought this to the attention of the registered manager, who told us that this person did not have a prescription for this, and was unsure as to why the person had it. Staff had not identified that the person was using this cream, or that it was not stored safely. We saw that pots or tubs of prescribed creams had not been labelled to identify when they had been opened and first used. This is important because some have limited shelf lives to be used by once opened.

We saw that a number of prescribed creams, ointments, thickening agents and skin barrier sprays were stored in a staff room area. Prescription labels affixed to some of them had been removed. Some had been prescribed for people who were no longer living at the home. Some had exceeded the manufacturer's expiration date for safe use. We brought this to the attention of the registered manager, who was unaware that they were there. They told us that it was likely they were due for return to the pharmacy for disposal, and did not know why prescription labels had been removed. We were concerned that as we had found the same types of medicines, with the prescription labels removed, in use in peoples rooms, that these were being used as stock items. We discussed this with the registered manager who agreed that this may have occurred without their knowledge. The registered manager took action to remove these medicines and arrange their safe disposal.

We saw that in the area where peoples nutritional supplement drinks were stored, one box of these had the prescription label partially removed, and the name of a person written onto it in biro pen. Prescription labels should not be removed or amended because it creates a risk that nutritional supplements would not be used as intended by the prescriber.

We saw that for one person their records showed that on four occasions in three weeks, their prescribed nutritional supplement was out of stock and that they did not receive it. We asked the nurse on duty about this and the registered manager neither could be immediately sure as to why this had occurred, but agreed to investigate this.

We concluded that systems for the safe management and storage of medicines did not properly contribute to people receiving safe care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff administering medicines to people. We saw that they ensured the storage trolley was closed and locked when unattended. People were offered a drink when taking their medicines, there was clear guidance about people's preferences available for staff to use. Medication administration records included a photograph of the person, and any allergies that they may have.

People told us they felt safe in the home and supported by staff who knew them. One person told us, "I am happy and safe here". Another person told us, "This is a comfortable and safe place to be. I feel secure."

We received mixed feedback from relatives of people living at the home. Most relatives told us their family members were safe and were supported by staff who had a good understanding of their needs and how to ensure their safety. One relative told us, "[Relative] is safe here and they understand his needs." However one relative told us that they felt that staff had not responded to suggestions to help keep their relative safe after they had fallen on two occasions.

Risks associated with people's nursing and care needs had been assessed. These included risk assessments for maintenance of skin integrity, nutrition, mobility and falls. A report of people's falls was entered in to their care records, which was used to monitor and identify any patterns in their falls.

For people living with diabetes, risk assessments and plans of care gave staff information on how to manage these risks. However, we found that this information was presented in a way that meant finding specific information was difficult to find. For example, we saw that for one person, information about how their diabetes was controlled with an injected medicine, was written in a nutrition and hydration section of their care plan. This meant that staff may not be able to find the information they needed to support people safely. We discussed this with the registered manager who agreed that this was difficult to find, and took action to sign post this information in a clearer way.

Incidents and accidents were reported and recorded at the home. The registered manager reviewed, logged and investigated any incidents and took action to try to reduce the risk of the event from re-occurring. This information was also sent to the registered provider's head office. The provider's quality team and regional operations manager reviewed these incidents. Discussion regarding these took place between the registered manager and the regional operations manager.

The registered manager ensured the management of risks associated with the premises took place. There were fire and personal emergency evacuation plans in place for each person living in the service to make sure they received safe assistance whenever there was a need to evacuate the premises. We saw completed records of fire safety checks, water temperatures, temperature checks. This helped ensure that the service was a safe place to live, visit and work in.

Staff we spoke with knew how to keep people safe and were aware of their roles and responsibilities in reporting any concerns or incidents. They told us this could be to their manager or to external safeguarding agencies such as the police or the local safeguarding authority. Staff had undertaken training in the safeguarding of adults, and could tell us how to recognise indicators of abuse. This meant we were satisfied that staff had a good understanding of keeping people safe from the risks associated with abuse.

People were supported by sufficient staff with skills and knowledge to meet their assessed needs. People told us that staff were available when they needed care and support. Staff confirmed there were enough staff on duty and they were able to respond to people's needs in a timely manner. Staffing levels were kept under review and additional staff could be used if people's needs changed. The registered manager told us a dependency tool was used to review staffing.

The provider had a system in place to assess the suitability and character of staff before they commenced employment. Records included interview notes and previous employment references. Staff were required to undergo a Disclosure and Barring Service (DBS) check. DBS checks enable employers to make safer recruitment decisions by identifying candidates who may be unsuitable to work with adults who may be at risk.

Requires Improvement

Is the service effective?

Our findings

We saw that a number of people living at the home were at risk of not eating or drinking enough in order that they maintain their health. People's care records identified where they were at risk, and what staff needed to do to reduce this. This included setting target amounts for people to eat and drink, and identifying any weight loss through regular weighing. We saw that for some people, daily records were kept so that everything that they ate or drank that day could be recorded. At the end of each day this was to be reviewed by a nurse or senior member of staff, depending on the level of support the person received.

However, we saw that these records were not always completed. We also saw that the results recorded on the person's paper based record, did not always prompt any actions to be taken when reviewed. For example, we saw that one person had not met their daily intake target of fluid on three days of a four day period. This record had been reviewed, showing a red stamp as being checked. However the section of the chart that prompted the reviewer to take action if the target had not been met, was not completed. For example, for this person we saw that their fluid chart showed a desired daily intake of 1000mls of fluid per day. On one day, this person only consumed 670ml of fluid, and no actions had been taken.

For some people, particularly those who spent long periods in their bedrooms, additional records were kept. This was so that staff could log people's intake of food and fluid where the person ate, and then transfer this information to the central records. We saw that these records were not always fully completed, and totals of people's intake were not added up. This meant that staff could not see if people had received enough to drink and take appropriate actions.

We saw that for one person, they had a care plan in their room that stated that all their drinks should be thickened using a specialist prescribed product. This was because the person was at risk of developing pneumonia due to swallowing problems. We saw that the thickening agent was in their room, however the drink they had at the time had not been thickened. We reviewed the persons main care plan, and saw that they had been reassessed by a speech and language therapist (SALT).The SALT reassessment stated that person was now at less risk, and as it was important to drink, they should no longer have their drinks thickened. However, this information had not been entered on to the care plan in their bedroom, and the product to thicken it was still there. This meant that there was a risk of staff using the care plan in the person's bedroom, and continuing to thicken the person's drink using the product that should have been removed. This meant that the person was at risk of receiving care from staff who had the wrong information about how to support them with their drinking.

We saw that for some people who were at risk of not eating enough, records were not always completed, and actions not always taken regarding this. For example, we saw that for one person who required a prescribed nutritional supplement to increase the amount of calories they received, action was not taken when they did not drink it all. We saw that on two separate days, no entry had been made at all to identify if they had taken their supplement or not. For some people who had their intakes of food monitored because they were at risk of losing weight, amounts that they had eaten were not recorded. For example, entries were recorded as 'porridge' or 'sandwich'.

We saw in one person's care plan that they required prompting as the person was living with dementia, and at risk of forgetting that they were eating. We saw that a recent update to the plan, stated that the person required constant prompting and encouragement to eat. However, during our observation of the lunchtime meal, we saw that the person did not receive this.

We concluded that not all people living at the home were receiving enough to eat or drink because records and associated actions were not always completed adequately where people were at risk of this. Information for staff to support people with eating and drinking was not always updated, and staff were not always able to provide the right level of care because of this.

This is a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014

People enjoyed a variety of freshly prepared foods of their choice. The cook showed us a rolling menu which they used to provide a wide variety of meals for people. We saw people given choice daily as to their preferred food option and alternatives were available. The majority of people we spoke with told us that they found the food to be of good quality and received adequate portions. Some people told us that they thought improvements could be made, but did not see it as a major issue. We saw that the provider regularly sought people's opinions on food through their satisfaction surveys. This confirmed our own findings that the majority of people were satisfied with the food provided.

People told us that they felt staff were well trained and knew how to support people. One person told us, "The carers all seem to know what they are doing." Another person told us, "The carers know what to do, they are confident in what they are doing." Relatives told us that they felt staff had received enough training to care for their relative. However, one relative felt that the home was supporting more people living with dementia recently, and that staff needed extra training to meet this need. We spoke with staff about this, and they told us that senior staff had recently undertaken additional training in this area, and were providing staff with support when needed.

All of the staff we spoke with told us they felt that they had received enough training to provide people with effective care. Staff told us that they had undertaken a lot of training. They told us that this was mainly carried out via E-learning, but a request for face to face pressure area training and been arranged. The records we checked confirmed that staff had received training. Staff's competency to perform their role had also been checked. The manager told us they had a schedule to ensure that this was completed regularly. Staff told us that they had regular supervision with the manager. Staff said that they found these sessions supportive and helpful in developing their skills. Supervision is a way of giving staff the opportunity to discuss their performance at work and any training or development needs.

Following a recent audit by the local clinical commissioning group (CCG), it was identified that nursing staff had not undertaken training in how to support people living with diabetes. After this concern was raised, the registered manager arranged for nursing staff to undertake this training. Nursing staff we spoke with at this inspection confirmed that they had completed this, and told us they had found it useful. We saw records that confirmed that all nursing staff had completed this.

The registered manager told us that they were currently recruiting a lead nurse. They told us that a key aspect of this role would be to ensure that nursing staff training, skill and competency was sufficient and regularly assessed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

For most people who lived at the home an application had been made to the local authority with regard to them remaining at the home to receive all care or leaving the home unescorted.

Care records provided clear information on the decisions people were able to make, and those with which they required the involvement of others. Records identified relevant individuals to involve in best interests decisions including relatives, legal representatives and healthcare professionals. Care records showed staff respected people's choice when receiving care. For example, if people did not always want to have support with personal care staff would respect this wish, then return to the person later, and ask if they needed any support.

Before our inspection, we received concerns form the local authority and the CCG that the relationship between the registered manager, provider and local health care professionals had deteriorated. There was concern that this would affect the healthcare support provided to people living at the home. The provider's regional operations manager, and the registered manager, told us that following a meeting to discuss these concerns, arrangements were being made to improve this working relationship. Representatives of the local authority and the CCG told us that they were monitoring this.

Records showed health and social care professionals visited the service as and when required. Care records held feedback from GP's, speech and language therapists, social workers and a tissue viability nurse. Staff identified people's needs and involved health and social care professionals appropriately.

Requires Improvement

Is the service caring?

Our findings

One person we spoke to told us, "It's difficult to build strong relationships when staff are so busy and don't have the time to talk to you". On this inspection, we found that staff did not always approach people or carry out support in a caring manner. There were incidences where people's care was task-led.

We found staff did not always treat people with dignity and respect. Staff we spoke with were able to tell us about the importance of maintaining peoples dignity and treating them with respect, and gave us examples of how they would do this. However, we saw that they did not always provide this in practice when supporting people. We saw that staff openly discussed people's personal care needs in front of others. Staff did not always provide people's personal care needs in a discreet and sensitive manner. We saw on a number of occasions that people were being supported with personal care by staff who had left the door to the room open.

We saw a person being hoisted above their bed, who was only wearing a short night dress, exposing their lower body which was not covered. We also saw that the bed safety rail had not been lowered, and in order to move them over this, staff pulled them by the ankles, which meant they bumped in to it. We saw that a person sat in a chair in their room with no clothes on, being supported to get dressed, but the door had been left open and the bedroom curtains had not been drawn. These practices did not uphold people's dignity or show respect.

Staff did not always knock on peoples doors before entering. On one occasion, we saw a member of staff enter a person's room, without telling them who they were or asking if it was okay to enter. They then opened and looked in the person's wardrobe without telling them. The persons whose room it was appeared surprised, and then asked the inspector who the staff member was. The staff member then left the room without speaking to the person. We saw that one toilet was unable to be locked from the inside by the person using it. We brought this to the attention of the registered manager who told us that they would address this issue.

On another occasion we observed a person who had removed their clothing exposing themselves inappropriately. This was observed by staff but there was no immediate attempt to intervene. We brought this to the attention of the registered manager who responded to this straight away. The registered manager used the call alarm in the room, as they required additional support from another member of staff. We observed the staff member responding to the bell to make a negative remark to themselves about the person, and that they were always pressing their call bell.

People were not always supported at meal times in a way that promoted their dignity. During the lunch time meal, two staff discussed a person's eating habits in front of several other people. We saw a member of staff write a note on a napkin with a pen, but then threw the pen on to the table where people were eating, landing in front of a person. The person then had to move the pen when their bowl of dessert was brought to the table. We saw that a person who was having difficulties in eating their meal. We saw that staff did not notice this and provide support for over 30 minutes. When staff did intervene, and prompted the person to

eat, the food had gone cold, and the person refused to eat it. Staff did not offer to reheat this meal or find another option for the person to eat.

We saw that staff supporting people to eat in the dining room, had little or no interaction with the person they were supporting. We observed four members of staff having a discussion amongst themselves in the dining area, about other members of staff. They did not engage in conversation with people. One staff member was observed to be remote and disengaged during lunchtime. They did not respond straight away when the person they were supporting asked for their meal to be reheated as it was cold. The staff member told the inspector that this person, "Always says their meal needs reheating." The staff member continued with other tasks before returning to take the meal away for reheating. Throughout the interaction the staff member did not display warmth or consideration.

These concerns constitute a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us that staff were caring towards them and were kind. One person told us, "The staff are nice enough to me, I can't complain. Staff treat me as if I matter to them, they speak to me nicely." Relatives we spoke to told us that staff were kind and caring. One relative told us, "Certain staff are lovely, most are kind. They do care about my [relative]." People and their relatives told us that they felt staff encouraged them to be independent, and knew what people needed to do this. For example, one relative described how their family member like to dress themselves, but could some times, "Get in a muddle." They explained that staff only intervened at this point, and gave words of advice rather than just taking over.

Many of the people living at the home were unable to share their views about the care and support they received, or to be actively involved in the planning of their care, due to their dementia. However, staff demonstrated an understanding of how to encourage and support people to make or be involved in day-to-day decisions that affected them. This included supporting people to make choices in what they wore, ate or how they spent their time. The registered manager told us they encouraged people's relatives' involvement in decision making and care planning, in order to benefit from their insights into their family members' wishes, needs and preferences. People's relatives confirmed their views were requested and listened to. The registered manager informed us that people would be supported to access independent advocacy services, as needed, to ensure their voice was heard in any important decisions to be made.

Requires Improvement

Is the service responsive?

Our findings

An assessment of people's needs was made before they came to live at the home. These assessments helped to inform care plans for the person and records showed that people and their relatives were encouraged to be a part of this process. People's preferences, their personal history and any specific health or care needs they had were documented.

Staff had a good understanding of the need for clear and accurate care plans which reflected people's needs. Care plans gave information for staff on how to meet the needs of people. For example, they provided information on how to support people with their personal care and encourage their independence. They also provided information on specific health conditions. Staff told us they accessed care plans to help them have a good understanding of people's needs. We did see however that although these plans did contain all the required information, they were collated in a way that made finding the required information difficult. We spoke to the registered manager about this, who told us that the clinical commissioning group had raised this as an issue recently during a quality audit. As a result of this, they were now adding 'signposting' book marks, this allowed the reader to navigate to other sections quickly where information was needed in more than one section of the plan.

We saw that people were able to choose when they wanted to receive personal care, or when they wanted to rise in the morning. However, we observed on some occasions, that peoples expressed preferences were not always met and they had not been offered choices. Staff sometimes made assumptions about what people wanted. For example, during a mealtime in the dining room, drinks had already been poured for people before they arrived at the table. No choice was given.

We saw that daily records, used to detail what personal care had been provided to a person, were not always completed. Staff were expected to completed daily records in files kept in peoples bedrooms, staff were expected to then add this information to the central record. We found that these records contradicted each other, and it was not clear what personal care had been provided. For example, we saw for one person that the record in their bedroom showed that care had only been provided on three days during the previous week. When we checked the persons central file, we saw entries detailing care had been provided on three of the days without an entry on the record in the bedroom. On one day for that week, there was no information to show that any personal care was given. This meant that we could not see that people received the care they had been assessed as needing. Staff did not always complete the records that they were required to do, and senior staff and management had not identified this as a concern through daily checks that took place.

People said the planned activities in the service were good, varied and that they were supported to take part in interests that were important to them throughout the day. They told us they could always choose which ones they wanted to join in. Examples included a cheese and wine night, Chinese New year celebration, coffee mornings, as well as sing a long and music sessions. One person said, "The activities co-ordinator comes to my room and plays her keyboard and sings, it cheers me up, she is really nice and kind." We observed that people were free to use the communal areas and were able to spend time in their bedroom if

they wished. People told us that they were free to choose whether they wanted to be involved in activities or not.

We spoke with the member of staff responsible for organising the activities in the service. They told us that they regularly consulted with people about what kind of activities they would like to do. They produced a calendar of events so that people would know about forthcoming events. We saw these displayed around the home.

The complaints policy was displayed in the entrance to the home. We saw any concerns or complaints were investigated and actions from these were implemented. Records showed recent concerns or complaints had been addressed. The registered provider monitored all complaints and concerns reported. They worked closely with the registered manager to ensure the appropriate management of these.

Staff were encouraged to have a proactive approach to dealing with concerns before they became complaints and relatives felt able to express their views or concerns. We saw and relatives confirmed, that visitors were welcomed in a warm and friendly way.

Requires Improvement

Is the service well-led?

Our findings

We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems that help registered providers to assess the safety and quality of their services. The registered manager had failed to maintain an oversight of the quality of the care people received. We saw that there were systems in place to monitor the quality of the service, and quality audits were undertaken. However, these had not been effective at identifying the shortfalls in the service that were identified during our inspection.

We found multiple breaches of the regulations. People were not always treated with dignity and respect and the provider had not ensured that people received person centred care. We found that record keeping processes needed improvement. Care records were not always kept up to date with changes in people's care need. Records did not always reflect the care that people had received and people's response to care. Medicines, fluid thickeners and nutritional supplements were not always stored securely or used as the prescriber had intended. Identified risks to people were not adequately monitored by staff and managers.

We found that audits and daily checks to ensure the cleanliness and safety of the building did not identify a number of issues that we saw during our inspection. This included hair washing equipment that was dirty with dead insects and hair that had not been removed from previous uses. We found in one person's room a table mounted cooling fan that had its safety guard tied on with string. We also saw in this room that the vanity unit was broken and had sharp edges. Safety equipment used to protect the person from the hard sides of their bed was very damaged and the covering was flaking away. Contents of a first aid box had exceeded their use by date, however this had not been identified during checks. A new box had been purchased but had not been yet been put into use.

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

During our inspection, we checked records and saw a recent safeguarding allegation, reported to the local authority, had not been notified to the Care Quality Commission (CQC). We spoke with the registered manager about this. They told us that they were unaware that a statutory notification to the CQC should have been made on this occasion. The registered manager took action to ensure that this was completed in retrospect.

When an authorisation of an application deprive a person of their liberty (DoLS) has been made, registered managers are required to make a statutory notification to the CQC. We checked records to see if the CQC had been notified when authorisations had been made and found that the registered manager had not notified us of all the authorisations made

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

We received mixed views from people and their relatives about how the home was run. Some people told us

that the registered manager was friendly and spoke to them when they saw them. Other people told us that they did not see them very often and said that they were not always present. One relative told us that they found the registered manager supportive and helpful. Another relative told us that the registered manager was unapproachable, but that did not manage the home well. They told us that they usually spoke to other senior members of staff who they found to be helpful. We spoke with the registered manager about how they engaged with people and their visitors. They told us that they had an open door approach, and that they held a weekly 'meet the manager' surgery. This meant that they made a time at which they were available to meet with people and their relatives This was advertised in the homes foyer in the reception area. The homes provider also used an electronic customer satisfaction questionnaire. This was available to be completed at any time in the home's reception area. We looked at the results of these and saw that the feedback was very positive in all areas. This included about how the home was run.

Staff we spoke with told us that they felt supported in their work. One told us, "The manager is a good boss, you can go to them with anything." Staff members told us that there was a good team spirit and motivation levels were high. They told us that they would speak with the registered manager if they had any concerns and they felt confident about doing this. They told us that they were aware of the whistle-blowing policy. (This is a term used when staff can raise a concern confidentially about people's safety). Staff told us that they had no concerns about the care of people using the service. Staff meetings provided an opportunity to encourage open communication and question practice. Records we saw confirmed this.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered persons had failed to notify the Care Quality Commission without delay of an allegation of abuse and of an authorisation of an application to deprive a person of their liberty.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always being treated with dignity and respect. Regulation 10 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were risks to people's safety associated with the way that medicines were managed. Risks to people, and the planned actions to help mitigate them, were not adhered to or adequately monitored. Regulation 12(1) and 12(2)(a) (b) (e) (f) and (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Not all people living at the home were receiving enough to eat or drink because records and

Treatment of disease, disorder or injury	associated actions were not always completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems for monitoring and improving the quality and safety of the service and having regard to the accuracy of records were not operating effectively. Regulation 17 (1) and 17 (2) (a), (b), and (c)