Key Healthcare (St Helens) Limited

Elizabeth Court

Inspection report

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St Helens
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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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Elizabeth Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home offers purpose built accommodation for to 44 people. At the time of our inspection, there were 41 people living in the home.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection we identified multiple breaches of regulations 9, 10,11, 12, 13, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns with the delivery of person centred care, dignity and respect, safe and appropriate care, safeguarding people from abuse, the recruitment of staff, staffing levels, staff support and the governance arrangements at the home. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

During our visit, we found people's needs and risks were not properly identified or managed. The majority of information in relation to people's care was generic and meaningless and staff had little guidance on how to provide safe and appropriate person centred care. This meant people's support was not always provided in a safe or dignified way and records showed that people did not always received the support they needed to maintain their well-being. There was also little evidence that staff were keeping track of people's progress on a regular basis to ensure the support provided continued to meet their needs.

There was a lack of any meaningful and consistent activities to interest and occupy people and they sat for the majority of the day in the communal lounge with the television playing in the background. People told us there was not much to do at the home.

We found that some incidents of a safeguarding nature had not been appropriately identified, responded to, documented or reported in accordance with local safeguarding procedures and the legal requirements of CQC. This meant the provider did not have a robust system in place to protect people from the risk of abuse. Some people's care was not always provided in such a way as to protect them from neglectful or degrading treatment. Furthermore some of the language used by staff to describe people's needs was not always respectful or considerate.

People's ability to make decisions about their care was not assessed in accordance with the Mental Capacity Act 2005. For instance some people had bed rails on their beds and deprivation of liberty safeguards in place without any evidence that they had consented to this or evidence that their capacity to consent to this

had been explored. There was no evidence that any best interest decision making had been properly undertaken or that other least restrictive options had been explored. The capacity assessments that where in place in some people's care files were generic and contrary to the MCA legislation designed to protect people's human rights.

The provider had a formal method for determining the number of staff needed on duty to keep people safe and meet their needs. We found however that the provider had not applied this method correctly. This resulted in the number of staff on duty being incorrectly determined. And during our visit we observed that the number of staff on duty was insufficient to meet people's needs at all times. The opinions of people who lived at the home and their relatives about staffing levels was mixed.

New staff were recruited after satisfactory pre-employment checks were undertaken. This meant there were systems in place to check that staff were safe to work with vulnerable people prior to employment. We found however that the manager had not ensured suitable recruitment and selection processes were subsequently followed when a staff member's employment status within the home changed. For example, if they changed their job role or were given more responsibility. This meant that there was no evidence that the staff member's competency for their new role had been assessed to ensure they were suitable. This was not good practice.

We saw that care staff had received regular supervision and appraisal in their job role but nursing staff had not. This meant that the provider had not ensured that nursing staff were given appropriate support to do their job role effectively.

We checked a sample of people's medications. We found that the balance of medication that each person had in the medication trolley matched what had been administered. The way people were given their medication however did not always follow best practice guidelines and the time that medicines were administered was not recorded. This aspect of medication management required improvement.

The provider had audits in place to check the quality of the service but these were ineffective. For instance the inadequacy of people's care planning information had not been picked up; deficiencies in the way people's support was provided had not been identified and the lack of adherence to the MCA had not been addressed. There was little evidence that there were robust processes in place to gain people's views on the quality and safety of the service or that staff practice at the home was monitored to ensure that it was safe and appropriate. This meant there was little evidence that the provider had robustly governed the service to ensure it was safe, effective, caring, responsive and well-led.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

-□Ensure that providers found to be providing inadequate care significantly improve.
-□Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
-□Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their

registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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.

The management of people's needs and risks was poor and people's support was not always provided in a safe way.

Safeguarding incidents were not always properly identified and the service did not always protect people from neglectful or degrading treatment.

The recruitment and selection of staff was not always robust. Staffing levels were not always sufficient to meet people's needs.

Medication administration did not adhere to best practice guidelines and record keeping was not contemporaneous.

Is the service effective?

Inadequate

The service was not effective.

People's ability to make decisions was not always assessed in accordance with the Mental Capacity Act.

Staff had received sufficient training to do their job role but the clinical practice of nursing staff was not properly supervised or reviewed.

People said the food and drink provided was satisfactory and they had a choice.

People's meal time experience and the support they received to remain independence at mealtimes required improvement.

Is the service caring?

Requires Improvement

The service was not consistently caring

Some of the language used by staff to describe people's needs was inappropriate and disrespectful.

Staff did not always respect people's right to privacy and dignity.

When people needed support, staff were kind and patient but outside of these times, there was little meaningful interaction between staff and the people they cared for.

Is the service responsive?

Inadequate

The service was not responsive.

People's preferences were not always documented and those that where were not always used in the planning and delivery of people's care.

People did not always receive care and treatment that met their needs.

People did not have access to a consistent or regular programme of access to activities to occupy and interest them.

Complaints were responded to appropriately but the complaints procedure displayed in home was poorly detailed and required updating.

Is the service well-led?

Inadequate

The service was not well led.

The quality assurance systems in place were ineffective and failed to identify and mitigate risks to people's health, safety and welfare.

There was no evidence that people's satisfaction with the service was sought. This meant the provider could not be assured people were happy with the service provided.

There was little evidence of robust managerial and provider oversight of the service to ensure quality and safety of the service.

Elizabeth Court

Detailed findings

Background to this inspection

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

This inspection took place on 14, 18 and 19 December 2018. The inspection was unannounced. The inspection was carried out by an adult social care inspector, an assistant inspector and an expert by experience. An expert by experience is person who has personal experience of using or caring for someone who uses this type of service.

Prior to our visit we looked at any information we had received about the service and any information sent to us by the provider since the home's last inspection. We also contacted the local authority quality assurance and safeguarding teams, the NHS infection control team and Healthwatch for their feedback on the service.

During the inspection we spoke with six people who lived at the home and three relatives. We spoke with the manager, the head of care (nursing unit), a nurse, two care assistants, the activities co-ordinator, a domestic, the chef and the maintenance officer.

We examined a range of documentation including the care files belonging to five people who lived at the home, six staff files, staff training information, a sample of medication administration records and records relating to the management of the service. We also looked at the communal areas that people shared in the home and visited some of their bedrooms.

During the visit we observed people's day to day care and their interactions with staff.

Inadequate

Is the service safe?

Our findings

We found that people's needs and risks were not properly identified or managed. Risk management planning and guidance for staff to follow in the provision of care to prevent or mitigate the risk of harm was poor and we observed that people's care was not always provided in a safe way.

For example, we observed the serving of lunch to one person who required support to eat. This person was asleep at lunchtime. We observed a staff member support this person to eat whilst they were still in a sleep induced state. They had to keep waking the person up between mouthfuls of food and at one point the person fell asleep with a mouthful of food still in their mouth. This was not very dignified or a safe way to provide nutritional support as it placed the person at risk of choking and aspiration pneumonia. We spoke with the head of nursing care and the manager about this during our visit.

We observed three incidences where inappropriate moving and handling techniques were used to support people with mobility issues. These techniques placed people at significant risk of an accident or injury. We spoke with the manager and the head of care (nursing unit) about the moving and handling techniques we had observed. They acknowledged that these techniques were inappropriate and unsafe. Some of the people living at the home were at high risk of a fall. Despite this they were observed to mobilise around the home in normal socks on vinyl flooring. Slipper socks or slippers were not in use to provide them with extra support and grip to mitigate the risk of a fall occurring. This practice was unsafe.

Some people had health conditions that placed them at risk of ill-health or unwanted symptoms. We found that these health conditions were not properly described in people's care plans. There was little evidence that any adequate clinical monitoring of these conditions was undertaken to alert staff to potential changes in a person's condition. Some people had pressure wounds but wound care assessments and the management of these wounds was unclear. People's wounds and the care they required was not clearly identified. There was limited information in place to establish if the clinical care provided was adequate or if people's wounds were healing. This was not good practice. We also found that people did not always receive the required repositioning support they needed to prevent a pressure ulcer from developing or from further deterioration.

We observed the administration of some people's medication. The nurse was polite, kind and patient with people during the administration of medication but was observed to put people's medication into their mouths with their fingers. This is not good practice as it increases the risk of medication becoming contaminated and unsuitable for use. We spoke to the manager about this who acknowledged that this was not best practice.

The stock balance of people's medication matched what had been administered and there were plans in place to advise staff when and how to administer 'as and when' required medications such as painkillers. There was no robust system in place however to determine whether a person required medication for pain relieft when they were unable to communicate this need verbally. This aspect of medication management required improvement.

These incidences were a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the provider's safeguarding and accident and incident records. We found that some incidents of a safeguarding nature had not been reported appropriately to the Care Quality Commission in accordance with legal requirements. Accident and incident records showed that some people had experienced unexplained bruising that had not been properly investigated or reported. Unexplained bruising under safeguarding procedures can be considered a potential safeguarding event. It should be reported to or, advice sought from the local safeguarding authority and CQC.

Some people who lived at the home did not have an accessible call bell in place in their bedroom to enable them to call for help when they needed it. There were no risk management plans in place to advise staff how to manage people's individual safety in the absence of a call bell. No assessment of people's ability or capacity to use a call bell had been undertaken and during the evening staff only checked on people's welfare every two hours. These checks were inadequate. We discussed our concerns with the manager.

The support provided to some people did not protect them from neglectful or degrading treatment. For example, one person had lost their teeth and hearing aids but no action had been taken to ensure they were replaced in a timely manner. Another person was unable to communicate verbally. They were observed to be distressed during the inspection but no efforts were made to understand the reason for their distress in order to provide the person with the support they needed. There were also no alternative communication aids available to this person such as a picture board to enable them to communicate their needs or feelings to staff members. This meant that robust processes were not in place to prevent and protect people from the risk of abuse or improper treatment.

This evidence demonstrates a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We chatted to six people who lived at the home and asked three relatives about the care their loved one received. Everyone felt safe with the staff team who supported them. We asked people if they felt there were enough staff on duty to meet their needs. Some people were unable to answer this but those who could told us that they felt that there were enough staff. When we spoke with people's relatives however two out of the three relatives spoken with told us the number of staff on duty in the nursing unit was insufficient. Their comments included ""I don't know, sometimes he's still in bed at 11.00. He's an early bird, it's not like him to be in bed at 11.00" and "The staff are great, but I think they're understaffed".

During our visit we found staffing levels to be insufficient. People were sat for long periods of the time without any meaningful interaction from staff and a staff presence in communal areas was sporadic. For example, two people sat in the lounge area in the nursing unit on their own for 30 minutes. They had no access to a call bell to call for help and no staff members checked on either person's safety or well-being during the 30 minute period. This was not safe.

We saw that the provider has a system in place to determine safe staffing levels but we found that the system had been used incorrectly. This resulted in staffing being under-estimated in the nursing unit and over-estimated in the residential unit. This did not make sense, as it meant that the most vulnerable of service users on the nursing unit had less staff support hours than those in the residential unit to meet their needs.

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

2014.

New staff were recruited after satisfactory pre-employment checks were undertaken. For example, a criminal conviction check was undertaken and previous employer references obtained before staff were permitted to work at the home. This meant there were systems in place to check that staff were safe to work with vulnerable people prior to employment. We found however that the manager had not ensured suitable recruitment and selection processes were subsequently followed when a staff member's employment status within the home changed. For example, if they changed their job role or were given more responsibility.

We found that four out of the six staff members whose files we looked at had changed job role since they first started to work at the home. There was no evidence that the manager had followed the provider recruitment and selection procedure to assess and select these staff members for these new or additional roles. This meant that there was no evidence that the competency of these staff members had been assessed prior to them taking on these new roles or responsibilities to ensure they were suitable. This was not good practice.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home employed a maintenance officer who undertook routine maintenance and regular checks of the home's fire extinguishers, fire alarm, bed rails, water temperature and general environment. The home's gas, fire and moving and handling equipment had all been inspected and certified as safe. New flooring had recently been installed in some areas of the home and the home was clean and free from odours. Some of the home's furniture was in a poor state of repair. For example the cushion covers on some of the home's sofa cushions did not zip up which meant the foam innards of the cushion were exposed. Some cushions were also stained. We spoke with the manager and maintenance officer about this. They told us that the home's furniture was due to be replaced in January 2019.

Accident and incidents were recorded. Records showed that staff took appropriate action immediately after the accident or incident to ensure people received any medical support they needed.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

We viewed the care records of five people with dementia type conditions and/or complex needs. We saw that people's consent had not been obtained by following the correct legal procedures when specific decisions about their care and treatment had been made. For example, for 'do not resuscitate' decisions (DNAR); deprivation of liberty safeguards, the use of bed rails and using the call bell system. There was no evidence that any best interest discussions had taken place with regards to these decisions or that any consideration had been given to the opinion and views of people when these decisions were taken.

Where people did have capacity assessments in place, these assessments were a generic blanket assessments of the person's overall decision making capacity. This was contrary to the MCA legislation which clearly states that an assessment of a person's capacity must be decision and time specific. There were no suitable arrangements in place to seek and act in accordance with people's consent.

We spoke with the manager and head of care (nursing unit) about the lack of adherence to MCA legislation. From these discussions it was clear that neither the manager nor the head of care understood this legislation or their responsibility within it.

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

We looked at the provider's training records. We saw that the majority of staff training was up to date. Staff members received training in a range of health and social care subjects relevant to their job role. For example training included: safeguarding, moving and handling, infection control, mental capacity and dementia; falls management; food hygiene, fire safety and first aid. Staff administering medication also received medication administration training.

Staff received an annual appraisal of their skills and abilities. Records showed that care staff received regular supervision but there was no evidence that nursing staff received clinical or other supervision in their job role. We asked the manager about this and they confirmed that nursing staff did not receive one to one

supervision with their line manager or clinical supervision with regards to their clinical practice.

The clinical supervision of nursing staff is considered an essential part of professional practice. It enables the provider to retain clinical oversight of staff practice to ensure people receive high quality care at all times. We found that there was no clinical lead nurse or professional within the home to provide clinical supervision to the nursing team. There was also little evidence that clinical practices were monitored within the home to ensure they were safe and to an appropriate standard. During our visit we identified concerns with the clinical management of people's wound care; medication administration, the implementation of the mental capacity act and the monitoring of people's physical well-being.

Nursing staff had not received appropriate support and supervision. This meant that the provider could not be assured that nursing staff continued to meet the professional standards of the Nursing and Midwifery Council (NMC).

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us that the food and drink provided was good and that they had a choice. People's comments included "I enjoyed breakfast"; "The food's nice"; "There's different things, I enjoy the food"; "It's very good" and "Some of it's not for me, I prefer English food. If I don't like it, they'll give me something different". The relatives we spoke with said "He never stops eating" and "He's got a good appetite, he eats everything".

We saw that people's risk of malnutrition was assessed and their weight taken regularly to monitor for any change. We found however that staff had little guidance on how to promote people's nutritional intake or what action to take to prevent malnutrition. We saw that one person had been referred to the dietician but the dietician's advice had not been included in the person's care plan for staff to be aware of. This aspect of nutritional management required improvement.

We observed the serving of lunch in both the residential and nursing unit. The mealtime experience in both units was different. In the nursing unit, people had no access to menus to promote choice. There were no tablecloths, napkins or condiments on the tables for people to use and the atmosphere was muted. People's meals were served promptly but the bread and butter provided by catering staff to accompany people's meals was not offered to people or given to anyone at all during the main meal.

In the residential unit, there were also no menus for people to choose from. There was a menu stand on entry to the dining room but the stand was empty. Tablecloths were on the tables but the tables had not been set with cutlery or condiments. People's cutlery was handed out to them when their meal was served. There was salt available for people to use on the catering trolley but this salt has been put in a vinegar bottle. It had a large hole in the top for the salt to come out of which may have made it difficult for people to control the amount of salt they put on their meal. During the main meal the staff ran out of plates before everyone had been served their meal. They also ran out of dessert spoons. There was a significant gap between the serving of the main meal and dessert, so much so that some people forgot they had not had dessert and started to leave the dining room. Staff members had to remind them that their dessert had yet to be served.

Some people required support to eat their meal. One staff member stood up to do this. This was not good practice or dignified for the person being supported to eat. One person was assisted to eat their meal by another person who lived at the home instead of a staff member. The atmosphere in the dining room of the

residential unit was chaotic and disorganised. Observations showed that there were not enough staff on duty at lunchtime.

For people who live with dementia, being able to eat and drink independently can become harder and harder as the person's dementia progresses. Dementia can cause difficulties with co-ordination and remembering the processes or sequences involved with eating and drinking. We observed one person struggling to cut up their meal. When we checked this person's care file we saw that staff had instructions to ensure this person's meal was cut up prior to serving. This had not been done. One person was trying to eat a piece of fish by spearing it with a knife and another person was trying to eat peas with their fingers. Despite this there was little in the way of adaptive cutlery or tableware to encourage people to eat independently and in a dignified way. For example, by using different coloured utensils; plate guards to prevent food dropping off people's plates and adapted knives and forks that are lightweight and easy to grip. Autonomy, independence and dignity of the people who lived at the home was not always promoted.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was pleasantly decorated but improvements to the environment were needed to make it more homely. The furniture in communal areas was low to sit on and some of the zips on the seat covers were broken. This meant the foam innards on some cushions were exposed. Seats were arranged around the edges of the room as opposed to being clustered together to encourage conversation and positive interactions. Observations showed that people shared pressure relief cushions in the communal lounge which were not cleaned between use. This was not good practice.

In the residential unit there was a staff display board which contained a photograph of each staff member and their name for people who lived at the home to refer to. This board however was not replicated for people who lived upstairs in the nursing unit.

There was a 'reminiscence' shop that had been set up to look like a shop from a previous era where people could purchase day to day essentials. On the days we inspected however this shop was not staffed and was not in use. There was a relaxation therapy room in the nursing unit with sensory equipment in place but a loud buzzing sound constantly emitted in this room. This made it a far from relaxing place to sit in and on all days of the inspection this room was empty and not used by any of the people who lived in the home.

Requires Improvement

Is the service caring?

Our findings

During our visit, we found that some of the language used by staff in front of them and their peers was inappropriate. For example, service users were described as being able or unable to "Feed themselves" and one person's care plan referred to keeping the person "Locked up for their own safety". This language was not sensitive or considerate.

We head some staff members discussing people's needs in front of the person and their peers as if the person was 'not there'. For example, one staff member said "If I leave (name of service user) in here, will you do her a dinner so (name of person) doesn't forget and doesn't wander". A senior staff asked other staff in front of people "Who needs feeding" at lunchtime and two other staff members were heard making similar comments. This type of practice depersonalised people and suggested they were considered a 'task' as opposed to a 'person'.

During lunch two people were supported to eat half asleep. One staff member wrapped an apron around the person's neck whilst they were asleep. They then woke the person and tried to assist them to eat their meal immediately. Another person was woken up for their lunch and then sat up by two members of staff and a pillow shoved behind their back whilst they were still half asleep. This was not very dignified or respectful. Some people were also given personal and protective aprons (used mainly in the delivery of personal care) to use whilst eating their meal which did not look very nice and did not promote their dignity.

On day one of the inspection a nurse was observed trying to take a person's clinical observations in the communal corridor just outside the dining room. There were a number of people eating their meal in the dining room at the time and the person whose observations were being taken was clearly visible. This person was shouting in distress and were objecting to having these clinical observations taken. This did not show that this staff member was considerate of the person's right to consent or privacy for the taking of these clinical observations.

Three people were sat in the communal lounge with socks which had their names on clearly displayed on the front or side of the sock for everyone to see. This was not very dignified or respectful. Observations of practice showed that the care and treatment provided to people was not always respectful or considerate of their privacy and dignity needs.

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

People who lived in the residential unit told us that staff were kind to them and patient when supporting their needs. People's comments include "They look after me well"; "They're lovely, helpful and kind". "Fine, no trouble, very kind". A relative told us "They're all very helpful and keep me up to date, pretty good, patient". All of the people we spoke with on the residential unit said they were happy at the home.

People who lived in the nursing unit were unable to tell us if staff were kind or patient. We spoke with their relatives. One relative of a person living in the nursing unit told us "They're (the staff) are friendly and nice". Another relative said "Most of the staff are very good with Mum. There's only two who could be more pleasant, one is very abrupt. It's the resident's home".

During our inspection we observed that staff were kind and patient with people when people were in receipt of direct support. There was little interaction between staff and people who lived at the home however outside of these times.

We asked people if they received sufficient support with their personal hygiene, everyone told us they did. One person said "Yes, I'm very particular and another person told us "You can have two a day if you want". Only one of the relatives we spoke with voiced concerns about the support the person received with regards to personal care. They told us "I think (name of person) needs showering and their hair washing at the moment. A few times their teeth haven't been cleaned or hair brushed. They (the person) are very particular about their teeth.

We checked people's personal care charts. These showed that people had regular baths and showers to maintain their personal hygiene and comfort. The majority of people we observed during our visit were smartly dressed.

We saw that people's bedrooms were personalised to them. People had family photographs and the keepsakes that were important to them close at hand. One person told us ""The folk here are very friendly. I like the way the rooms are set out". We saw that some people's bedrooms contained household items such as a small dining room table and kettle to enable them to entertain their visitors in their own bedroom. One person said "I've got a kettle, tea bags and hot chocolate in my room".

Relatives were made welcome at all times of the day and visited without any restrictions. The relatives we spoke with confirmed this. One said,"It's a nice environment and the grandkids are always welcome".

Inadequate

Is the service responsive?

Our findings

Each person's care plan contained a 'support plan at a glance' and a care passport which provided some information about the person and their preferences. This information however was not always fully completed or included in people's care plans to ensure their individual needs and preferences were known to staff. The majority of guidance given to staff on how to provide safe and appropriate care was generic and meaningless. Terminology such as 'put interventions in place to minimise risk' and 'staff to be aware of hazards' was generic and failed to identify what specific person centred interventions and hazards needed to be taken into account.

Information in some people's care files about their needs did not make sense. For example, one person's care record stated that they were unable to sit in a 'normal' armchair safely. On all three days of the inspection we saw that this person spent most of their day in an armchair in the lounge contrary to this advice. We asked the manager about this. They were unaware the person's care record stated this. They were also unaware of any reasons as to why the person was unsafe to sit in an armchair.

Where people's care records contained some information about their preferences this information had not always been included in the person's care plan. For example, one person's 'at a glance' support plan stated they disliked certain food but this information had not been included in the person's eating and drinking care plan. This information was also not included in the diet notification sheet provided to catering staff in respect of the preparation of this person's meals. This meant that important information about the person had not been used to plan and design their care so that their preferences could be met.

One person's 'at a glance' support plan stated that the person liked sweet foods such as puddings; yoghurts and cake but the diet notification sheet provided to catering staff made no reference to these preferences. These preferences were also not included in their eating and drinking care plan.

All of the people whose care files we looked at lived with dementia or a dementia type condition. Despite this their care plans did not contain adequate information on the type of dementia they lived with and how this impacted on their day to day lives. There was little information about each person's day to day abilities nor any suitable guidance to support staff on how to promote these abilities. There was no person centred information to help staff support people to cope with changes to their level of cognition, orientation and memory. Where people experienced behaviours that challenged there were no strategies in place to help staff monitor the early warning signs of distress or guidance on how to support the person's emotional needs. This meant there was a risk that people's emotional needs would not be met in a responsive or person centred way in order to reduce their distress and any possible confusion.

People who were able to speak to us during the inspection felt staff knew them well. Their comments included "Yes, they're very good, I don't know how they put up with us"; "Yes, they're very helpful". The opinion of relatives was mixed. One relative told us that they were surprised to sometimes find their loved one still in bed at 11am as they had always been an early riser, another told us that they sometimes found the person was not dressed in the way they preferred. This did not indicate that staff always knew people's

preferences.

A review of people's needs and care was undertaken monthly but these reviews were not meaningful. The majority of these reviews simply stated 'no changes care plan to continue. There was little evidence that people were involved in planning and reviewing their own care or that the person's care had been adapted to meet the person's changing needs or views as a result of these reviews.

Observations, a review of records and feedback received showed a lack of consistent and regular activity planning was in place. There were two activity co-ordinators employed to work at the home. On all three days of the inspection, access to social and recreational activities that promoted people's well-being and met their preferences was poor. Minimal activities were offered to people in the residential unit. The activities that were provided did not correspond to the activities advertised as on offer that day. No activities were observed to take place on all three days of inspection in the nursing unit.

People who were able to talk to us about the provider's activity programme told us that there were limited activities for them to become involved in at the home. Comments included "I get bored, I like knitting, I make children toys"; "No (activities), sometimes I get bored. I spend my time sitting here missing nothing". "(No activities) not that I know of, I would like to play bingo"; "I might have a little walk out. At first I got bored, but I got used to it" and "There used to be (activities), they used to do themed things every month".

A relative of a person who lived in the nursing unit told us "There have been a couple of things, games. A woman comes around now and again throwing a ball and that's it". Another relative said "The last activity I saw was months ago. A lady got people to wrap foil round a sword. More seems to go on downstairs (in the residential unit)". The residential provider had not ensured people's care and treatment was appropriate, met their needs and reflected their preferences.

The above evidence indicates a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the how the provider handled and responded to complaints or concerns people had about the service. The provider's complaints procedure was displayed in the entrance area of the home which was inaccessible to people who lived at the home. The complaints procedure was poorly detailed and out of date. For example, the complaints procedure made reference to people directing complaints to a 'named team leader' or the manager but failed to provide the contact details for the team manager or manager or any information on how to make the complaint (letter, email, telephone or in person). It also referred people who wished to escalate their complaint to an objective body to the 'Complaints Ombudsman' instead of the Parliamentary Ombudsman.

We looked at the provider's complaints records. We saw that people's complaints had been responded to appropriately by the manager. The people we spoke with during our visit told us that the manager was approachable and friendly. People's comments included "She's a lovely person, I can talk to her if I've got a problem"; "OK, I can talk to her, you just put your hand up and she's there. She's always on the go" and "I don't have much dealings with her, but I could go to her if I had a problem".

The relatives we spoke with told us the same. Comments included "She's very approachable"; "She's nice" and "Yes, "yes, she's sorted out problems".

Inadequate

Is the service well-led?

Our findings

The provider did not have adequate or effective governance systems in place to ensure that the service was well-led. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

For example, we identified concerns with the accuracy and completeness of people's care records. There were audits in place to check people's care records but these audits only looked at whether the documentation was physically in the person's care file. They did not check if the information about the person and their needs was accurate, complete and up to date. This meant the concerns we had about people's care plans and risk management plans had not been identified by the manager or provider and addressed.

There were no adequate systems in place to ensure staffing levels were determined correctly or that staffing levels were sufficient. During our visit we observed staffing levels required improvement.

The system in place to track safeguarding incidents was ineffective. This was because it failed to recognise that people's unexplained injuries could be an indicator of potential abuse. In addition, not all of the safeguarding incidents identified by the provider's safeguarding system had been reported appropriately to CQC. This meant the system was not effective in mitigating the risk of abuse or for ensuring the provider complied with the health and social care regulations.

The provider's medication audits were ineffective. They failed to identify and resolve the issues we identified during our inspection with regards to the way in which medicines were administered to people at the home. The audits in place also failed to identify the lack of accurate contemporaneous record keeping with regards to medication administration or the time taken to complete a medication round.

There were no effective governance systems in place to monitor staff practices on a day to day basis to ensure people's care and treatment was safe and appropriate. During our visit we identified concerns with regards to moving and handling; wound management; clinical monitoring; nutritional support, person centred support and dignity and respect.

We found that the knowledge of the manager in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards was limited. The manager did not have a full understanding of this legislation and their responsibilities within it and by consequence its implementation at the home was poor.

We looked at the arrangements in place to seek the views of the people who lived at the home on the quality of the service provided. We found that the system in place were tokenistic. Some satisfaction questionnaires had been given out to people in 2017 and 2018 to seek their views about the service but the number sent out and completed was minimal. In 2018, only 10 questionnaires were sent out for completion to gain people's views of the service and only three were returned. In 2017 satisfaction questionnaires were only given to people who lived in the residential unit. There was no evidence that where people were unable

to, or found it difficult to communicate their views verbally that alternative means of gathering their views had been sought. This meant the manager and provider had not ensured that people's opinions about the service and the care they received was used to improve the service.

There was no evidence that the provider had sufficient oversight of the quality and safety of the service. The manager told us that the provider visited the service regularly. There was however no evidence of these visits or the checks that had been undertaken. This meant there was no evidence to show that the provider had ensured people who lived at the home were in receipt of a safe, effective, caring, responsive and well-led care.

At the end of our visit, we discussed our concerns with the manager and they acknowledged that improvements were required to the service overall. During our inspection the manager was helpful and receptive to our feedback. The staff we spoke with told us they felt supported by the manager in their day to day job role.