Phoenix Healthcare Limited

Warren Lodge Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 3, 4, 5, 10 and 11 September 2018 and it was unannounced. We undertook this inspection due to a number of concerns raised.

Warren Lodge Care Centre is a care home without nursing. People in care homes receive accommodation and personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service supports people requiring care for reasons of age or frailty, some of whom are living with dementia. The service is registered to accommodate up to 55 people, during the inspection there were 42 people living at the service. The service is divided into two units known as the Main House and the Courtyard. The Courtyard is designed specifically to meet the needs of people living with dementia.

The service did not have a registered manager as required. At the last inspection the registered person had taken immediate action following the resignation of the registered manager to appoint a new manager. However, during this inspection the home manager was still in the process of applying to CQC. A registered manager is a person who has registered with the CQC 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. The home manager, four operations managers and the nominated individual assisted us with our inspection.

The registered person did not ensure their safeguarding systems were operated effectively to investigate and follow the provider's procedure after becoming aware of an allegation of abuse. Not all staff were up-to-date with their safeguarding training.

The registered person did not ensure staff kept clear and consistent records when people's care and treatment needs changed. In some cases, this put people at risk. They were not having their individual health and care needs met on time. There was inconsistent and ineffective support for people who became distressed or who were unable to make their needs known. When we raised queries or issues with support or records at our inspection, the evidence was not always available. We gave the provider the opportunity to provide the evidence needed but they were not able to.

We did not receive information to evidence the provider operated safe recruitment and selection processes to ensure suitable staff were employed. Staff training records indicated which training was considered mandatory by the provider. Not all staff were up to date with, or had received, their mandatory training. We saw evidence that learning was not always put into practice when staff supported people. Staff felt some training was missing to help them care for people more effectively. The provider could not be sure staff had the appropriate knowledge and qualifications to meet people's needs. Staff did not have regular support and supervision sessions to review their work and performance. However, staff felt supported to do their job and could ask for help when needed.

People had access to health care professionals. However, staff did not always record and act upon health issues promptly. Therefore, appropriate care and treatment was delayed and did not help people stay as healthy as possible. People had sufficient to eat and drink to meet their nutrition and hydration needs, however support from staff at meal times was not always available.

People's safety was compromised in the service as the premises were not well maintained. People received their prescribed medicine safely and on time. Storage and handling of medicine was managed appropriately. We found some errors with recording and storage which was not picked up by the provider's audit system. There were no specific plans for people receiving medicine covertly and anticoagulants as the provider's policy.

Most of the staff knew people's individual communication skills, abilities and preferences. However, they did not always follow their knowledge or have detailed guidance for staff to follow to reassure a person if they were distressed or uncooperative. Staff were not always following the care plan to provide the right support to people.

We observed kind and friendly interactions between staff and people. People and relatives made positive comments about the staff and the care they provided. There was an activities programme and people were involved in activities. However, not all people had opportunities for social engagement and meaningful activities according to their interests to avoid isolation.

The provider had a system to assess staffing levels and make changes when people's needs changed. The provider was using agency staff to ensure the right numbers during shifts and was trying to book the same agency staff to maintain continuity of care and support. Staff felt there were often times when they needed more staff to support people appropriately.

Staff followed the principles of the Mental Capacity Act 2005 (MCA) when supporting people who lacked capacity to make decisions. However, we could not be sure all staff understood people's capacity and helping them make decisions in their best interests. We reviewed information held regarding Deprivation of Liberty Safeguards (DoLS) to ensure people's liberty was not restricted in an unlawful way and people's rights and freedom were protected. Although the provider had taken some action with the local authority to apply for DoLS, we did not have clear information regarding all the people living in the service to ensure appropriate measures were in place. We have made a recommendation about staff training on the subject of restraint, consent, MCA and DoLS.

The provider had systems in place to assess and monitor the quality of care. However, the quality monitoring system did not effectively identify all issues, practices or concerns with the service. Without an effective system the service was not able to make improvements where and when necessary so that people could receive the support and care they needed. There was a management team of three senior staff at the service to help address the issues and concerns raised by us and other professionals. However, we saw little evidence of ongoing and sustained improvement.

We were concerned that the lack of overview of the service, inconsistent record keeping and proactive approach prevented improvements being achieved promptly. The provider did not take prompt action to ensure people were protected against the risks of receiving unsafe and inappropriate care and treatment. The provider's own quality assurance systems and audits had not identified all of the shortfalls and risks to people's safety we identified during the course of our inspection.

The provider investigated and responded to people's complaints. However, they did not record verbal or

informal concerns raised, as per the provider's complaints procedure. Annual questionnaires were sent so people and relatives could share their views.

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

The provider is working alongside with the local authority and relevant healthcare professionals to ensure people's immediate safety. The provider has a current action plan in place with the local authority, which is regularly reviewed and updated.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe and has deteriorated to Inadequate for this key question.

There were enough staff on duty. However, the deployment of the staff did not always allow them to spend time engaging with people and meet all people's needs.

The service did not always identify and manage potential risks to people. The registered person did not ensure premises were managed well to keep people safe.

Medicines management was not always safe. The provider's recruitment processes were not robust.

The provider had not always notified the relevant authorities of allegations of harm or abuse.

Cleanliness and hygiene standards had been maintained to prevent cross infection and illnesses.

Is the service effective?

Inadequate

The service was not effective and has deteriorated to Requires Improvement for this key question.

People's needs were not always met because staff did not always follow the care plans. Care plans did not contain detailed guidance.

Staff did not always receive the required training that would enable them to meet people's needs effectively. Staff did not always have the knowledge they needed to support people in stressful situations.

Staff did not receive regular supervision but felt they were supported to carry out their jobs.

The provider did not keep accurate records or take swift action when people's health deteriorated.

Although some Deprivation of Liberty applications were made to

local authority, we did not receive sufficient information to ensure people were deprived of their liberty in a lawful way.

Most staff understood people's rights to consent to their care and showed respect to people making their own decisions. However, not all staff were aware of the importance of following the principles of the Mental Capacity Act and help make best interest decisions for people that would reduce the risk of harm.

People had sufficient to eat and drink and gave us mostly positive comments about the food and mealtime experience.

Is the service caring?

Requires Improvement

The service was not always caring and has deteriorated to Requires Improvement for this key question.

People were not always supported with care and respect. Relatives and most people were positive about the staff and the care they received. However, this view was not always supported by our observations.

We also observed when people were treated with kindness and respect. Staff were caring when attending to people's physical, emotional and spiritual needs.

People's privacy and dignity was respected. People were encouraged and supported to be as independent as possible.

People's right to confidentiality was protected.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs. It has deteriorated to Requires Improvement for this key question.

Care plans did not always show the most up-to-date and important information on people's needs, care and welfare. Therefore, people's individual and complex needs were not always supported.

Staff did not always interact with people or respond appropriately to them if they needed help or support.

There was an activities program. However, there were not enough meaningful activities for all people to participate in as groups or individuals to meet their social needs. Visitors were welcomed and people could maintain relationships important to them.

The service managed complaints that had been raised. However, they did not always record all verbal or informal concerns raised.

Is the service well-led?

Inadequate

The service was not well-led and it has deteriorated to Inadequate for this key question.

The registered person did not ensure notifications were submitted in time to the CQC to inform us about events in the service. There was no registered manager for over nine months. These circumstances limit the rating for well-led to no better than requires improvement.

People were put at risk because systems for monitoring the quality of the service and risks were not effective.

The registered person did not organise and lead the service successfully so that concerns were addressed swiftly. The management team did not carry out regular audits to have an overview of the service and issues.

Problems with the service and necessary improvements were not always identified and this had an impact on people. We did not always see evidence of action plans or action taken where concerns had been highlighted.

Staff felt they were supported by the management team. However, their suggestions were not always taken on board. They felt at times not all staff members worked as a team.

Warren Lodge Care Centre

Detailed findings

Background to this inspection

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

The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risks. These were pressure care, falls management, moving and handling, managing incidents and accidents, communication and understanding of best interest decisions for people. This inspection examined those risks.

This inspection took place on 3, 4, 5, 10 and 11 September 2018 and was unannounced.

Over the five days, the inspection team consisted of the lead inspector, three additional inspectors, a specialist advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We carried out this inspection due to a number of concerns raised. We looked at all the information we had collected about the service. This included previous inspection reports, information received from health and social care professionals and information from others with a connection to the service. We also looked at notifications the service had sent us. A notification is information about important events which the service is required to tell us about by law.

During the inspection we spoke with 11 people who use the service and five relatives. We spoke with the home manager, operations managers and received feedback from 14 staff including care assistants, senior staff, activity coordinators, domestic staff, and kitchen staff.

We observed interactions between people who use the service and staff during the five days of our inspection. We spent time observing lunch in both dining rooms. We received feedback from two external professionals. We looked at 11 people's care plans and related monitoring records, medicine management records, eight staff recruitment files and agency staff information, staff training records and the staff training log. Medicines administration, storage and handling were checked. We reviewed a number of documents relating to the management of the service. For example, various audits, meeting minutes, activities plan, incidents and accidents information, complaints and compliments, service maintenance and checks records.

Inadequate

Is the service safe?

Our findings

People felt they were safe living at the service and could ask staff for help. Relatives also felt their family members were safe. However, we were aware at the time of our inspection there was a significant number of safeguarding investigations ongoing. The provider was working together with the local safeguarding team to investigate and address these.

The provider's systems and processes to investigate and prevent abuse of people living at Warren Lodge Care Centre were not always operated effectively. During the first day of our inspection, we were informed of an allegation of abuse by one of the people living in the service. We told the management team of this on the same day so they could start investigating and take action as they were not aware of this prior. On the third day of our inspection, we asked the management team whether the necessary safeguarding procedures had been followed regarding the allegation of abuse. The management team had not raised a safeguarding alert with the local authority nor had they submitted a notification to CQC. We advised them they needed to do this urgently. By failing to inform the relevant authorities of this allegation of abuse, this placed the person at risk of ongoing harm or abuse.

On the fifth day of our inspection we were informed of second allegation of neglect identified by one of the visiting professionals. After the inspection, we were informed of a third allegation of neglect that had not been notified to us. We raised this with the provider after the inspection, who was not able to explain why they had not informed the Care Quality Commission of this incident and told us they were aware of their responsibility to report such matters.

At the time of our inspection, only 19 staff members' safeguarding training was up-to-date. As part of their role, staff must receive safeguarding training that is relevant and suitable for their role. The purpose of safeguarding training is to enable staff to recognise different types of abuse and how to report concerns. Training should be updated at appropriate intervals so staff. Since our inspection, the provider had worked with the local authority to arrange safeguarding refresher training for all staff. Although there were systems and processes established to protect people who use the service from abuse and improper treatment, the registered person did not ensure these systems were operated effectively.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person did not ensure the provider's systems and processes to protect people from abuse and improper treatment were operated effectively.

People's needs and risks to their safety and wellbeing were assessed. However, there was a recent change in recording mechanism as a new online recording system was introduced. At the time of our inspection, the record keeping system was in transition and this was used along with paper copies of people's records. This change proved confusing and some records were incomplete. There was little detailed guidance for staff regarding more complex care needs and a lack of signposting where to find guidance for it. Care plans also needed more information on physical activity, exercise, mobility and transfers to ensure staff were aware of how to encourage people to remain safe and be active as much as possible. As some people were at risk of

developing pressure ulcers, this would also support the prevention of skin deterioration.

Prior to our inspection, we received information of concern about the management of pressure care at the home. We found people who were at risk or who already had pressure ulcers, information in care plans was not always written clearly to indicate exactly how to care for their skin condition. For example, part of the support with skin integrity was to check the pressure mattress was working properly. However, there was no accurate monitoring system or documentation in place to ensure the person's mattress was inflating and deflating correctly. The online recording system had a box in green stating "Done". However, it was not clear how this would establish the mattress condition and if it was working accurately. The electronic recording of mattress information was discussed with several members of staff. Once we pointed this out to the management team, the recording was changed to include more accurate information on the mattress checks. A nationally recognised assessment tool for risk of skin breakdown was completed inconsistently. In one person's file it was identified on the wound and skin tool contained in the care plan, that the person had a wound on one of the heels. However, there was no date relating to it, but only a statement that they were referred to the community nurse team. We were unable to locate any assessments, monitoring, clinical care plan or if the community nurses had visited and assessed the person in a timely manner. The online system showed the skin integrity risk assessment tool had not been completed between 8 and 31 August 2018, which stated the person had no pressure areas of concern. However, according to the care plan from April to 25 August 2018 the person had ongoing problems with their skin.

Risks to people's safety had not been consistently assessed to have plans in place to minimise these risks. We observed on three occasions when people were helped transfer from one place to another (chair to wheelchair and wheelchair to a chair). We observed people found it hard to transfer from one place to another, even though staff were very supportive and encouraging. One person was being transferred from the wheelchair and the brakes were not put on. Only later the staff put them on to stop the wheelchair moving backwards. The staff supported the person to stand up by giving a little push up on their back and we saw the person was struggling to transfer to the chair. Another person was using a handling belt around their waist to help them stand up from the chair in order to sit in the wheelchair. Two other people did not have this belt on. Therefore, we looked at the care plans for all three people to review the guidance on safe transfers and mobility. However, there was no information what measures should be followed to ensure people remained safe. There was no reference to a moving and handling risk assessment. The care plans did not indicate how the person wished to be transferred and the support they would like to receive. Only reference was given to some aids used. There was little information written to ensure their safety was maintained while transferring so injuries were not sustained. We could not be sure that moving and handling practices were always safe.

People involved in accidents and incidents were not always supported to stay safe. When people had accidents, incidents or near misses, staff would record the information on the forms including details and immediate action taken. However, the management investigation was minimal or not recorded consistently. We found body maps completed for incidents or accidents without matching incident or accident form. For example, one person had 12 body maps completed since June 2017 which included ulcers on legs. There was no information noted in the care plans that these had improved or were no longer of concern. The manager was not able to elaborate more why there were so many body maps but no consistent investigation into each and prevention measures put in place.

The incidents and accidents were not monitored consistently to gather necessary information to mitigate the risks, identify themes and trends, and put safety and prevention measures in place. The registered person did not ensure the management team always reviewed incidents to identify trends so actions could be taken to reduce the risk of recurrence. For example, we looked at three incidents in August 2018 where

people had fallen but not sustained an injury. Where the form asked for a manager's investigation and root cause analysis, these had not been completed. However, a manager had signed these off to say the form, investigation and actions were completed. We spoke with the home manager regarding this and they could not confirm all incidents and accidents had been adequately investigated.

In the month of August 2018, one person had 10 separate falls. One of which had resulted in an injury. The incident forms completed had information on initial actions taken. However, the manager's investigation into each incident did not provide actions to prevent recurrence. The management team updated a monthly spreadsheet of all incidents and accidents that had taken place and what actions were taken. We looked at information for June, July and August 2018. Some areas of action were identified such as to ensure incident/accident forms were completed fully and recorded on the online system. Staff had to ensure forms were signed and given to the manager to complete a full root cause analysis. Staff had to ensure they recorded progress of the incident such as skin tears and healing. These actions were not completed consistently. We did not see and were not provided with sufficient evidence action had always been taken to investigate the incident or accident. Therefore, there was insufficient information to be used to look for trends and themes or that lessons learnt were taken from these events to prevent recurrence, injury or harm.

This was a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person did not ensure care and treatment was provided in a safe way. They did not assess the risk to health and safety of service users or mitigate such risks.

The registered person had recruitment procedures in place to ensure suitable staff were employed. Staff files included most of the recruitment information required by the regulations. This included a health check and a Disclosure and Barring Service (DBS) check. A DBS check confirms candidates do not have a criminal conviction that prevents them from working with vulnerable adults. Additionally, interviews were designed to establish if candidates had the appropriate attitude and values. We found some discrepancies with employment history and dates, proof of identify including a recent photograph and gathering evidence of conduct and reasons for leaving regarding work in health or social care. We also reviewed information held on agency staff. We noted a few queries such as training updates and one DBS record. People were at risk of having staff providing their care who may not be suitable to do so. We listed all discrepancies to the management team so they could rectify them. However, we did not receive any further information.

This was a breach of Regulation 19 and Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not followed their established recruitment procedures or obtained the information required by the regulations to ensure the suitability of all staff employed.

We looked at the management of medicine in the service. We observed some good practice while staff were supporting people to take their medicine. People's medicines were administered correctly. Staff were polite, asked if they were ready for their medicine, explained what it was for and ensured people took it. The medicine administration record (MAR) sheets were signed afterwards. A few people asked for some pain relief and the staff responded to these requests swiftly. The medicine trolleys had always been left locked every time we checked it. However, not all staff who administered medicines were up to date with their medicine training. Thus, people were placed at risk because the registered person did not ensure their medicine policy was followed to ensure staff were competent at all times to administer medicine.

We reviewed all medicine stock and found one bottle of eye drops past the opening due date, and supplement drinks past the best before date. We also found one of the medicines was not signed in the register with other specialised drugs kept in a separate cabinet. The deputy manager explained the stock

should be checked monthly however, it was evident the checks did not pick up the discrepancy. This was also not picked up by the medicine audit until we noted to the deputy manager.

Some people had to take anticoagulant medicine. We asked staff about the process of ensuring people received this medicine on time and in the right doses. The staff had to communicate with community nurses to administer the medicine and warfarin clinic to set the dates for each International Normalised Ratio (INR) blood test. The staff were able to explain the process of this medicine administration. We asked if people had a care plan specifying all the steps to take to ensure they were getting their medicine the right way. However, we were told there was no care plan and staff knew what they were doing. We reviewed the medicine policy. It stated the service "has a specific care plan in relation to warfarin [an anti-coagulant drug] for each individual" as part of the good practice within the organisation. The policy also stated to "ensure a separate warfarin administration record was maintained" but it was recorded on the same sheet with other medicine. This meant the registered person did not ensure their medicine policy was followed correctly which placed people who were receiving this medicine at risk of harm.

We noted two people needed to have their medicine administered covertly. We saw the service had contacted professionals such as their GP to discuss the matter and follow the right procedure. We noted to the manager that if the medicine had to be administered covertly, they should ensure the person had a specific care plan for a certain length of time for that particular medicine. This should be also regularly reviewed and in line with the Mental Capacity Act 2005 legal framework. We asked to see the covert administration of medicine care plans for two people and best interest discussion records. However, the management team were not able to provide us with them. The medicine policy clearly indicated steps to take ensuring the service acted in the best interest of the person and followed the law but these were not followed.

We asked the staff about how medicine was handled if it was refused by people. They explained the refused medicine would be put into small bags and returned to the pharmacy. The management team said the correct process was to push the pod underneath out of the biodose tray and take the medicine pod to the person. Biodose is a single system for administering solid oral tablets and capsules together with liquid medications. Staff would ask the person if they wanted their medicines. If the person said yes, the staff would peel the seal back and away from the pod then give it to the person from the pod to avoid secondary dispensing. If the person said they did not want their medicine, staff would return the unopened pod back to the tray with the seal intact and document the person had declined the medicine, with date and time of refusal together with their signature. This information would be written on a sticker supplied by the pharmacist and attached to the refused pod. We checked the medicine trays for these two people and the medicine was still there on some of the dates they refused it. Some pods did not have all the medicine in or film lids, and could easily fall out. The medicine administration record sheets did not consistently indicate what was done with the medicine when refused and if they tried again to give it to the person. It was not always recorded and it was not clear when the medicine was given covertly or if it was returned to the pharmacy.

This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not ensure care and treatment was provided in a safe way. They did not ensure the proper and safe management of medicines.

We reviewed what premises and maintenance checks were carried out. The service conducted regular checks of the fire alarm system to ensure this was working correctly in the event of a fire. Where fire doors had signs to say they must remain shut, these were closed and secure. There was some evidence fire doors were checked to ensure they were working properly. However, records were not always clear when there

was an issue with a fire door that this had been addressed. For example, we looked at audits that had been done on 07 September 2018 and they indicated that some of the fire doors were not working correctly. In the column "Defects/Action taken", this was left blank. Therefore, we could not be sure if action had been taken to address the issue.

Maintenance staff completed regular checks of the call bells in the service. This consisted of checking they were intact and there was no damage. They also checked when the call bell was activated the communal display units showed the correct location of the call bell and that the bell was audible. However, when an issue had been identified, there was no evidence this had been addressed. For example, checks completed on 13 August 2018 stated the maintenance staff "can't find…" the call bell in one of the rooms. There was no evidence that action had been taken to address this. We saw the extractor fan checks were completed in the building to ensure they were all in working order. We saw for a number of the rooms comments had been recorded "Needs replacing". However, the "Action from inspection" record was blank. We could not be sure if these had been completed. Regular audits had been completed to ensure the laundry room was checked and that health and safety standard of the provider was being met. However, when an issue was identified, it was not always clear what action had been taken. For example, the checklist said, "Is the floor clean and free of trip hazards?", and this had been ticked, "No". There was no evidence of what action had been taken to address this. We asked the home manager and they were unable to confirm what had been done.

An external contractor completed a water risk assessment on 02 February 2016. The risk assessment highlighted nine areas that were deemed to be "Where items are identified which present a significant H & S (health and safety) risk". One of the significant risk items was that "In house staff conducting legionella tasks [were] not adequately trained". An action was given to "Carry out legionella awareness training with a Legionella Control Association accredited company". We asked the home manager if this has been completed and they advised, "I believe it's covered in the infection control training". We asked if this met the requirements of the risk assessment action plan, however they advised they did not know for sure. Another significant risk highlighted was "Poorly serviced valves can harbour microbes, including legionella". Thermostatic Mixing Valves (TMV) outlets were checked weekly by testing the temperatures. We saw records showed these had been completed regularly and were within the appropriate and safe temperature which evidence that the TMV outlets were in working order. We spoke with the maintenance staff member who advised they had replaced a TMV in the laundry last week. They advised they "only record temperatures in areas where residents go, like bedrooms". They confirmed they did not record the staff areas. There was no evidence the TMV had been serviced annually.

Temperature control is the traditional strategy for reducing the risk of legionella in hot water systems. Health and safety guidelines state the hot water should be stored at least at 60°C to reduce the risk of legionella. There was no evidence the hot water tank temperature had been checked to ensure the risk of legionella was reduced. We spoke with the maintenance staff member who informed us that, "I do check it, there is a thermostat on the side of the tanks…". They confirmed they did not record this result anywhere. We asked the home manager what had been done regarding each action as we could find evidence these had been actioned. However, they were unable to tell us and advised they would need to speak with other members of the management team to get this information. The home manager later confirmed they spoke with the provider's regional maintenance person who confirmed that actions had been completed. After inspection, we received an update to the action plan from the water risk assessment without any dates when it was completed.

There was a clear lack of oversight from the home manager of maintenance required in the building. They advised us they were going to complete a spreadsheet of all maintenance related actions to have a better oversight of this. Actions were not completed in a timely manner to make the service a safe place to provide

care and support to people.

This was a breach of Regulation 12 (2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person did not ensure the premises used by the service provider were safe to use for their intended purpose where people received care.

The service carried out other checks such as gas safety checks, lighting checks, and equipment checks and servicing and these were in date. Staff followed a cleaning schedule and used appropriate personal protective equipment to help protect people from the risks relating to cross infection. They ensured the service was kept clean, tidy and odour free.

The manager said they used a dependency analysis for calculating staffing numbers on each shift according to the needs of people. Due to recent changes in the permanent staff team, a number of agency staff were working alongside permanent staff. The service aimed to book the same agency staff to ensure people got familiar with them and to help maintain consistency in the support and care provided. The manager said they had sufficient numbers of staff to meet people's basic care needs. People had their dependency score calculated however it did not reflect the support they needed accurately. For example, one person had a score for low dependency needs. However, their care and support needs were reviewed for August and September 2018. It said, "[Name] needs support with day to day needs". This indicated they had 'medium' dependency needs on the scale the service used.

Staff were not always deployed in a way that kept people safe or supported appropriately. For example, there was one staff member helping people with drinks while one person using the service was following them repeatedly asking for help. Another person dropped their drink on the floor and it had to be cleaned. The same staff member was trying to clean up the spillage. The person was still asking for help and it was clearly overwhelming for this member of staff. There were other staff around however at no point did anyone notice the person was following and then standing right behind the staff asking them for help. Finally, a member of staff could assist the person with finding an item that was missing. They spoke to the person in a reassuring way and walked together with them to their room. We observed staff were very patient with people however it was clear not all staff were confident and knowledgeable to support all people with complex needs. The deployment of staff did not always ensure people were supported to meet their complex needs such as being confused or distressed. Most of the staff felt there were often times where they could have had more staff to help carry out their role and responsibilities. We observed on a few occasions staff were helping people eat while standing or standing further away watching them eat rather than sitting down together to have a chat, particularly encouraging to eat those who needed that. Some staff felt there were not always enough staff during mealtimes to support those who needed assistance to eat.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person did not ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to ensure they can meet people's care and treatment needs.

Inadequate

Is the service effective?

Our findings

People did not always receive effective care and support from staff. Staff were not always guided by the best practice and knowledge. Staff were not always up to date with their training. People had mixed views about the skills and caring nature of some staff. Comments included, "No, I don't in all honesty [think staff have the skills to look after people]", "Some days I'm fed up with it here and some days it's ok", "The staff are very good" and "Oh yes, the staff are pretty good here. In fact, I'd hate it here if it wasn't for the staff".

Staff did not always have the training they needed to meet people's needs and ensure their safety in the service. We reviewed the training matrix provided to us which recorded training the provider had determined was mandatory as well as role dependant training. There were 50 staff in total recorded on the matrix. Not all staff members' training was up to date. For example, only 12 had their fire training, and only 18 staff had their manual handling training up to date. Two staff had training in pressure ulcer prevention and one staff had training in falls prevention. 20 staff members did not update or have dementia training. None of the staff had completed or updated sessions in challenging behaviour, incontinence and duty of care, despite the fact that there were people living in the service who had these support needs.

During our inspection we noted some incidents between people and staff or observed a few incidents between the people where they had to be supported to manage their behaviours. Looking at the records of these, we could not be sure staff had sufficient understanding of how to support people. Some staff also felt more detailed training on challenging behaviour and dementia was missing. They felt it would help them understand and support people better, especially in situations when people get anxious or distressed. Only senior staff administered medicine to people. Out of 11 senior staff only one was up to date with the training. As all out of date training was indicated in rose colour, we asked the management team to provide us further information of any training booked. We only received information to say six senior staff had received medicine training, one was booked to complete it on 17 September 2018 and one senior staff was off sick. However, it was not indicated on the training matrix sent with other post inspection information so we were not sure who still needed to complete their medicine training.

We reviewed support and supervisions for staff. This is a meeting between staff and their line manager to discuss staff's practice, development needs and any other areas of support. The manager had a matrix compiled to record the sessions completed. Staff felt they were supported by the manager and could come to see them for advice. The manager told us they were encouraging staff to come to them and work together as a team. The management team were working with staff to ensure they were supported and felt valued. The manager said there were opportunities for further training and qualifications to any interested staff members. However, not all staff were sure they could get further qualifications. Looking at the matrix, the majority of the staff had only one session of supervision this year to review their performance, professional development and discuss any matters. Therefore, we could not be sure the management had an overview of staff performance and development needs. This also meant people were not always getting appropriate care and support.

This was a breach of Regulation 18 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014. The provider did not ensure staff supporting people were appropriately trained, supervised and able to obtain further professional development in order to perform their work.

People had access to health and social care professionals including a GP, dietitian, occupational therapist, community nurses, and the community mental health team. A GP visited the service and reviewed people's health regularly. However, due to inconsistency of recording and reporting of the illnesses or health deterioration, people were not always referred to health professionals in a timely way. There was no continuity between recording and providing care and treatment to people. We found examples of illnesses or health deterioration which were identified but not acted on immediately. For example, we found one person was supposed to have been referred for an x-ray as they complained about the pain. The notes indicated the person was seen by GP and "GP will organise X-ray for left knee and hip". There was nothing else provided to answer our query if the person went for this procedure. We also asked if they had a medication review as per GP notes. However, the manager was not able to confirm from the notes this happened on that day or if it was the date for the next review. Several people's files we saw had an information leaflet "React to Red" and assessment attached to it which was a tool to observe and monitor people's skin integrity. If the skin condition deteriorated, staff would follow steps to ensure this was picked up early and actioned to prevent injury and harm. However, this document was at the back of the files and not updated regularly even though a number of people were at risk of pressure damage.

People's changing needs were not always monitored appropriately to ensure their health needs were responded to promptly. People were not always referred appropriately to the dietitian and speech and language therapists (SALT) if staff had concerns about their wellbeing. For example, following concerns raised regarding one person's swallowing and a request to the GP for a SALT referral, the GP prescribed thickened fluids. However, they did not assess the stage of thickening required and as the instructions were not clear, no thickener should have been used until clarification was sought. The staff assumed the stage and offered fluids with stage two thickeners to the person. This was reported as a safeguarding incident as there was no written instruction from a health professional. Once the mistake was identified by a visiting professional, an urgent SALT referral was made to ensure the correct process was in place to help the person with swallowing.

Care plans were in place to meet people's needs in different areas. However, they were not regularly reviewed or detailed enough. People did not always have appropriate care plans to help them and staff look after their specific conditions. For example, one person had to have a dementia care plan as part of their care. Their specific medicine had to be reviewed regularly as per notes in the file. We asked to see the care plan and reviews for this person, but it was not provided to us. As staff's knowledge and skills varied, this affected people's support and time to respond to their needs. People's health care needs were not monitored consistently. This meant we could not be sure any changes in their health or well-being prompted a referral to their GP or other health care professionals. The disjoint between records and actions put people at risk of their health failing rapidly without appropriate action being taken. One professional said the staff were very caring. However, they needed help with understanding how to support people with more complex needs, managing falls, and incidents between people. Furthermore, they felt the service could be more proactive in identifying issues rather than waiting for something to happen and become a problem.

This was a breach of Regulation 9 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not ensure people's care and treatment was appropriate and met their needs.

People told us they were able to make choices about what they had to eat. We received mostly positive

feedback regarding the quality of food provided. Some said, "Mostly it's very good but I am fussy too", "It's on and off – but they are good cooks" and "The food is not bad". However, people's needs and support with meals were not always followed as recorded in their care plans. For example, one person chose their meal option and when it arrived, started eating without hesitation. When they ate about half of the meal, they put the cutlery down. Staff asked if they were finished and the person said, "Yes, thank you". The care plan stated the person needed prompting to eat as they may have a poor appetite. Rather than encouraging them to eat a bit more, staff just took the answer and removed the food. Later it was written in the daily notes this person ate both of their meals but it did not refer to the proportion of it not being actually consumed. Another person was eating very slowly, sometimes putting an empty fork in their mouth or staring at the plate in front of them. Staff did not notice the person may have been struggling to eat their food. Other people on the same table were also eating slowly. However, when they finished their meals, the person had almost a full plate of food still. No staff approached them to check if everything was alright. Almost an hour later the person was offered pudding and they agreed to have some. The care plan stated this person also needed encouraging to eat their meals and have drinks. On a few occasions we observed one person was supported to eat however, staff did not engage in any conversation with them. The care plan stated the person liked to have a chat, needed reassurance and prompting with eating and drinking. There was the lack of knowledge of service users' dietary needs such as the need for encouragement to eat to ensure sufficient food and fluid intake.

We also observed positive and respectful practices during lunch time. People were offered a choice from the menu for their meals. We saw if people did not want it, they were offered other options they preferred. When speaking to people, most of the staff would come down to their eye level to have a chat or listen to their request. Everyone ate at their own pace and it was a calm atmosphere. We observed staff continuously offered various drinks to people and there were drinks available throughout the day. If people got frustrated with something during lunchtime, staff were very patient trying to help them to resolve any issues. For example, one person was finding it difficult to hold their cutlery. One staff noticed this and suggested to try a different fork. Staff brought a fork with a different handle. We saw it made a difference to the person and they could actually enjoy their meal. Some people chose to have their meals in their rooms. For example, we observed one staff member assisting a gentleman eating lunch in their room. The staff was consistently kind and pleasant. The atmosphere was calm and relaxed despite the person becoming anxious at times. The staff member was able to reassure them and gently encourage them to continue eating, taking time and care. The staff member was very attentive throughout and would rub the person's shoulder in a warm and caring manner.

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. The manager demonstrated a good understanding of mental capacity considerations and assuming capacity to ensure people could make their own decisions. However, we noted to the manager some files had consent forms signed by the family members and it was not clear if staff had checked they had a legal right to do that. We discussed this with the manager. They agreed this had to be changed to evidence people's consent was sought and recorded in line with the MCA legal framework.

We observed staff were asking for consent, giving time to people to respond and respecting those decisions. However, not all staff were aware of the MCA and their responsibilities to ensure people made decisions that were in their best interest. Some people were living with dementia or other cognitive problems and they were at risk of harm such as skin pressure damage or injuries from falls. This also had an effect with making best interest decisions relating to people's care. For example, if someone refused to get up, change

positions or receive personal care, staff accepted the answer as the decision made assuming capacity. As they were at risk of harm or injury, we did not always see evidence of a consistent and clear proactive approach to encourage people to change their mind and prevent any harm.
People's care plans did not always have guidelines to ensure staff supported them appropriately including personal care, emotional and behavioural support and consent. Where people may show behaviour that challenged, the staff did not have enough detailed guidance on how to minimise the risk without restricting people or their independence. For example, we looked at one person's records and there were no plans in place for managing their behaviours. Thus, staff were not aware of triggers and there were no agreed de-escalation procedures. Staff advised us if the person became agitated during personal care, they would leave them for 15 minutes. We looked at an updated support plan for personal care that included an action for staff to hold one hand each if the person became unsettled during personal care. This way two staff members distracted the person, trying to engage in conversation about babies helping them calm down. The staff advised us they had not been trained how to hold this person's hands whilst giving personal care. The staff were holding both hands so that the person could not remove them therefore restraining them. The staff member was not aware this was a restraint. This was discussed with the home manager who was not aware that by holding person's hands staff were using restraint. This was also discussed with the management team. Afterwards, they had a group discussion with all the staff team throughout handover sessions to ensure all staff understood how to support this person without restraining them. The support plan was also reworded to include clear instructions for staff and support with personal care. We did not find any further record of best interest discussions with family on how support with personal care should be managed for this person.
We recommend the service finds out more about training for staff, based on current best practice, in relation to understanding restraint, seeking consent, MCA and DoLS

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. We looked at the information to find out if there was anyone living in the service who was subject to a DoLS authorisation. The manager had made some applications to the funding authorities for the required reviews of DoLS assessments and authorisations. At first, we were informed there were 11 people with DoLS authorisations. During inspection this was rectified to seven. We looked at the information the manager had regarding DoLS. We could not be sure this was accurate or consistent to ensure required applications were made appropriately and in a timely manner. For example, one person had a DoLS authorisation in May 2017 and the expiry date was May 2018. For the same person, there were two more dates noted for another authorisation and application. It was not clear if it applied to the date of May 2018. Another DoLS application was made in July 2015 but there was no information to confirm what the outcome of this application was. We informed the manager notifications informing of the outcome of DoLS were not sent to CQC. We also queried two applications made when people had capacity as indicated on the DoLS spreadsheet. One of the people had one to one support in place to keep them safe from falls mainly. We asked for the evidence of discussions held with this person as they would have had to agree to this kind of support. This was not provided to us. We could not be sure the service had fully followed the principles of the MCA prior to judging whether the person was being deprived of their liberty or not.

The design of the premises was mostly suitable for the needs of the people with dementia. In the courtyard side, some elements of the interior helped people living with dementia. For example, the doors to people's rooms were depicted as their front door, brightly painted and furnished with door handles and knockers. People were assisted to locate their rooms using these colours and photographs. The décor had some points of interest such as artwork dedicated to royal family or being at the beach in the relevant corridors.

There was dementia signage indicating what other doors were, for example toilet or dining room door. Toilet seats were white and did not stand out against the décor in the toilets rooms. Best practice guidance states ensuring good colour contrast on sanitary fittings make toilets easier to find and see, helping people to maintain continence. We observed aids such as coloured crockery used to support some individuals when eating, were not used. The service did not use colours to highlight light switches. This could be done by having coloured switches or making sure white switches show up against the wall colour. This would help people to find and use light switches independently. People were able to walk around the corridors and there were a couple of areas to sit down for quiet time. However, the signage to guide people where to go when coming out of their bedroom was minimal.

The main house presented a light, bright environment where people moved around freely. There were areas available for people to enjoy activities, spend time following personal interests and places to entertain visitors. We saw people and their visitors helped themselves to snacks and made themselves drinks when they wished. The service was keen to use new equipment which could reduce risk and support high quality care. Signage and décor throughout the service was appropriate and tasteful, making it welcoming to all. The outside areas were well designed and provided a pleasant place for people to sit outside or enjoy outdoor activities.

Requires Improvement

Is the service caring?

Our findings

We received mostly positive feedback from people and relatives about people's care and treatment. Some people felt the care and support was affected because not all staff understood what they wanted due to a language barrier. Some people felt the staff did not always have time to spend one to one time to chat as they could see how busy they were. Most of the staff agreed they did not always have time to spend with people and get to know them as an individual.

However, although we received mostly positive feedback, our findings and observations throughout our inspection showed that people did not always receive dignified, respectful care. For example, one person preferred to sit in the chair rather than a wheelchair. During our inspection we observed only a few times where they were transferred into a chair while in the lounge. The person also told us they often stayed in the wheelchair rather than being transferred to a chair. We looked at daily notes and it was recorded once or twice during the day. Some dates did not have any entry for the morning so it was difficult to determine what support, if any, this person received. As the daily notes were split into "morning, afternoon, evening and night" it was not clear how long the person would be sitting in the wheelchair or a chair, or stay in bed. Their care plan stated they were at risk of pressure damage so frequent changes of position were important to keep a good skin integrity. We spoke about this to the management who explained the person was always welcomed to ask any staff to help them transfer. However, we felt it was also important staff knew the importance of keeping good skin integrity and regularly asking the person if they wanted to move from their wheelchair to the chair.

Staff knew people's individual communication skills, abilities and preferences but did not always follow their knowledge or take time when a person was clearly distressed to reassure them. We observed on a few occasions, one person was saying a name or "help" occasionally. However, the times we observed, we did not see staff approaching them to check if everything was alright. We asked if we could help, and they asked us, "When is [name] coming?". It was a family member but there was no reference in the care plan of how to support this person when they were asking for this name. The care plan also referred to the person becoming verbally aggressive and to give them space to calm down. The care plan said the person may ask repetitive questions due to their memory. However, it did not indicate how to support this person to ensure they felt reassured and safe in the service. People received care and support from staff whose knowledge varied about people and their needs.

Staff did not always show concern for people's wellbeing in a caring and meaningful way and did not respond to their needs quickly. There was a mixture of observations of how staff supported people who could become anxious and exhibit behaviours which may challenge others. People's records included information about their personal circumstances and how they wished to be supported. However, we observed this was not always followed. For example, there were people walking around the courtyard side. Some staff would notice them at times to greet them or ask if they were alright. Other staff would not always acknowledge their presence to check if they wanted something. We looked at people's care plans which indicated these people needed reassurance as they may feel lost or become anxious. Looking at the care notes in their daily record there was no continuous and clear evidence to indicate people were supported

appropriately to ensure they remained calm and enjoyed their stay in the service. Where people became agitated or stressed, this was not always recorded and sometimes lacked information of what was done. This meant the manager did not have an overview of people's conditions, their wellbeing and would not be able to seek appropriate support if needed.

We also observed there were times when people were treated with kindness and compassion when staff were supporting them and it was evident some staff knew people well. There were examples where staff spoke calmly and politely giving people time to respond. Interactions we observed between some people and staff were gentle and kind. We observed a staff member supporting a person appropriately whilst they were walking, and they both were engaging in a conversation. We saw how a staff member sitting with one person who was holding two dolls was engaging them in a conversation about the dolls. The person was enjoying the company and time spent with staff.

People felt they were treated with kindness and compassion in their care most of the time. Some said, "Yes, most of the time. Now and again gets a bit funny" and "Like in all walks of life, there are different people". Most of the people appeared happy and contented. People felt the care was not rushed and staff were available most of the time. People said staff knew how they liked things to be done and would ask for permission to help. We observed staff were polite towards people. They gave them time to respond to their questions and instructions and patiently repeated their requests if required. For example, we observed one person being very challenging towards a staff member and at times abusive. The staff member remained calm and ensured the person's needs were being met and that they understood what was being asked of them.

Staff told us they understood the importance of showing respect to people and considering their needs. They said, "Treat people how you wish to be treated", "Speak to them as if they were a member of your family", "I'm not treating everyone the same but as an individual" and "Be polite and respectful." People responded to staff well and clearly felt comfortable in their company. For example, one person was wandering around the courtyard area looking a little lost. A staff member observed this and approached the person and spoke with them. They then took a short walk together and chatted. The person then looked less anxious and appeared more settled. Staff were seen engaging warmly with people. Between tasks in the service, staff were seen chatting and interacting with people. One staff member was seen laughing and joking with a resident who was obviously very comfortable in the staff members presence.

People were encouraged to be as independent as possible. Some people said they did not need any help but they were aware staff would support them when needed. Others agreed staff were encouraging and praising them for doing things for themselves. Staff understood this was an important aspect of people's lives. For example, giving time and encouraging people to get involved in activities, encouraging them to come to eat with others, and getting involved in personal care. Staff said people were encouraged to be as independent as possible. They were there to help if someone needed assistance but they also encouraged people to carry out even small things themselves.

Staff always asked people for their consent before doing things. People had an opportunity to make choices where appropriate. We observed staff distributing drinks to people in their rooms, always knocking doors first. We overheard their comments to people showing care and friendliness. For example, "Cup of tea?", "Hello [person's name], no sugar isn't it" and "Hello [person's name], how are you getting on with your drinks? Would you like another?" This member of staff demonstrated a kind and caring demeanour and when approached said in a genuine manner, "I love them all – every one of them." Occasionally people became upset, anxious or emotional. We observed some interactions where staff were polite, supportive and patient. They would kindly explain the situation and the next steps they would take in order to support

the person. For example, one person had to be supported to go to their room and change their clothes. The staff showed respect and stayed calm during the process helping the person transfer from a chair to the wheelchair. The person was getting upset but the staff remained calm, patient and supportive. They were encouraging the person to move but kept the reason for the change of clothes discreet. We saw most staff interacted with people in a friendly manner. They would chat, hold hand and smile at each other. From people's reactions it was clear people felt relaxed and happy with their company.

People's bedrooms were personalised with pictures of friends and family, paintings, flowers, favourite books and other items important to the person. The service was spacious and allowed people to spend time on their own if they wished. We observed people and their appearance. They looked well cared for with clean clothes, hair done and people wore appropriate footwear.

People's right to confidentiality was protected. All personal records were kept locked in the office and were not left in public areas of the service. Staff understood the importance of keeping information confidential. They would only discuss things in private with appropriate people when necessary.

Requires Improvement

Is the service responsive?

Our findings

People had their needs assessed before they moved to the service. Information had been sought from the person, their relatives and other professionals involved in their care. This information was then used to compile the plan of care and support.

During our inspection, the service was using three systems to monitor and record people's care needs and support provided. These were a recently introduced online record system, a file with all information about the person and a file called "Grab and Go" with a care plan and other relevant forms. However, information in these records was not always clearly explained or recorded, and some information was missing about how care, treatment and support should be provided. For example, a care plan stated one person could be anxious, confused, and delusional as well as display behaviours that challenged. The guidance for staff regarding this was very general. It stated, "You must ensure her safety and the safety of others, observation needed, try and assist [service user] to engage in activities or take a walk in the garden." There were no suggestions of how long to try something or suggestions of things which have been shown to work. It was therefore difficult for staff, particularly those who were unfamiliar with this person, to feel confident in managing the behaviours or to know when to seek help. The care plan indicated specific behaviour charts should be used to record behaviours. Although Behavioural observation and management charts (BOMC) were in place and completed, there were inconsistencies in the recording between these charts, emotional support records and the care notes record (called a care story). For example, on one day staff had recorded in the BOMC that the person was resistive to care but no action was recorded nor were there any records in the emotional support record or the care story record. Three days later, staff had recorded in the BOMC that the person was wandering and they were taken for a walk outside. There was no record of this in the emotional support records. The care story referred only to the person being taken outside but it did not reveal why or the benefits derived from it. On two other days it was noted the same person had been resistant to care on three occasions. However, again no further information was recorded in the emotional support record or the care story to indicate the outcome or the actions taken at the time. This made it difficult to follow what had happened, actions taken, the response and eventual outcome.

We looked at another person's care and support. Their care plan had been updated to reflect recent changes but these were not always dated. Therefore, it was not always clear as to when the changes took place. For example, there was no date to verify when one to one support started or when an increase in falls had been noted. Information contained in the care plan was not always accurate. For example, the plan stated no walking frame was used by this person. However, throughout the care story notes a Zimmer frame was referred to as being used to aid mobility and we observed a frame in their room. While the care plan indicated there had been an increase in falls and a falls management plan was in place, there was no clear signposting in the care plan to this management plan. There was a copy in the 'Grab and Go' folder in the person's room where staff could refer to it quickly if they know it was there. Guidance for staff within the care plan referred to reassurance, talking and helping the person understand what was said. This was general in nature and gave no specific guidance such as what type of things to talk about, what kind of reassurance the person may respond to or how to offer help they would accept. The care plan stated staff were required to complete BOMCs for any "combative behaviours" and stated time should be included. The records showed

conflicting information. For example, on 13 August 2018, agitation was noted on care story notes and in the emotional support chart but not on the BOMC. No time was recorded, nor duration or how resolution was reached. On 28 August 2018, the care story notes referred to an episode of resisting care and behaviour that challenged. It was again referred to in the emotional support notes with a duration and actions that brought about resolution. However, this had not been cross-referenced to the BOMC. This meant the registered person did not ensure there was sufficient information to allow people to be supported appropriately and to remain safe.

There was a program to engage people in activities, maintain their social skills and achieve emotional wellbeing. Activities were listed and available to people, visitors and staff throughout the service. We observed a few activities going on and we saw people enjoyed getting involved, chatting to others in between. There was a hairdresser available and staff doing holistic therapies with people. During an afternoon activity session people were encouraged to join in if they wished. Staff took the time to explain the activity patiently to a person who forgot what the game was after each of their goes so that they remembered what to do. In the courtyard, a beads activities session was taking place attended by four people who were all talking about their lives and appeared to be having fun. However, people gave us a mixed feedback regarding activities. Some felt they were great and gave plenty of opportunities to get involved. Others felt there was nothing for them and they did not always feel they wanted to engage. We also observed when activities were not happening, the majority of the people were sitting in the lounges in a big circle with the television or music on. Sitting in smaller circles would have encouraged more interactions between people. We observed a few people having a chat about their past and memories. However, this was not happening on a regular basis. We saw in the files people had their activity table called 'typical week for [name]'. However, it was difficult to see from care story notes if people were doing those activities or if staff were encouraging them to get involved. Even though the service had a programme of activities, some people may not be protected from isolation and there was a lack of stimulation for them. People were not always helped to maintain their emotional wellbeing or encouraged to participate in an activity suited to their needs.

This was a breach of Regulation 9 (1) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not ensure care and treatment met people's needs and reflected their preferences.

We looked at whether the service was compliant with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people who use services. Records indicated whether people had disabilities or sensory impairments. There was some guidance in communicating with people in a manner they could understand. The manager was not fully aware of the Accessible Information Standard and its requirements. We spoke about the standards and what it meant to people and what kind of records to keep. We asked to see the provider's policy but we did not receive it. The manager agreed they had to review people's communication needs to ensure the information was highlighted and in line with the guidance. This would ensure all information presented was in a format people would be able to receive it and understand it.

We saw there had been four complaints since the last inspection in November 2017. These had been investigated and responded to. There was clear evidence the provider had taken appropriate action regarding the concerns raised in the complaints. The home manager informed us they only recorded investigations when they received a formal written complaint. They advised us if it was an informal or verbal

concern or issue, they "will try and address it straight away". However, they did not record this anywhere. They said they would discuss these in the handover meeting. This does not meet the provider's internal complaints policy which states verbal and informal complaints should be recorded. This meant informal or verbal complaints and concerns could not be used as an opportunity to improve the service. We saw the service received a lot of compliments regarding the care and support provided to people. The manager thanked the staff and appreciated their work. Most people and relatives felt they could approach the manager or staff in the team if they had any issues to report. Some people said they were not sure about raising issues or it was not always followed through. The staff felt they could approach the management team with any concerns should they need to.

People were supported to develop and maintain relationships with people that mattered to them. We observed relatives visiting people throughout our inspection. People could stay and spend as much time as they wanted with their relatives in their rooms, lounge or dining room. We observed some people chose to sit outside as the weather was good and staff supported them to go out in the garden.

One person was receiving end of life care and one person was due to be reviewed by the GP. We reviewed records and care in place for the person receiving end of life care. Staff recorded repositioning and food and fluid intake at regular intervals. An air mattress was in place and on the correct setting. Shortly afterwards their relative arrived to visit and the person roused. The person was offered lunch and took a small amount of the meal but ate a full dessert and took some fluid. We noted the care plan stated repositioning should occur two hourly, however, observations of care and records indicated turning took place four hourly. Our review of the care records indicated four hourly turns had been carried out and recorded between the 1 August and 3 September. We noted the fluid intake output records from 1 August to mid-August were scant indicating a low volume had been offered to the person. However, this appeared to be an issue with all records looked at and in mid-August recording reflected an improved fluid offering and intake. Deterioration in this person's condition had been reported to the GP and this was reviewed again to be receiving end of life care and the community nurse was to advise on care of a pressure sore. Family was involved in discussions about the care and support, as well. The person had started having swallowing issues and this was reported to the GP to request a referral to speech and language therapist. The care plan was updated to include an end of life plan. This provided guidance for staff of what they should observe for and report. It noted a form for Do not attempt resuscitation and the person was not for hospital admission. The person also had anticipatory medicines prescribed.

Inadequate

Is the service well-led?

Our findings

There are principles that we must take into account when making judgements about the rating. CQC has determined that there are certain indicators that potentially limit a rating. There are four principles regarding events and circumstances that mean the well-led key question can never be rated better than 'requires improvement'.

One of those principles is, "Statutory notifications were not submitted in relation to relevant events at a location without good reason." We use the information from notifications to monitor the service and ensure they respond appropriately to keep people safe. The registered person had not notified CQC about significant events consistently. They did not ensure notifications of allegation of abuse, allegation of neglect, serious injury and the outcomes of Deprivation of Liberty Safeguards applications were submitted in good time and without delay, as required.

This was a breach of Section 1, 2 and 4 (b) of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

It is a condition of registration with the Care Quality Commission (CQC) that the service has a registered manager in place. At the last inspection in November 2017, we noted there was a manager in post who had begun their application to become registered with CQC. The manager had been employed previously in another of the provider's services and was fully aware of the ethos and values the provider had in place. However, during this inspection there was no registered manager yet. The manager of the service was still in the process of applying to register.

Another of the four rating limiting principles is, "The location has a condition of registration that it must have a registered manager but it does not have one, and satisfactory steps have not been taken to recruit one within a reasonable timescale". Although the manager had been recruited in October 2017, the registered person did not ensure the manager was registered soon after their recruitment in order to meet the condition of their registration.

This is an offence of section 33 of the Health and Social Care Act 2008. The registered person has failed to comply with their conditions of registration which requires a manager registered with CQC to manage a regulated activity.

There have been a number of serious injuries that were notifiable incidents indicating duty of candour was applied. Duty of Candour, Regulation 20, is intended to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. The relevant person may be the person using the services or someone acting lawfully on their behalf as defined in the regulation. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. It requires the provider to understand their own role, and to put policies and processes in place to

ensure they are supported by all their staff to deliver it.

We asked the manager to provide us evidence that the regulation had been followed when serious injuries happened and people were supported accordingly. People were supported to go to hospital to treat injuries and update the care plan most of the time due to changes in their care needs. However, there was a lack of evidence to show staff had followed the regulation and their own policy to complete all the actions set out.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to record and keep a copy of actions taken as required in the Duty of Candour regulation when a notifiable safety incident occurred.

The registered providers must have systems and processes which assess, monitor and improve the quality and safety of the service. We found that whilst the provider had quality systems in place, these were ineffective in identifying and mitigating the risks posed to people, such as in regard to pressure care and medicine management. Staff did not always report changes promptly. For example, the service worked with community nurses to help staff look after people's skin and any damage such as pressure sores or skin tears. During one of the visits the community nurse team identified there were more people who needed help with their skin integrity than the service had identified. One person had their legs dressed to help them with healing. The home manager explained the person was not always compliant with the treatment and would remove the dressings against the community nurses' guidance, which affected the wounds and skin tears. We looked at the care plan to see guidance for staff to support this person with their treatment. However, there was no information what to do if the person started to remove their dressings.

The home manager explained the communication and work with community nurse team was not always clear or effective. They introduced a communication book to ensure all people who needed support and care with their skin, were noted for the staff to monitor their skin integrity. The home manager felt since then the working together had improved. However, when we asked about the manager's overview of people's skin integrity and issues, they were not able to provide clear evidence it had been done. We also observed when instructions were written by the nurse team they were not always followed. For example, it was noted one person should not wear socks or shoes while their skin got better. However, we observed this person throughout the day and they were wearing socks and shoes at all times. People were not always protected from risks associated with their health and the care they received. Since our inspection, the provider has continued working alongside the community nurse team in regard to people's skin health and pressure care needs.

We reviewed quality monitoring meeting minutes and service review reports for June and July 2018. The information was recorded inconsistently and was not accurately reflecting the records we viewed. For example, it said that one person in July lost weight. We found at least two who lost weight and two did not have their weights recorded for July. It was noted there were no pressure ulcers in July. We were notified about four cases of pressure ulcers that were grade 3 and above. It was not clear if the monitoring review would include other pressure ulcers lower than grade 3 to ensure they were not getting worse.

Where staff were using system "React to Red" to monitor and assess people's skin integrity, this was not recorded consistently. For example, one person's skin integrity was reviewed this year in January, February, May, July and August. However, part of the care plan review, there was a note at the end of June 2018 to say there was an open wound in the lower part of the body. This was not recorded on "React to Red". The staff did not record positioning charts consistently to monitor and maintain good skin integrity. The care plan stated the person was at risk of pressure damage and needed regular turning and assessment of pressure areas to protect the skin integrity. There was an inconsistency of the monitoring and weights of this patient.

For example, for year 2018, January and February had nothing documented. In March, April, May, June, July there were no weights recorded, but only ticked box to say the weight checks had been undertaken. This person had complex needs and behaviours needing staff's input however there was no accurate information recorded about appropriate support provided. The folder that contained most of the information about the person, could not be located. We could not view if appropriate action was taken to ensure this person received necessary care and support.

People who were on anti-psychotic medication were discussed as part of the quality monitoring and identified as needing positive behaviour support plans. It was commented that it had to be implemented as soon as possible. We did not see such plans in people's files or detailed guidance in the care plans. Another point discussed was, "Identifiable trends or learning points for further action, communication or creative problem solving". It was agreed training such as dementia, understanding of medication and end of life had to be sought by looking into specialist training for staff to enable their professional and personal development. This was not achieved as per the training matrix reviewed. These items raised or discussed were recorded in July and we still found the same issues at this inspection.

The information gathered in these reviews and records did not reflect accurate overview of the service and issues to be addressed. Where issues or improvements were identified, it was not evident if action had been taken. For example, the July report said, "Although good understanding in general it has been identified that some staff needs more support in order to understand better the needs of the residents with dementia." We noted to the management team throughout our inspection that not all staff knew how best to support people with dementia with confidence as they did not have the necessary skills and knowledge. This meant the information gathered in July was not used to bring improvements in the service to ensure people were supported and cared for appropriately.

The review also looked at falls and falls resulting in harm. There was a comment, "Increase in falls for the month of June, discussing how to reduce the falls even further and prevent any falls resulting in harm." It was not clear if any analysis was done to look at those falls and the increase. the service had been working together with an external agency such as the falls team. However, we did not see any clear evidence of effective falls prevention as people still had falls and some in high numbers. Furthermore, there was a falls prevention policy that stated a root cause analysis should be completed following any fall that has taken place and any learning identified and any care planning or risk management information updated. Senior staff would have to complete monthly falls analyses which should be "viewed by the Registered Manager". We did not see evidence of this practice being consistently carried out. This meant the registered person did not ensure their falls prevention policy was followed to ensure people's safety and reduce the risk of falls as much as possible.

We looked at another quality monitoring review completed at the end of August 2018. The same areas were covered but again recording of issues or information was inaccurate or inconsistent. For example, the report for July noted one person with significant weight loss. However, the report at the end of August said, "There were no residents with significant weight loss in July. Discussed serious concerns regarding residents' nutrition. We all need to reflect on why we are here." We did not receive any further information to support these comments showing that significant work had been done to review and address those serious concerns about nutrition.

Due to a number of concerns raised by external professionals, the provider compiled an action plan in June 2018 covering those areas of concerns and issues, actions to be taken and date of completion. The information in the action plan did not reflect the evidence we found during our inspection on the actual progress of addressing the concerns. For example, the service was still using three systems to record

people's care, needs and support and the transfer onto the online system had not progressed as per the action plan. We did not always have access to certain documents to review the information such as care plans because the files could not be found. Thus, we could not be sure if all the necessary information was available to the management team to review, monitor and assess the quality of the service, and care and support provided. We shared our concern about the lack of overview of the service due to inconsistencies in recording.

In response to concerns identified by other professionals, an additional team of management was deployed at the service in June 2018. Despite this, the progress of addressing the issues was not as quick as expected and frequently there was little evidence to support that action had been taken. The management team was reactive rather than proactive and we had to point things out before action was taken. For example, as part of the action plan for the provider, we received daily reports about the service and what was happening in order to monitor it. It also included specific people's daily fluid intake and some of them did not meet the daily target. One of the professionals asked about actions taken to address this. We received a reply stating this person would be seen by the GP. However, when we asked the manager if this person was on the GP list for that day, they were not sure what the reason was for it. When the person saw the GP, they said they often forgot to drink fluids. The care plan also indicated the person needed prompting to eat meals and drink plenty of fluids.

Some people had diabetes and we asked to see any specific plans around how to manage it including blood sugar monitoring. There was nothing specific available so we queried if there was any information when and how to check the person's health in regard to having diabetes. The manager agreed for the GP to review these people. We received notes after the inspection that the GP saw one person indicating they did not need a regular blood sugar monitoring. There was no information about other people being reviewed regarding their diabetes.

One person had to be transferred from the chair to their room and it took three staff to do that. However, once the person was in the wheelchair, they were finding it difficult to bend their knees so their feet could be placed on the footplates. All staff were really encouraging the person to work together but it was not successful. In order to protect person's dignity, they moved the person pulling the wheelchair backwards while two staff held each foot off the floor so it would not drag. We noted this practice was not perfect and the management team agreed. We asked if they were planning to ask for input from a professional to discuss this event and consider other safer options should this occur again. The manager agreed to seek advice but they did not identify the need to seek advice themselves in the first place. Therefore, until we raised it with the management team, this was not identified as part of the monitoring of people's needs and responding to it promptly, as well as, assessment and monitoring of the service provided to people.

Records were not always completed accurately or altered when necessary. Some of the wording used on paper records and online system was not clear. For example, staff were recording in care story notes the person needed "high level of intervention" however staff were unable to explain what it was. It was not clear what this intervention involved. Some people were described as "combative" without a clear explanation of their behaviour. Staff used words like "had a meaningful moment" or "content" but it was not clear what it was or if staff were asking the person how they actually felt. A number of care records we reviewed were not always clear and legible to ensure they indicated the care and support needs for the person. Some of the sentences did not have punctuation or a clear ending. Care notes did not always indicate the outcome of the event. For example, the person "got out of bed, refused personal care, bed made, ate their food, was a wake, on average was content." It was not clear why they refused the care and how staff supported them to have it eventually. Some of the entries in the care plans were explaining the condition a number of times. However, they did not provide guidance on how to help the person to deal with that condition or help them

to calm down if they became anxious or stressed. There was a great deal of repetition in the care story notes which could become confusing to read. They did not always present an accurate and chronological picture of the care and support people received. The registered person did not always ensure people and staff were protected against the risks of unsafe or inappropriate support and practice because accurate records were not maintained.

During our inspection, we reviewed a number of people's care plans and related care and support documents. As the information was recorded inconsistently, the management team could not always answer our queries in regard to people's care and support, and action taken to ensure their safety. There was a lack of oversight of people's needs particularly complex ones, support needed, and action taken to address the issues. Therefore, the management team could not always identify and manage risks effectively to ensure people received safe and appropriate care and treatment.

This was a breach of Regulation 17 (1) (2) (a) (b) (c) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not operated an effective system to enable them to assess, monitor and improve the quality and safety of the service provided. They did not ensure there were established processes to ensure compliance with the fundamental standards (Regulations 8 to 20A).

Staff had defined roles but did not always understand their responsibilities in ensuring the service met the desired outcomes for people. However, not all staff had the knowledge and skills to support people and their complex needs. From staff feedback, we could see they were interested and motivated to make sure people were looked after well and able to live their lives the way they chose to. We observed some good practice. However, during the inspection we also observed some practice that was poorly managed.

Quality assurance and satisfaction surveys had been sent out to people living in the service, their relatives and healthcare professionals recently. The results were not available yet so we were unable to review them or any action plans drawn up. The service had posters up called 'you said, we did' showing people's feedback they gave to improve and adapt the service. However, we did not receive evidence that this poster was effective and the registered person was proactive in identifying and rectifying issues and concerns raised since May 2018.

The staff team had some meetings and discussed different topics including practice at the service, care and support of people, care planning, safeguarding, medicines and training. Relatives and people using the service had also had some meetings. People, relatives and staff said they could raise any issues with the management and they were approachable. People and those important to them had opportunities to feedback their views about the service and quality of the service they received. However, people, relatives and staff were not consistently empowered to contribute to improve the service at all times using their input.

Staff were aware about the ongoing issues in the service however some commented that the management team could be more open with them about what was going on. The staff were positive the service was managed well however they were not all confident suggestions made were taken on board. Some staff mentioned that team work could be improved and they, "need to give respect to each other and each other's opinion". They felt the management team was supportive and staff felt comfortable going to them with concerns. Some staff said, "I do love working here and I am happy to make our residents happy", "Yes we always give 100%!" and "We care! And we know our residents very well". The home manager worked alongside staff which gave them an insight into their practice and how best to support the people. The home manager was developing the staff team to display appropriate values and behaviours towards people. They had recognised the challenges of ensuring the staff worked as a team and supported each other. They

promoted a positive culture and tried to engage staff in reflecting on practice and any lessons to be learned. The management team worked together with the staff team to help them remove task orientated support and use reflective practice. They praised their staff team, saying, "I've seen very attentive care, dedication, commitment. Staff doing things out of comfort zone to please people...this is why I'm here. [Staff] said they are proud to work here and that makes me happy."

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 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 Registration Regulations 2009 Notifications of other incidents How the regulation was not met: The registered person had not notified the Commission about specified incidents without delay. Regulation 18 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Section 33 HSCA Failure to comply with a condition Section 33 of the Health and Social Care Act 2008. Failure to comply with conditions How the condition was not met: The registered person has failed to comply with their conditions of registration which requires a manager registered with CQC to manage a regulated activity. This is an offence of Section 33.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA RA Regulations 2014 Person-centred care How the regulation was not met: The registered person had not ensured service users' care and treatment was appropriate, met

their needs and reflected their preferences.
Regulation 9 (1) (a) (b) (c) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not met: The registered person had not ensured care and treatment was provided in a safe way for service users. The registered person had not assessed the risk to health and safety of service users or done all that was reasonably practicable to mitigate any such risks. The registered person had not ensured the premises used by the service provider were safe to use for their intended purpose or were used in a safe way. The registered person had not ensured the proper and safe management of medicines. Regulation 12 (1) (2) (a) (b) (d) (g) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not met: The registered person had not ensured that the established systems and processes to protect people from abuse and improper treatment were operated effectively. Regulation 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance

How the regulation was not met:
The registered person had not established and operated effectively a system or process to enable them to: assess, monitor and improve the quality and safety of the
service provided and to assess, monitor and mitigate risks related to the health, safety and welfare of service users and others
The registered person had not ensured there were established processes to ensure compliance with the fundamental standards.
The registered person had not maintained records for each service user that were accurate, complete and contemporaneous.
The registered person had not sought and acted on feedback from relevant persons and other persons for the purposes of continually evaluating and improving their service.

Regulation 17 (1) (2) (a) (b) (c) (e) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed
How the regulation was not met:
The registered person had not followed their established recruitment procedures to ensure the suitability of all staff employed. The registered provider had not ensured the information specified in Schedule 3 was available for each person employed.
Regulation 19 (1) (2) (3) (a) and Schedule 3.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour

Regulation 20 HSCA RA Regulations 2014 Duty of candour
How the regulation was not met:
The registered person had failed to record and keep a copy of actions taken, as required of this regulation, when a notifiable safety incident

occurred.
Regulation 20 (3) (e) (6)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not met: The registered person did not ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to ensure they can meet people's care and treatment needs. The registered person had not ensured staff supporting people were appropriately trained and supervised in order to perform their work and were not enabled to obtain further qualifications appropriate to the work they performed. Regulation 18 (1) (2) (a) (b)