Lancewood Limited

Queens Oak Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 3 September 2018 and was unannounced.

Queens Oak Care Centre is an 89 bed purpose built care home set out over four floors. The service is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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. 82 people were residing at the home when we visited.

At our last inspection in August 2017, we made a recommendation in relation to the storage of confidential records. We rated the service 'good' overall.

On 17 August 2018, Lambeth Council informed us of their decision to formally suspend all new long and short-term placements at the home with immediate effect. This decision was made in response to concerns raised about the quality and safety of care being provided.

This inspection was brought forward due to concerns about the safety and stability of the service.

The service did not have a registered manager in post. A home manager had recently been appointed and told us she would be registering with the CQC to become the registered manager in due course. 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.

CQC was not able to monitor the operation of the service effectively because the provider was not always notifying us of safeguarding concerns, incidents, accidents and events that prevent the service from running normally.

Staff were not always effectively deployed. People told us that staff did not always respond quickly to their requests for assistance. This meant people were left unsupervised for long periods and their care, treatment and support delayed unnecessarily. As a consequence, staff were not always supporting people to maintain their dignity.

Care plans contained some information about what was important to people and about how their needs should be met. However, this often lacked sufficient detail to implement responsive person-centred care.

Risk assessments did not always provide clear guidance to staff as to how to manage identified risks associated with people's care and support.

Staff were not always following safe practice in regards to the administration and recording of people's

prescribed medicines. People were not always having their medicines reviewed in a timely manner.

Staff training was not well managed and systems were not in place to ensure all staff practiced in a safe and caring way.

Staff understood how to recognise and respond to safeguarding concerns to keep people safe. However not all staff were aware of how to raise a concern outside the organisation.

Staff were responsible for ensuring people had enough to eat and drink. However, we observed drinks being left out of reach and people being left with drinks in their hands with nowhere to place them. Snacks such as biscuits, cakes and fruit were available throughout the day for people to help themselves to. However, this may have meant staff were unable to monitor those with specific nutritional needs.

People told us there were not enough activities. Despite there being an activities coordinator in post, adequate steps had not been taken to ensure regular and meaningful activities were appropriately planned, organised and accessible.

People did not always experience meaningful and caring interactions with staff. This was needed to reduce the risks of social isolation and to enable people to feel involved in their care.

Complete and contemporaneous records were not always in place. Accident and incident records were incomplete and did not always evidence the action taken to prevent similar events happening again.

People's sensitive information was not always being treated confidentially, carefully and in line with the Data Protection Act.

Staff were not always following good infection prevention and control procedures. We saw evidence of mice droppings despite the ongoing intervention of pest control services.

It was unclear whether complaints were being managed effectively as records were incomplete and outcomes of investigations were not clearly explained.

Managers completed a range of audits. However, these had not identified or addressed all of the shortfalls we found during our inspection.

The Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions, and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection, appropriate applications had been made to the local authority in relation to people who lived at the service.

Staff worked closely with healthcare professionals and made appropriate referrals when needed.

There were examples of good care, with staff showing affection and compassion towards people.

Staff gave positive feedback about the support, advice and guidance available to them.

We found breaches of the regulations relating to person centred care, dignity and respect, premises, complaints, staffing, and service governance. We issued a warning notice in relation to breaches of

regulation 12 safe care and treatment. You can see the action we have told the registered provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were poorly managed.

Staffing levels were insufficient and impacted on people's safety and well-being.

Risk assessments were not routinely updated after a change in people's care needs.

People's health was at risk due to poor infection control practices.

Safe recruitment processes were being followed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not always being appropriately supported through a process of training and supervision because some supervision sessions were behind schedule and some training was overdue.

Systems in place to monitor people's food and drink intake were not effective.

People were supported to attend medical appointments when this was needed.

Is the service caring?

Requires Improvement

Aspects of the service were not caring.

Practices that undermined people's dignity and privacy had not been addressed.

More attention to people's cultural and religious needs was required and the recording of people's life histories required further development.

People were able to personalise their living spaces as they wished.

Relatives told us they felt welcome when they visited their family members.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care was often task focused and care plans were not being routinely reviewed, updated or audited.

Records of complaints, accidents and incidents were not well managed.

People who stayed in their rooms did not always benefit from activities that met their individual interests.

Staff sought advice and guidance from health and social care professionals when needed.

Is the service well-led?

Requires Improvement

Aspects of the service were not well-led.

Statutory notifications, required by law, were not always sent to the CQC. This meant CQC was not able to effectively monitor the operation of the service.

Quality monitoring systems were failing to identify and rectify shortfalls in service delivery in an effective and expedient manner.

People's health and well-being were at risk because the provider had not maintained standards of care.

Staff reported that the management team were approachable and supportive.

Queens Oak 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 3 September 2018 and was carried out by three adult social care inspectors, two specialist advisors with nursing experience, a medicines specialist and two experts-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.

Before the inspection took place, we reviewed information we held about the service. This included notifications which providers send us about certain changes, events or incidents that occur and which affect their service or the people who use it. We contacted the local authority's adult safeguarding and quality monitoring teams to ask if they had any information to share. We used this information to plan our inspection.

We did not ask the provider to complete the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we spoke with 16 people using the service and 11 relatives. Some people could not let us know what they thought about the home because they could not always communicate with us verbally. Therefore, we spent time observing interaction between people and the staff who were supporting them.

We spoke with 14 staff members including nurses, senior care workers and care workers and domestic staff. We also spoke with a receptionist, a maintenance person, an activities co-ordinator, the home manager and three members of the quality management team. We spoke briefly with a visiting GP and dentist.

We had a tour of the service and visited communal areas and the home's garden. With people's permission, we looked in their bedrooms and bathrooms. We reviewed 18 people's care plans and risk assessments and

quality checked 16 sets of medicines administration records (MAR). We looked at seven staff recruitment files, induction and training information. We also looked at policies and procedures, meeting minutes, maintenance records, audits and a selection of other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

On 17 August 2018 Lambeth Council notified us of their decision to formally suspend all new long and short-term placements at Queens Oak Care Centre with immediate effect. This decision was made in response to concerns raised about the quality and safety of care being provided to people using the service. We have been informed that Lambeth Council commissioning and care management teams are working closely with the provider and management team to implement and monitor a detailed improvement plan. At the time of writing, the suspension of all new placements was still in place.

Medicines management was unsafe. Staff were not always following the provider's medicines policies and procedures nor adhering to national guidance in relation to the safe management of medicines. We found evidence of unsafe and ineffective administration of people's medicines, examples of poor medicines practice and a number of recording errors including gaps, omissions, misinformation, and corrections made without explanation.

Medicine administration records (MAR) indicated that people received their medicines in the morning, at midday, tea time and night time. On the day of our visit, the lift was out of order which meant that the medicines trolley could not be transported to all units and staff were required to transport medicines on a tray to different units. On one unit, this meant that staff began administering morning medicines at 10.15 am. On another unit, staff absence meant that people were unable to receive their morning medicines until an agency staff member had been sourced and allocated to provide the required support. As a result, people were receiving their morning medicines well after 11.00 am. Action was taken to ensure one lift was back in working order on the morning of our inspection. However, a second lift is currently waiting repair and it is likely to be several weeks before it can be utilised.

We noted that one person was being prescribed time specific medicines. No specified times other than morning, midday, teat time and night time were noted on this person's MARs. The provider's own medicines policy states…..'There is evidence to suggest that Parkinson's medicines should be given within 30 minutes of the prescribed time. Staff told us that midday medicines were administered after lunch at around 2.00 pm. Therefore, we could not be assured that people were receiving their medicines safely and in line with prescriber or manufacturer recommendations.

A further concern was noted when we observed a member of staff signing a person's MAR for three consecutive doses of medicines. This member of staff explained that the person in question had declined to take their medicines and so medicines had been put into medicine cups and left to one side of the medicines trolley. The provider's medicines policy states….'Take the medication to the person, when the medication has been taken the MAR must be signed using indelible ink. If the person refuses, the appropriate code must be used on the MAR.'

For another person, we noted instructions relating to the administration of medicines that required crushing. When we queried this, a member of staff told us this was an error and medicines did not in fact require crushing. However, a bank staff member on duty had followed the incorrect instructions, crushed the

medicines and added them to a person's food thereby administering medicines covertly. Another care plan stated, '[Person's name] likes to take [their] medication in [their] own time.' There was no clear explanation as to what this meant or how staff managed the risks associated with self-administering or whether they observed medicines being taken.

Where medicines errors had occurred, relevant incident/accident reports were not routinely completed. For example; One person had been prescribed a pain relieving topical gel to be applied three times daily. However, this person's MAR showed that the gel had been applied four times daily between 24 and 29 August 2018. The error had been noted and a new MAR obtained however a member of staff told us that an incident/error form had not been completed. It was therefore not always possible for the provider to demonstrate what learning was taking place to prevent further incidents when errors had occurred.

Infection control practices were not always being followed. We observed a member of staff directly handling an effervescent medicine for one person without using disposable gloves. The Royal Marsden Manual of Clinical Nursing Procedures states when administering oral medication……'Empty the required dose into medicine container and avoid touching the medicine.'

The shortfalls outlined in the above seven paragraphs relate to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored in two separate treatment rooms. Fridge and room temperatures were recorded appropriately and demonstrated acceptable temperature levels were maintained. Medicines we looked at were found to be in date and labelled correctly. However, we found that medicines boxes and packages labelled with people's personal information were being disposed of without due consideration to confidentiality and data protection regulations. On one unit we also noted that an open GP communication book along with other paperwork containing confidential and personal information was left on a desk in the middle of a unit. This meant people using the service could not be assured that their sensitive information was treated confidentially, carefully and in line with the Data Protection Act.

Staffing arrangements were not always organised in a way that provided a good level of attentive and consistent care. People told us, "There are no staff here", "They could do with more staff" and "The staffing is sparse at the weekends." Staff told us, "We try our best here, but sometimes we are short of staff, we have to use agency" and "Sometimes we do not have enough staff." Relatives told us, "They don't have enough staff", "They're overstretched" and "Staff don't have enough time." During our inspection, we noted that people's call bells were not ringing in the home. We asked people if they had a call bell and if they knew how to use it. Responses included, "Nope, I don't have a call bell", "I do, but it's not working", "[Staff] quite often take it away, I just have to call, call, call", "[My family member] has a call bell but won't use it" and "I don't think so, I don't remember seeing one." The manager told us that people rarely used call bells as they were unable to do so and that staff monitored people closely if they were in their rooms. We were told that staff conducted night time welfare checks but did not see and were not provided with any records to evidence that welfare checks also took place during the day.

It was unclear how staffing numbers were determined to ensure that staffing levels were based on people's individual needs to ensure these were met. There were staff vacancies at the time of the inspection and the manager told us that they were in the process of recruiting. We were told that most absences were covered by bank or permanent staff, with some use of agency staff particularly when shifts needed to be covered at short notice. A high proportion of people living in the home were living with complex physical and mental health conditions. Staff were often required to support people in pairs, particularly when using hoists and lifting equipment. This meant staff were not always in communal areas of the home as they were providing

care in people's bedrooms or elsewhere. We saw that people assessed as high risks of falls were either walking about or standing and changing position unaided. Where people were seated they were often blocked in by walking aids placed directly in front of them. Staff were unaware that this may be viewed as restrictive practice. Insufficient staffing levels were impacting negatively on the health, safety and wellbeing of people using the service.

These above two paragraphs relate to a breach of Regulation 18 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

Risk assessments were completed for each individual person in relation to mobility, moving and positioning, falls, nutrition, skin integrity and continence. However, these did not always provide clear guidance to staff as to how to manage identified risks associated with people's care and support. For example, one person's care plan detailed risks in relation to skin care and the person's refusal to receive personal care on a regular basis. We could find no risk assessment in place to ensure that this was managed effectively to minimise any risk of harm. Repositioning charts were in place for people at risk of developing pressure ulcers. Records were not always completed in full and we noted data omissions without relevant explanations. For example; one person's four hourly turning charts stated they had been turned twice on 24 and 30 August 2018 and only once on 25 and 26 August 2018.

Where people had been identified as at risk of choking or becoming hypoglycaemic there was no accompanying information explaining what to do if the event occurred. Other risk assessments were not always easy to follow. For example, one person had a risk assessment for smoking, this was high risk as the person smoked in their room against the home's policy, refused to wear a smoking apron and also used other substances such as paper and tobacco to make cigarettes. However, at the bottom of the risk assessment there was a statement declaring that this person wasn't smoking at the moment. This person's risk assessment had not been updated making it difficult to assess what the current level of risk was at the time of our visit.

A further risk assessment sated, 'Catheter in place which [person] empties [themselves]....Staff to help monitor that [they] do this correctly, at risk of infection, observe for infection.' We could find no specific risk assessment in place stating what the signs and symptoms of infection might be or what action to take if an infection was suspected. Another person's falls risk assessment stated that they needed support with transfers but there was no further guidance for staff about what support the person required to transfer safely. One member of staff told us, "We follow people around if they have poor mobility and check their footwear fits properly." This approach would have been unfeasible and untenable considering the number of residents at risk of falls and low staffing levels.

The shortfalls outlined in the above three paragraphs relate to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff confirmed they had been shown how to use hoists correctly and were confident using them to ensure people were supported safely. Hoists were seen to be in good working order. A member of staff told us, "I always transfer with two people and I have been trained.'' However, training data showed that a very high proportion of staff had not completed refresher training in this area. We have since been provided with further evidence to demonstrate that 21 members of staff completed moving and re-positioning refresher training on 4 and 5 September 2018.

The provider had appropriate safeguarding policies, procedures and systems in place. Staff confirmed they had completed safeguarding training. Staff were clear about the need to report any concerns they may have

about people's welfare and understood the term whistleblowing. Whistleblowing is when a worker reports suspected wrongdoing at work. A worker can report things that are not right, are illegal or if anyone at work is neglecting their duties, including if someone's health and safety is in danger. Not all staff were aware that concerns could also be reported to local authority safeguarding teams, social workers, CQC and the police if they suspected a crime had taken place. Despite this, staff told us they felt confident the manager would respond and take appropriate action if they raised concerns.

Correspondence from the Lambeth local authority raised concerns around staff understanding of safe evacuation procedures and lack of training in this area. We did not see refresher fire training included in the list of upcoming training for 2018. A colour coded system for fire evacuation was recorded on the doors of people's rooms and a record of this kept on all floors. We asked a member of staff responsible for fire marshal duties on one unit how many people were present on the morning of our visit. We were given conflicting information and staff appeared to have difficulty computing numbers and accounting for absences. Delays in the provision of correct information meant that we can not be assured people would be safely evacuated from the premises in the event of an emergency.

We were aware that there were people living at the home who presented with behaviours that challenged the staff and people using the service. An incidents log dated August 2018 recorded 15 episode of behaviours that challenged the staff and service. These were referred to as 'episodes of aggressive and agitated behaviour'. Recommendations for managing and minimising these incidents included, 'review of anti-psychotic usage', 'focus on activity and engagement required', 'GP review', 'staff training in responding to and managing behaviour that is challenging'. There was no information to state who was responsible for following up the recommendations or how the recommendations were going to be implemented. There was no record of managing behaviour training in the training matrix provided by the manager and nothing stated on the forthcoming training plan for 2018 to indicate that this training had been planned. We have since been provided with information to demonstrate that 28 members of staff have completed training in areas such as managing agitation and behaviours that challenge, the use of psychiatric medicines, de-escalation techniques, managing complex needs and common mental health conditions. We will check staff understanding and awareness of behaviours that challenge during our next inspection of this service.

On 24 September we received a notification relating to an incident involving an admission to hospital as a result of one person striking another with their walking frame. We have written to the manager to request further information in relation to this matter. We have also requested information relating to any other similar incidents that have taken place which we are not aware of to ensure that appropriate safeguards are in place and the necessary action is being taken to keep people, staff and visitors safe.

The home was not always clean and tidy throughout. A relative told us, "I'm hoping things will improve with the mice. I've seen them running round this room." Rodent droppings were seen in a person's footwear and a number of relatives reported that mice were an ongoing issue of concern despite the intervention of pest control. We detected unpleasant odours in individual rooms and saw used tissues on communal floor areas, a blocked toilet and linen stored on open shelving in shared bathrooms. We observed a member of domestic staff placing cloths and sponges used for floors, toilets and sinks in one single container. These issues potentially put people's health at risk.

The above issues are a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff records included evidence that pre-employment checks were carried out before new staff were appointed and commenced employment. This included requests for written references, Disclosure and

Barring Service (DBS) checks and confirmation of identity. DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands helping employers reduce the risk of employing a person who may be unsuitable to work in care.

Requires Improvement

Is the service effective?

Our findings

People's views about whether or not staff had the skills and knowledge to meet their needs was mostly positive. Staff told us they completed an induction and were provided with opportunities to shadow more experienced staff until they felt confident in their skills and abilities. There is an expectation that CQC regulated providers ensure induction programmes for new staff meet the requirements of the national standard of good practice. For example; the Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It provides reassurance to everyone that staff have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support. The provider's current induction programme did not incorporate the Care Certificate.

Staff confirmed they completed mandatory training such as safeguarding, infection control, equality and diversity, basic emergency first aid, moving and positioning and dementia awareness. However, key training had not been organised in a timely manner and records showed that much of this essential training was out of date. We noted that over 50% of staff members required updates in most of the above areas and almost 90% of staff required refresher training in moving and positioning. The manager confirmed that this information was accurate and stated that plans were in place to update staff training. We were told that moving and positioning training had been arranged for 4 September 2018, safeguarding training for the 6 September 2018 and mental health legislation training for the 7 September 2018. We will check this training has been completed at our next inspection. We will also check that supervision and appraisals are taking place in line with the provider's policies and procedures as at the time of our inspection, not all staff were up to date with their supervision sessions.

People's views about the meals they were served elicited mixed responses. Comments included, "Sometimes [the food's] not up to scratch", The evening meal is dreadful" and "The food's quite good and you get a reasonable choice" and "I've got no complaints." Relatives told us, "The food has improved. There's more English food; it used to be Jamaican food everyday but [my family member] can have cheese and biscuits now", "There are no menus just something written on the board. [My family member] can't have dairy so [they] have porridge with water…the food's OK", "[My family member] likes the food here; [they've] put on weight."

Menu boards were available in order to display what meals were on offer each day. However, these were not being used effectively and were not always showing the correct meals available on the day. There was a choice of main meals, including vegetarian and halal options. People who required pureed or fork mashable food were provided with meals in line with the guidance and recommendations recorded in their care records. People who required support to eat and drink were assisted by staff who were seated, and who undertook this task with patience and at an appropriate pace.

People were offered fruit juice and water during their meal and snacks of fresh fruit, cakes, biscuits and crisps were available throughout the day. Although it was positive that people could help themselves to snacks, this may have meant staff were unable to monitor those with specific nutritional needs. More consideration was required in relation to healthy eating requirements, meal schedules and the needs of

people living with diabetes and/or specific dietary requirements.

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. There was a mental capacity section in people's care records. However, these lacked specific detail about how decisions had been made. Details regarding Lasting Power of Attorney (to manage people's finances) were also incomplete meaning it was not always possible to ascertain whether relatives managing people's finances had the legal authority to do so.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. Some people had been assessed for risks in relation to leaving the building without support and the use of bed rails. Records confirmed that appropriate DoLS applications had been submitted for some of the people living at the home.

Requires Improvement

Is the service caring?

Our findings

We asked people whether staff treated them kindly. Comments included, "I can't criticise them. They're all beautiful, kind and caring", "The staff are kind and caring", "Yes they're very caring" and "On the whole, they're friendly, kind and helpful."

However, we heard from relatives that people's privacy and dignity wasn't always respected and promoted. A relative told us, "There are times [staff] leave [my family member] soaking wet. They seem to change the pad and then leave the wet sheet on or change the sheet but not the pad." Further comments from relatives were as follows; "I notice that sometimes pads leak and it shows on [their] trousers because they are not put on properly. I would like [staff] to pay more attention to that" and "I can see that [my family member's] hair hasn't been washed and it needs it. There's plenty of shampoo in the bathroom. They just sit [them] in a chair and run the shower over [them]." We found one person in a state of disorder, their hands covered in faeces and bed linen soiled. Their room door was open and they were partly exposed to people walking past. We alerted staff to this situation.

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

Care plans included some information about people's life history. However, details were brief and did not always provide a picture of the person and the life they had led prior to living in the home. Some information was available about people's individual preferences and interests. For example, people had specified their food preferences and activities they liked to partake in such as reading a newspaper, letter writing and favourite type of TV programmes. One person told us, "I like to watch the football and I watch that on Saturday night and some other games." Another person explained, "I like doing puzzles and reading; there's a library in the TV room. I've got my own TV so I can watch what I want." We noted that this person had access to puzzle books and pages from newspapers and magazines.

People's cultural and religious needs were considered when support plans were being developed. Care records stated whether people held a particular faith. We were told that a Sunday service took place within the home.

Staff were able to describe how they communicated with individuals who were unable to communicate verbally. This included writing things down and reading body language and facial expressions. One person told us, "We all talk and laugh and joke. All say good morning." From our observations, staff spoke kindly to people when they had the time. A relative told us, "[My family member] talks to people here where [they] didn't used to before. Since being here [they're] much more engaged in the conversations."

The premises were well-appointed and close to local amenities. Rooms were basic but spacious and most had en-suite shower facilities. People were able to personalise their rooms as they wished with photographs, pictures and soft furnishings. Bedroom doors displayed people's names and/or the name they preferred to be known as.

People and their relatives were able to access a landscaped garden area which provided separate seating areas and a range of plants, shrubs and flowers. A relative told us, "The garden is nice but they could do with more parasols." People told us they felt welcome when they visited their family members.

Requires Improvement

Is the service responsive?

Our findings

People's views about the range of activities on offer varied. Comments included, "The party (BBQ) was good", "I like all of the activities", "[Staff] do my nails" and "There's not always a lot on" and "There are no activities. I never go anywhere." A relative told us, "There are not enough activities and I'd like to see more music-based activities. The CD player in the café doesn't work." Another relative asked, "Why don't they seek volunteers to come in and play games with the residents?" Where it was stated that people should be encouraged to partake in activities there was little or no information as to how this could be achieved. For example; one care plan stated, '[Name of person] would like staff to engage [them] in activities in the home so as not to feel isolated.' There was no further explanation of how this would be achieved and an evaluation report simply stated that this person had 'no interest in activities' and 'take [them] down for activities.' This lack of detail made it difficult to ascertain what if any activities this person had been encouraged to participate in and what outcomes had been achieved.

Activity schedules were out of date on the day we inspected. The bread making activity that did take place was not accessible to large numbers of people and we did not observe anyone watering plants, arranging flowers, playing dominoes or cards as advertised. We found little evidence of person-centred activity planning and observed no one to one activities taking place on the day we visited. We did however observe people sleeping in communal lounges with the television switched on. We heard a self-playing electronic piano switched on and playing the same music all day and we observed people calling out and isolated in their rooms. Lack of any meaningful, purposeful, stimulating and appropriate activities was likely to be having a significant impact on people's health and well-being.

The issues in the above two paragraphs relate to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was some evidence that people and their relatives (where appropriate) were involved in the development of their care and support plans. Care documentation was available in paper and electronic form and included information about people's medical history, mental and physical healthcare needs, emotional, social and cultural needs. We looked at how the provider complied with the Accessible Information Standard (AIS). This is a framework put in place from August 2016 which made it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Care records contained information explaining how each person communicated and ensured staff knew whether people required dentures, hearing aids and/or glasses.

We were told that care plans were reviewed on a monthly basis. However, we found evidence to suggest care plans were not being routinely reviewed, updated or audited. For example; one persons' care records stated that they had cellulitis of both legs. We could find no evidence of an accompanying care plan to advise staff how to manage this condition. For another person living with diabetes, assessment scores had not been completed for the month of August 2018. A further care plan noted that a person had a grade one pressure wound but this was not mentioned in the personal care section of this person's support plan. Some entries in the care documentation used inappropriate terms, lacked specific detail and/or were

incomprehensible. For example; one daily entry read, '[Person's name] has been well behaved today.' Another entry read, '[Person's name] was a bit calm today but occasionally [they] always agitated.' Further entries referred to this person by the incorrect name, the incorrect gender and stated two different ages.

The provider worked in collaboration with health and social care professionals and sought advice and guidance when needed. We saw evidence in people's care records that referrals were made to specialist nursing teams, dietitians, speech and language therapists, occupational therapists and podiatrists. A mobile dental unit and a GP were in attendance on the day of our inspection. However, fluid input/output monitoring charts requested by the GP could not be located at the time of their visit. Staff on duty stated that they had not been informed of this request. This information was important in determining correct medicines dosage for a particular person who was unwell. People were referred appropriately to hospital services and the service used a red bag system to ensure that people had everything they needed when they went to hospital and to ensure that hospital staff had all the information that they needed to meet people's needs.

Staff members from various different departments attended a morning handover meeting where any concerns, issues and/or updates were discussed. We were told that information from these meetings was then disseminated to staff on different units. We were unable to confirm how, when and whether or not this exchange of information took place on the day of our inspection. Daily records were maintained but information was not always sufficiently detailed to provide an accurate picture of people's health and wellbeing and not all staff were informed about people's care and support needs.

The manager told us the service implemented the Gold Standards Framework (GSF). GSF is a model of care that enables good practice to be available to all people nearing the end of their lives, irrespective of diagnosis. Staff attended a multi-disciplinary team GSF meeting every three months to discuss people's end of life care and implement recommendations. Although we noted some information in people's care records in regards to end of life preferences, details about the care people wished to receive was in the main generic. For example; '[Person] wants to remain at the home, should be given pain relief and family updated' and '[Person] wants to have a peaceful death at care home.' This information lacked specific details as to who if anybody people would like present and what, if any, spiritual support was preferred.

'Do not attempt cardiopulmonary resuscitation' (DNACPR) forms had been completed (where appropriate) and these were currently being reviewed by a GP. The purpose of a DNACPR decision is to provide immediate guidance to those present on the best action to take (or not take) should the person suffer cardiac arrest or die suddenly.

We asked people whether they had any complaints and if so, did they know who to make a complaint to. Comments included, "I probably wouldn't complain; it's easier to keep myself to myself", "Yes, I can complain if I have to" and "I haven't complained. The provider had a complaints policy and procedure in place and information on how to make a complaint was on display in the home. The provider had recorded five formal complaints received since January 2018. These related to the delivery of personal care, sightings of mice, the environment, staff attitude and staffing levels. According to the provider's complaints log, only two of these complaints had been investigated and only one complaint was closed and completed. Outcomes of investigations were not explained and therefore, we were unable to ascertain whether complaints were being managed effectively.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

Providers must notify the CQC without delay of all incidents that effect the health, safety and welfare of people who use services. We were not always receiving notifications of safeguarding concerns and/or other incidents or events. For example, we saw a recorded incident where staff had used inappropriate moving and re-positioning techniques when transferring a person. We noted a further incident where a relative had raised concerns about neglect. These incidents have not been reported to us as required by law.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We have requested that in future all notifications are sent us in a timely fashion so that where needed, action can be taken.

The previous registered manager left the service at the end of March 2018. The current manager had been in post since 27 April 2018 and was therefore relatively new to the service. She was keen to develop and improve the service and was working closely with quality managers and local authority representatives to ensure the home provided a safe, effective, caring and responsive service. A service improvement plan was in place although this did not address all of the shortfalls we identified during our inspection.

People and their relatives told us, "The new manager seems to have expedited changes, there's new furniture and new menus but the staff have no badges", We've been pleasantly surprised with the home and how the staff and the rooms are" and "I'm very happy here, they are lovely people." Not everyone we spoke with knew who the manager was. Staff were positive about the service and said that there was a supportive working environment with good communication between senior staff and staff on individual units. Staff told us the management team were visible and approachable.

The management team completed weekly and monthly quality audits. We looked at a summary of falls for August 2018. This showed how many falls had taken place and who had fallen. However, there was little evidence to demonstrate that falls were fully explored and action had been taken to identify and address any patterns or reduce the likelihood of people falling again. The manager told us they completed a call bell audit and told us it was easy to monitor how long staff were taking to respond to call bells as bells could be heard within the units. In light of people's comment regarding their calls bells as outlined in the safe section of this report, we have concluded that call bell audits are neither accurate nor effective.

An infection control audit had been completed for June 2018. This highlighted unmet criteria such as; unlocked clinical waste bins, unlabelled clinical waste bags, undated sharps bins, unwashed hoist slings, unwashed mattresses and the use of appropriate hand washing techniques. Sections headed 'issues to be addressed' had not been completed and evidence of location and observations made had not been completed. Staff explained that some of these issues had been addressed but we were not provided with concrete evidence to demonstrate that action had been taken and/or issues resolved.

Medicines audits for July 2018 identified some but not all of the issues we outlined in the safe section of this report. Where criteria were unmet, no plan of action was recorded. The provider was not currently using a

pharmacy service to audit medicines and therefore a robust and independent overview of the administration of people's medicines and any errors was not available. This meant opportunities for learning from mistakes was not being routinely promoted.

Of particular concern, considering the ongoing pest issue, were the results of the last catering audit carried out by the provider. This showed that of 130 specific criteria ranging from cleanliness in kitchen and dining areas, hygiene, safety of equipment, food storage and menu quality, only 29 of the criteria had been met. This and the above three paragraphs demonstrate that quality monitoring processes were failing to identify shortfalls or where these had been identified, was failing to address, rectify and remedy concerns.

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

Relatives were invited to attend monthly meetings at the service and meeting dates were clearly posted in the main reception area. The provider sought feedback from people using the service, relatives and staff through the use of feedback forms and annual surveys. We asked for copies of the latest feedback about the service and were shown a survey results form dated August 2017. This consisted of three comments as follows: Staff team? - Mostly good however more information is needed; What we do well? - Information is good and the home keeps in touch and responds quickly; What could we do to improve? - More activities. This information lacked sufficient detail to provide a clear overview of what people and their relatives felt about the service, staffing and the management of the service. We have since been provided with the results of a survey dated February 2018 based on 16 returns. As above, the results of the survey do not provide sufficient information to gauge people's satisfaction of the service provided.

A copy of the most recent report from CQC was on display at the service and accessible through the provider's website. This meant any current, or prospective users of the service, their family members, other professionals and the public could easily access the most current assessments of the provider's performance. Further useful information was available in the main reception area in relation to agencies and services that provided support to elderly people. The provider's welcome brochure stated, 'The happiness and welfare of the people who live [the home] and their families are of paramount importance; we do all that we can to provide a relaxing and harmonious environment in which individuals can enjoy life to the maximum and families are reassured that their loved ones are in good hands. The management team were aware that significant improvements were required before they could ensure that everyone using the service was receiving safe, good quality and compassionate care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents People who use services and others were not protected against the risks associated with unsafe care because the provider was not always notifying CQC of incidents and or accidents which it is required to do so by law.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who use services were not receiving care and treatment that met their needs or reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People who use services and others were not protected against the risks associated with undignified and disrespectful care provision.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People were not always being protected against the risks of cross contamination and poor hygiene practices.

Regulated activity	Regulation

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Systems in place for managing complaints were ineffective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality monitoring was not sufficiently robust to identify shortfalls or where these had been identified, address, rectify and remedy concerns.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People who use services and others were not protected against the risks associated with unsafe and/or inappropriate care because staff had not received or updated training in a timely manner.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe care and treatment and the mis-management of medicines.

The enforcement action we took:

Warning Notice