Pearlcare (Richmond) Limited

Beechy Knoll Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 8 and 9 August 2016. The inspection was unannounced which meant the provider did not know we would be inspecting.

Beechy Knoll Care Home is a residential care home based in Sheffield. The home provides care for older people and people living with dementia. The home is situated close to local amenities and transport links. The home is registered to provide accommodation and personal care for 40 people and on the day of our inspection there were 35 people using the service.

The home had a registered manager in place and they were present on the first day 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.

We spoke with a range of different team members; the deputy manager, care staff, kitchen staff domestics and maintenance staff who gave us mixed reviews about the registered manager.

From looking at people's care plans we saw they were written in plain English but not in a person centred way. The care plans did not all contain people's personal history and information on care needs was task orientated. These were not regularly reviewed by staff or updated by the registered manager.

Individual care plans contained risk assessments. Some were individualised but others were generic. The risk assessments identified risks but did not describe the measures and interventions to be taken to mitigate risks and ensure people were protected from harm. Some of the care plans we viewed showed us that people's health was monitored and referrals were made to other health care professionals where necessary but others indicated this was not always the case.

On the day of our inspection people who used the service were not supported by sufficient numbers of staff to meet their care needs. We could see in the staffing rotas that there had been recent staffing issues and people who used the service had not been supported by enough people on a regular basis.

When we looked at the staff training records they showed us that staff were not always supported to maintain and develop their skills through training and development opportunities. We found that some training had expired and staff needed to attend refresher training.

When we looked at supervision and appraisal records we saw that these had been carried out, however they were ineffective and did not address staff wellbeing or performance.

We also viewed staff recruitment records which showed us recruitment practice was not always robust.

We observed how the service stored and administered medicines. We looked at how records were kept and spoke with the management team about how staff were trained to administer medication. We found that medicines were not stored safely and numerous medication errors had taken place. Audits had not identified these issues and staff did not all have the knowledge and skills to appropriately administer medicines.

During the inspection we witnessed some positive interactions between staff and people who used the service. However staff did not always respect people's dignity when communicating and supporting people.

Activities were not always provided. We saw that some activities took place and also saw evidence that people were being supported to go out but this was not regular or consistent.

We saw people were encouraged to eat and drink sufficient amounts to meet their needs. We saw people enjoying their meals however the daily menu was not developed with the people who used the service to incorporate their likes and preferences.

We saw the service had a complaints and compliments procedure that was in place and this provided information on the action to take if someone wished to make a complaint and what they should expect to happen next. We saw evidence that this complaints procedure was not adhered to.

We found a quality assurance survey had taken place previously and we looked at the results. Relatives told us that they had been asked to take part in the surveys. There were no actions identified that were in place to make improvements to the service as result of peoples suggestions.

The program of audits carried out by the registered manager were ineffective and not carried out regularly.

We found that the service didn't provide an environment suitable for people living with dementia.

The service was unable to provide people with a choice of bathing or showering as there were no working showers on the premises.

During the inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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 recording of topical medicines was not carried out correctly and some medicines were not stored safely.

At times people were not given their prescribed medicines.

At times the service didn't provide sufficient staffing levels with the right skills mix and experience to keep people safe.

People did not have adequate risk assessment in place.

Is the service effective?

Inadequate

The service was not effective.

People's nutritional needs were met but choice was limited.

The service had not met the requirements and principles of the Mental Capacity Act 2005.

Staff training was out of date

The environment was not suitable for people living with dementia.

Staff appraisals and supervisions were not adequate.

Is the service caring?

Inadequate

The service was not caring.

People were not always treated with dignity.

People's personal care needs were not always met.

Advanced end of life care plans for people were not always in place.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were not person-centred to reflect people's preferences and interests.

Activities were not always planned and organised to ensure they took place regularly.

The service had a complaints and compliments procedure in place but failed to adhere to it.

Is the service well-led?

Inadequate

The service was not well led.

There were inadequate audits carried out by the registered manager to monitor the quality of the service.

Quality assurance surveys took place but no actions as a result of this.

Up to date and accurate records were not being kept.

Beechy Knoll Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 8, 9 August 2016 and was unannounced. This meant that the service was not expecting us. The inspection team consisted of two Adult Social Care inspectors. At the inspection we spoke with nine people who used the service, eight relatives, the registered manager, the deputy manager, two domestic staff, maintenance worker, the electrician, two kitchen staff and five care staff.

We looked at five people's care plans from the service, three staff records that included recruitment and supervisions and three staff training records.

Before we visited the home we checked the information we held about this location and the service provider, for example we looked at the inspection history, safeguarding notifications and complaints. We also contacted professionals involved in caring for people who used the service, including the local authority contracts team who were able to share their views with us.

Prior to the inspection we contacted the local Healthwatch. Healthwatch is the local consumer champion for health and social care services. They give consumers a voice by collecting their views, concerns and compliments through their engagement work.

During our inspection we observed how staff interacted with people who used the service and with each other. We spent time watching daily routines to see whether people had positive experiences. This included looking at the support that was given by the staff, by observing practices and interactions between staff and people who used the service.

We also reviewed records including medication administration records (MARs), safety certificates, care plans and records relating to the management of the service such as audits, rotas, complaints, action plans, surveys and policies.

Inadequate

Is the service safe?

Our findings

At our inspection we spoke with people who used the service and asked them about the staff at the service and if they felt there were enough to support them safely. One person told us; "Sometimes we can wait twenty minutes for the staff to come and other times they come straight away, it depends how many there is and how busy they are."

During our inspection to establish staffing levels we looked at staff rotas and we spoke with the register manager about the staffing levels. We observed three care workers and one senior care worker on duty during the day. They were supporting 34 people in a building over 2 floors with a very complex layout. When we asked the registered manager whether a dependency tool was used to calculate safe staffing levels we were told they did not use one. The registered manager stated that they "Just knew" that the service needed four staff at present and five staff when full.

Despite being told by the registered manager that there should be a minimum of four staff on shift during the day we saw evidence that there were regularly only three staff on duty. For example, on 30 July 2016 and 2 and 5 August between 4pm to 9pm there was only three staff on duty. Again on the 3, 5 and 7 August 2016 between 7am to 4pm there were only three staff on duty.

When we asked the registered manager about the staffing levels they told us that they had been short staffed and working in the kitchen and covering shifts themselves and they also told us; "We have never used agency staff to cover shifts".

We spoke with care staff and asked them how staffing levels affected their role. One member of staff told us; "Not everyone who needs a bath can have one when there is only three of us in," another told us; "I don't have time to talk with people and I worry when I go home that I have done everything and have to double check. The low [number of] staff puts a lot of pressure on us there's quite a few residents to look after." "If there is only three staff we do the odd bath but not as many as we should." Another told us; "I like my job but at times it is hard, I don't like that we are understaffed it's really hard, I get stressed."

When we looked at summary sheets of people's personal care we could see only three people had received a bath in the previous eight days. When we asked the care staff about this they told us that three people received a bath during the day and three on an evening. We were shown how baths were also recorded on the daily routine worksheets and on checking these found that during the 7:00am to 4:00pm shift nobody had been bathed on 3, 4, 6 or 7 August 2016. Between 4:00pm to 9:00pm nobody had received a bath on 30 July 2016, 2, 4, 5, 6, 7 or 8 August 2016. The deputy manager also told us that people did not receive baths if there were only three staff on duty and produced rotas between 23 July and 12 August to highlight how frequently this was occurring.

On the first day of our inspection one of the people who used the service suffered a fall and went to hospital via ambulance. The person went to hospital unaccompanied and we were told by a member of staff that nobody had escorted the person to hospital because they were short staffed.

This meant that the provider was not staffing the service with suitable numbers of staff to support people who used the service in a safe way.

These findings evidenced a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18: Staffing.

During the inspection we discussed all aspects of medicines with the deputy manager. We observed the medicines administration process and looked at the medicines administration record sheets (MARs). Of the 16 MARs that we looked at we found that medicines were not recorded as being given on a number of occasions with at least one missing signature on each of the 16 records. We found that these medicines were still in the blister packs and had not been administered. For example:

On the 6 August 2016 six people missed at least one dose of their medicines. On 7 August 2016 sixteen people missed at least one dose of their medicines. During our inspection we asked the deputy manager why there were missing signatures on the MARs and whether the lunchtime medicines round had been completed on 7 August 2016. The deputy manager could not give us a satisfactory explanation. Not giving people their medicines as prescribed can mean that they won't be effective and can lead to a worsening of a person's health.

When we looked at the medicines records we found that there were no 'when required' medicine (PRN) protocols in place for anyone who was prescribed medicine in this way. The protocol is to guide staff how to administer those medicines safely and consistently. For example, how the person communicated they were in pain which could be for example by facial expression. When we asked the member of staff who was administering medicines about PRN protocols they told us they did not understand what PRN was. When it was explained they said they would ask people (if they wanted their medicines). We then asked about those people who were unable to say when they needed medicines and how staff monitored this. The same staff member told us "We just know." And was unable to give any other evidence of how or when they administered PRN medicines. When we looked at the Pearlcare Administration of Medication Policy it stated 'The MAR chart should contain clear instruction regarding PRN medication which is given 'as required' and these should also be recorded in the residents' plan of care. The guidance should specify the exact circumstances under which the medication should be given, how often it can be given and what dose.' We found that this policy was not being adhered to.

During the inspection we witnessed a care staff member dispose of a discarded medicine inappropriately. They removed the medicine from the bedroom but placed it into a bathroom bin. This was not in line with policy and the MAR chart was not updated to reflect that person who used the service had not received this dose. This medicine was used to reduce the risk of strokes. No explanation was offered to the relative who was present or the person regarding the missing dose or any implications of missing the dose. Advice was not sought and the incident was not recorded.

When we spoke with the relative they told us; "I regularly find the peach tablet on the floor, I tell the staff and I put it in the bin." The Pearlcare Administering Medication Policy states; 'Out of date or unused drugs must be disposed by a waste handler who is licenced with the environment agency to deal with such waste. A secure container for such waste is provided.' Whilst this would be standard practice in a nursing home the NICE guidelines states that "Care home providers should keep records of medicines that have been disposed of, or are waiting for disposal. Medicines for disposal should be stored securely in a tamper-proof container within a cupboard until they are collected or taken to the pharmacy." By disposing of medicines in a normal waste bin and not recording this, the provider was failing to adhere to their own policy and the NICE guidelines.

At the inspection while looking at the medicines we asked the deputy manager to show us the medicines returns book they used when returning unused medicines. The deputy manager was unable to provide this and told us they couldn't find it. The deputy manager later arranged for the pharmacy to forward a copy of the returns record. Only one copy of the return dated 26 June 2016 was received. We were unable to check this against any record held by the service to see if this was the most recent return or if the information was accurate as no returns records could be found during the inspection. This meant that no stock checks of medicines had been carried out at the service.

During our inspection we established that a number of people who used the service had prescribed topical medicines and creams. While looking at the MAR sheets we found that topical medicines were not being recorded and there were no body maps in place to show how and where creams should be applied. When we asked the deputy manager to show us the MARs for the topical creams they were unable to locate them. We found that eye drops and creams that were being used that had a short shelf life were opened and not dated when they were opened. We found eye drops in use that had passed their use before date. This meant that creams and topical medicines were not administered safely.

We found that room temperatures in the medicine room were regularly recorded above 25 degrees Celsius. Between 1 May 2016 and 9 August 2016 the temperature was recorded at 26 degrees Celsius on at least 40 occasions. Some entries on the temperature chart were illegible making the exact number of days impossible to confirm. At its maximum the temperature reached 27 degrees Celsius on five occasions and 28 degrees Celsius on two occasions within the same three month period. The recommended temperature for storing medicines is below 25 degrees Celsius as above that temperature medicines may become ineffective.
On the first day of our visit person was taken to hospital by ambulance without the necessary care records. The failure to send care records meant that hospital staff were not alerted to any of the person's health conditions or care needs until their family member arrived. The registered manager was present when the fall was reported and an ambulance was called but failed to ensure the person transferred to hospital with an escort or the necessary paperwork.

We looked at the arrangements that were in place to manage risk, so that people were protected and their freedom supported and respected. We saw that risk assessments were not in place in relation to the people's needs such as nutrition, falls and pest control. This meant staff had no clear guidelines to follow to mitigate risks.

During our inspection we observed that one of the people who used the service was not provided with a call bell in their room. The person spent a considerable amount of time in their room. When we asked the maintenance worker they told us that the person had been without the call bell for some time and that they had passed this onto the management. When we checked the maintenance records we established that the call bell was missing for 12 months. When we looked in the persons care file there was no risk assessment in place to mitigate the risk of not having a call bell. When we asked care staff they told us; "I didn't know it wasn't working." When we asked the deputy manager they told us; "I thought it had been fixed". We asked care staff what they did to reduce risks for the person and they told us that they would carry out regular checks on the person. During our inspection there were no observations carried out and when we asked staff how they monitored this they were unable to produce any records to show that they carried out such checks.

We saw that in one person's bedroom there was ant powder sprinkled around the edges of the room. Ant powder was also found sprinkled in one of the ground floor lounges. In the person's bedroom their toiletries were placed on top of the ant powder. When we spoke to the person's relative they told us; "The ant powder

has been down since May. Look at it." When we asked the maintenance worker about the ant powder they told us they didn't know anything about it. We also found opened containers of ant powder in the cleaning cupboard. When we asked care staff about the ant powder they told us; "The domestic staff put it down." When we asked the deputy manager they told us there had been a problem with ants but could not give us a satisfactory explanation regarding the use of ant powder. We found that there were no risk assessments in place to mitigate the risks to the person who had ant powder in their room.

We also saw that a personal emergency evacuation plans (PEEP) were not in place for each individual who used the service. These plans provide staff and other professionals with information about how they could ensure an individual's safe evacuation from the premises in the event of an emergency. This meant that people who used the service were at risk of not being safely evacuated in the event of a fire at the service.

During our inspection we looked at the five year electrical installation test results assessment of the installation in terms of its suitability for continued use was 'unsatisfactory'. The document stated that unsatisfactory assessment indicated that dangerous and/or potentially dangerous conditions had been identified. We saw no action plan linked to these findings and no proof of any work carried out by the electrician. When we asked the registered manager about any work that had been carried out she was not able to give us any information or show us any updated documents but suggested we speak to the electrician. We spoke with the electrician who had carried out the inspection. They confirmed that some remedial work had been done but that they had been 'fitting it in when they had time' and did not have a report to confirm what work had been carried out and what work was still outstanding. This meant that there was no record of what work needed to be completed.

We found that all accidents and incidents were entered into an accident book and the information from here was transferred on to a summary sheet but we found no written evidence of analysis of this information or any actions that were in place to reduce risks. The registered manager was not able to provide any further information or evidence regarding actions taken as a result of this recording. The most recent summary sheet was dated June 2016. Although the falls were listed and counted the lack of any further analysis meant any patterns or trends would not be identified and therefore no lessons were learned to prevent future incidents. Very little information relating to accidents and incidents were kept. This meant that accidents and incidents were not being monitored and lessons were learned to prevent future incidents from re occurring.

From the three staff files we looked at this showed us that the provider did not operate a safe recruitment system. We found staff recruitment was not managed safely. For example, one staff file contained only one reference and another file contained two inadequate character references. Neither was dated and one was signed by a person with the same surname as staff member. We saw there were gaps in employment history of two staff members but there was no record to say whether this had been picked up or investigated. We did not have opportunity to discuss this with the manager.

We found that cleaning schedule records were completed regularly. However we found malodours throughout the service in the hall ways on both floors. We found a used incontinence pad in the laundry room. We also found in three people's bedrooms that their duvets were not protected and didn't have any covers on them. This meant that the service was unable to protect people from the risk of cross infection.

We looked at the equipment that was used for moving and handling people who used the service. We found two hoists and a stand aid that were situated in the ground floor bathroom and we were told that nobody who used the service had their own individual slings. We were shown that there were two different sized slings for the hoist and one sling for the stand aid. We asked the care staff which slings were used for which

person and they told us there were two sling colours and they told us; "We just know which one to use." They also confirmed the slings were shared by all those who needed to use them. There was no information in the care plans we looked at to say which size sling should be used for each individual. There was an infection control risk of cross contamination due to slings being shared.

During the inspection we found that the premises were untidy and unclean in areas. In one of the stairwells we saw an open pack of incontinence pads on the floor, three headboards for beds, a pressure mattress and five wheelchairs. These issues identified around the premises meant there were potential risks associated with infection prevention and control, health and safety and fire hazard.

When we looked in the kitchen of the service we found that recording of fridge and food temperatures had not taken place for over a week. There were forms kept in the kitchen which showed daily checks had been carried out, however the last of these forms was completed on 17 July 2016. After this date a record of daily checks had been made on a plain A4 sheet of paper. Temperatures were last recorded on this sheet on 21 July 2016. After 21 July 2016 we saw 'all checks done – on my own' was written on the sheet of paper by kitchen staff with no further details and no food temperatures. When we asked kitchen staff why this was they told us the correct forms had not been provided by the registered manager and they had been covering the kitchen single handed therefore they had not carried out the checks. There were no records of any checks at all between 31 July 2016 and our visit on 8 August 2016. The registered manager told us that she had worked in the kitchen on 6 and 7 August 2016 and we saw rotas confirming this yet there were no records to indicate checks had been undertaken on either of these dates. This meant that people were at risk of food poisoning by incorrect food temperatures not being monitored.

All of the above findings evidenced a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12: Safe Care and Treatment.

Inadequate

Is the service effective?

Our findings

When we arrived to carry out our inspection at the service we were led by the registered manager to the activity room where there was an immediate and overwhelming smell of cigarette smoke. When we entered the room there was a staff member taking their break in the activity room and the registered manager asked them to move outside. Directly outside the activity room was a table and chairs that staff used to take their break and at this time there were three members of staff using the area to smoke. The activity room was used by the inspection team as a base throughout the inspection and during this time we saw staff regularly used the outside area for smoking breaks. During our inspection we did not observe this area being used by people who lived at the service. This meant having a smoking area so close to the building that the room designated for activities became a thoroughfare for staff and an unpleasant environment for non-smokers due to the odour coming in through the door.

During the inspection we spent time in all areas of the home used by the people who used the service. The home provides a service to people with dementia type illnesses on both the ground and first floor of the home. Other than some pictures on bedroom doors there was no further evidence of adaptations to the environment to show good practice guidelines had been put into practice. For example, there was no evidence of contrasting colours being used to aid independence, for instance on light switches, grab rails and bathroom/bedroom doors. Corridors were all similar in colour, and bedroom doors did not have a picture or memory box people could associate with to help them find their personal space.

We saw that the physical environment throughout the home did not always reflect best practice in dementia care. The Department of Health, Health Building Note 08-02 Dementia-friendly Health and Social Care Environments (March 2015) states; The use of colour and the layout of the buildings, can make an enormous improvement in people's quality of life, and can reduce the impact of their dementia and help them live more independent lives. The correct colours, textures and layout of the buildings can help to reduce confusion, isolation, and anxiety, and help people live well with their dementia.' This meant that the environment was not suitable for people living with dementia.

During our inspection found that one person who used the service was not provided with the equipment they needed to meet their needs. The person had a discharge summary from the service they had previously used which stated that a chair seat alarm had been used due to high risk of falls. We observed that no chair seat alarm was in place for this person. The deputy manager confirmed that no equipment was in place to meet the persons needs and that they had not yet been assessed. The care records we saw for this person contained no reference to an assessment being undertaken. When we spoke with the person's relative they told us;" We thought everything like that would be put in place automatically, like it was in the other place." This meant that this person who used the service was not provided with equipment to meet their needs.

During the inspection we saw that there were sharp items left on the shower chair in the small shower room on the ground floor. These appeared to be the broken handles from pots of paint. We brought this to the attention of the registered manager who told us that this shower room was only used as a toilet as the shower was not working. The items were removed after they had been pointed out. We were also shown the

upstairs bathroom by the registered manager and were told that this bathroom was also not in use. A second upstairs bathroom had been converted into a cinema room. There was no working shower in the service at the time of our inspection and no bathroom at all on the first floor meaning that people had to use the two bathrooms downstairs. This arrangement meant that people were not given the choice of whether to bathe or shower and their dignity was at risk of being compromised whilst moving between floors after bathing.

These findings evidenced a breach of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 Regulation 15: premises and equipment.

During our inspection we found that staff training in medicines was mostly out of date and in need of refreshing. The training matrix showed that nine staff members who had accredited medicines training were last trained in 2011, including the registered manager. However we saw that three of these staff had certificates dated 2013 and 2015 within their files. This showed us that the matrix had not been updated by the registered manager and training was therefore not correctly monitored. We saw no evidence of medicine's competency assessments being carried out. We also saw on the same training matrix that training in dementia care was out of date for 18 staff some by as much as 2 years. This meant that the staff providing support to people who used the service were not appropriately trained to meet their needs our observations and discussions with staff confirmed there was a training requirement. For example staff did not wear the tabards provided to alert others that a medication round was being undertaken and did not have knowledge of PRN protocols.

We looked at staff supervisions and appraisals and found that they were very basic and didn't provide an adequate level of support. Supervisions and appraisals are a process for the registered manager to support staff individually, monitor their performance and to give them an opportunity to raise any concerns and discuss the people they are supporting and their own wellbeing. We looked at supervision records of four care staff over a twelve month period and we found no evidence of development or wellbeing discussion. For example within the supervision record of one staff member under topic for discussion: uniform and notes from supervision: '[Name] always wears the correct uniform' this was all that was noted from the supervision and no other recorded discussion. The appraisal records were merely a 'tick box' sheet where staff were rated from zero to four across a range of performance areas with zero being the lowest rating and four the highest. We saw that one care staff member had been scored three in every area with no additional comments added to give context or understanding to the rating. This showed us that staff were not supported appropriately.

These findings evidenced a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18: Staffing.
We saw records that showed us that some community professionals were involved in the care and treatment of the people who used the service, such as community nursing teams and the speech and language therapy team. However we saw evidence that showed us people were not always supported to attend medical appointments and in one person's file we could see that they had received letters from healthcare professionals for non-attendance of appointments. This meant that people were not always supported to access other healthcare services.

These findings evidenced a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12: Safe Care and Treatment.

We saw people were encouraged to eat and drink sufficient amounts to meet their needs. Throughout the inspection we observed people being offered drinks. The menu that we looked at offered one main course.

When we spoke with kitchen staff they told us that the current menu wasn't developed with the people who used the service and didn't incorporate people's choices. However if people didn't like something they could have something else.

We could see that people with special dietary requirements such as diabetes were catered for. When we looked in the kitchen we could see that people who had guidance from the speech and language therapy team had their food prepared as required. People's guidance was on display in the kitchen for staff to see. However when we looked in the care plans of people who had a special diet there were no details highlighting the risks associated with not following the guidance.

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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that DoLS applications had been submitted to the local authority and the registered manager understood their responsibilities with regard to DoLS.

We discussed DoLS with the registered manager who was aware of their responsibilities with regard to DoLS. The service had a MCA/DoLS policy in place and we found that this had insufficient content to provide guidance on best practice or working processes. DoLS applications were submitted as far back as September 2014. When we asked the registered manager, they were unable to provide us evidence of any follow up they had carried out at the time of our inspection. The registered manager assured us that they would forward this information to us immediately following our inspection.

During our inspection saw a certificate that stated the scales used to weigh people who used the service had not been calibrated since 2014. The registered manager informed us that the scales had been calibrated more recently than 2014 and that they didn't have a copy within the service. The registered manager assured us that this would forward the up to date certificate following our inspection.

Where possible, we could see that that people were asked to give their consent to their care and they had signed a section within their care plan to confirm their consent.

Inadequate

Is the service caring?

Our findings

When we first arrived at our inspection the service appeared quiet. People who used the service were sitting in the ground floor lounges and there was no visible staff presence. When we asked the people who used the service and their relatives about the care staff we received mixed comments. One person who used the service told us; "The staff do their best, sometimes things go smoothly without hiccups and sometimes not." Another told us "They have their odd moments, some are a bit rough and not very good." Another told us; "Staff do everything for us, if we want something or if I'm not very well then they look after us." One relative told us; "[Name] is content here." Another told us; "We are not made welcome, we are never offered a drink."

We saw some staff interacting with people in a positive and caring way. However when we spent time observing the support taking place in the service we saw that people were not always respected by staff and their dignity was at times compromised.

During our inspection we saw people who used the service drinking from plastic 'Tommee Tippee' feeder cups designed and sold for the use of small children. When we went into the kitchen we found that there was a large stock of these and they were regularly used for people's drinks. We observed one person drinking from one of these cups with the lid removed. As this person did not require a cup with a lid or spout there was no reason for them to be given this type of cup rather than regular crockery. We asked kitchen staff why they were in use and they told us, "We have always used them, people need them to have a drink; we just pick them up from the supermarket when we see them." When we asked if they had ever had any specialist equipment they showed us some plates that they used that had a raised lip on them. There were no specialist cups for people to use only the Tommee Tippee cups. Specialist equipment for adults is readily available and the use of equipment specifically designed for use by babies and toddlers was not preserving the dignity of people using the service.

During the inspection we observed care workers respond to a call bell in one of the lounges and one of them shouted across to the person who had requested help asking if they 'needed to go to the toilet'. The lounge was busy with other people who used the service and visitors. The visitors who were present when the call bell rang told us before staff attended to the call bell, "That will be [name] they always pull it when they need the toilet." This indicated that staff had been similarly indiscreet when attending to the person's person care needs previously. This behaviour was degrading for the person involved.

During our inspection we were shown by the registered manager a cupboard in one of the bathrooms that contained a large amount of nightwear along with underwear garments. The underwear had someone's name clearly written on them in large black letters. All of these garments were all crumpled and stuffed onto a shelf with no regard for the fact that they were people's personal items. The registered manager told us they were kept in the bathroom 'to make things easier for staff' when they bathed people. We were shown how all the items had people's initials or name marked on them but some markings were unclear and easy identification was not always possible meaning people were at risk of being placed in the wrong person's nightwear. This practice showed a disregard individualised care and for the dignity of people using the service.

This findings evidenced a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 10: Dignity and Respect.

We saw that there were posters on display for visitors and people who used the service to explain how they could access support from an advocate and other useful contact numbers, however these were tucked away upstairs beside the medicines room and not accessible to all visitors. An advocate is someone who supports a person so that their views are heard and their rights are upheld.

At the time of our inspection there was no one who used the service in receipt of end of life care. One person's file we looked at did have a record of forward planning and had a 'do not attempt cardio pulmonary resuscitation' (DNACPR) in place. Other care files that we looked at did not contain any advanced care plans to guide staff in the event of someone needing end of life care. In one person's care plan that we looked at we found a sheet that stated; '[Name] has discussed her end of life with her family and it will be them that deals with it when the time comes.' This meant that peoples end of life plans, wants, wishes or beliefs were not always considered or in place for people who used the service.

Inadequate

Is the service responsive?

Our findings

When we looked at the care plans we could see that they were not person centred. The care plans gave details of the person's care needs and some risk assessments. They were presented in a format that focused mainly on tasks and not the person. The care plans didn't give an insight into the individual's personality, preferences and choices and they contained no life history or information about the person's likes and dislikes. For example, one person who used the service had a social assessment form within their plan which should have included life history and preferences. This section was not completed but stated 'please ask family to complete' and this had been blank since April 2013.

On the 9 August 2016 we found that one person who had lived at the service since 26 July 2016 had no care plan in place. The service user had a cardboard folder that contained an admissions document, a body map highlighting a pressure area, a MAR sheet and a document from the previous care service provider that stated that the person needed two to one support for mobility and a chair sensor. This person had no further documentation in place in relation to their care.

These findings evidenced a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 9: person-centred care.

During our inspection we found that the service had a complaints procedure in place. We witnessed a family member of a person who used the service attempting to complain about the service to the deputy manager. They were told by the deputy manager to read the policy on the wall and that they wouldn't take their complaint. The deputy manager suggested they speak with the registered manager and not them. The deputy manager then suggested that the relative should speak with the CQC inspectors during the inspection to raise their complaint with us.

The relative told us that they had wished to complain about the care their family member had received. The deputy manager made no record of the family member approaching them to raise their complaint. On 8 August 2016 the registered manager showed us feedback forms that were placed in the entrance to the service for people to make comments or complaints. The relative confirmed that the deputy manager had not directed them to these and had only pointed at the complaints procedure on the notice board. The Pearlcare complaints policy states, 'Front-line care staff who receive a verbal complaint are instructed to address the problem straight away.' This meant that the service was not dealing with complaints appropriately.

When we asked the staff and relatives if they knew how to make a complaint and we received mixed comments, they told us; "I would go straight to the manager." One relative told us; "I would call the manager." Another relative who had complained in the past told us; "There's no use going to the manager with a complaint, I would go higher."

These findings evidenced a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 16: Receiving and acting on complaints.

During both days of our inspection there were no activities provided for people who used the service. We did see in the activities file that activities had taken place previously and there was a part time activities coordinator employed. On the file the last recorded activities took place on 2 August 2016, a whole week prior to our inspection. We received mixed feedback about the activities on offer for people. One relative told us; "They have enjoyed days out, flag making and crafts." Another told us, "[Name] is good with the activities but there is just not enough of them." Another relative told us; "I have never seen any going on." The activities coordinator was not present during our inspection and there were no alternatives arranged for people to take part in. this meant that people were not offered stimulating activities.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection visit there was a registered manger in place. They had been registered with the CQC since 1 October 2010. They told us they had worked at the service for 21 years and had been the registered manager there for 11 years.

During our inspection we found that medicines were not being stored, administered or recorded safely. Further information relating to this has been detailed earlier in the report under the section headed 'Is the Service Safe?' We looked at medicines audits that had been undertaken in January, February, March and June 2016. These medicines audits had failed to identify any of the issues we found during our inspection. For example, they stated that the dates and times of opening medicines was being recorded on the boxes/bottles and initialled by the administering senior care assistant and the temperature of the room where medicines were stored was within the recommended safe range yet our inspection found that this was not the case. The most recent medication audit had been carried out by the registered manager, on 22 June 2016, no medicines audit was carried out in July 2016.

We looked at the Pearlcare administration of medication policy which stated, "Managers and supervisors in the home have a duty to effectively manage all risks relating to the management and administration of medication in compliance with regulation 13 of the Health and Social Care Act 2008 (regulated activities) regulations 2010." This policy had not been updated since October 2012 and therefore quoted the old legislation.

An effective system of audits was not in place and those audits that were being undertaken were not completed correctly. For example mattress audit sheets stated 'to be completed by staff when bed changes are being carried out on a weekly basis.' Although some checks were being done, not all rooms were being checked on a weekly basis. Some mattresses had not been checked since 13 and 14 June 2016.

We saw weekly pressure care audits were carried out by the registered manager. These highlighted service users who had areas of redness and pressure areas, however care records for one person who used the service contained a body map that highlighted that they had an area of redness and this person was not included on pressure care audits.

As the registered manager was not available on the second day of our inspection we did not have opportunity to see care plan audits during our visit. Following the inspection we requested that these be sent to us. We were sent one care plan audit completed by the registered manager on 28 April 2016. This audit was merely ticked to say what documents were present, there were no comments made in relation to the quality of the information. No further examples were provided.

The registered manager told us that they did a daily walk around of the service but did not provide any records to evidence this. They had failed to identify areas of concern such as ant powder on the floor of a bedroom, the malodour in corridors and the items being stored in a stairwell. The call bell that was out of action had been reported to the registered manager by the maintenance worker on 5 May 2016 but no

action had been taken by them to address this.

The registered manager was aware of practices within the service such as Tommee Tippee cups being provided for people and nightclothes being stored in a communal cupboard in a bathroom. They did not say anything during the inspection to indicate they found these practices unacceptable and had not taken any action to address them. We did not see any evidence during the inspection to indicate that the registered manager had challenged this type of institutional practice.

The registered manager told us that the regional manager and registered provider regularly came to visit the service and they felt they received a good level of support from them both. We saw the area manager had completed audits of the service in February 2016 and May 2016 but the actions that were highlighted had not been addressed. For example it was noted that staff should not use the conservatory for breaks and when we arrived at the service we found that staff were in this area taking their break.

The quality assurance of the service included an annual survey of people and their relatives. Although we saw evidence of this taking place there was no evidence of any action plan being produced in response to it. One of the relatives we spoke to told us they had raised the issue of lack of activities in the most recent survey but they had not seen any improvement as a result of this.

These findings evidenced a breach of regulation 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance.

A number of the issues highlighted during the inspection were linked to inadequate staff numbers. The registered manager was responsible for creating staff rotas on a weekly basis and had failed to ensure that enough staff were available to provide an appropriate level of care to those people using the service. Despite telling us that the service needed four staff on each shift as a minimum there were regularly only three staff on the rota.

On the second day of our inspection we observed the deputy manager refusing to take a complaint from a family member and referring them to the complaints policy on a notice board before suggesting they speak to one of the inspection team.

One of the people who used the service told us, "We don't see much of the manager, the staff are alright, there's good staff." Another person we spoke to did not know who the registered manager was.

One relative we spoke to told us, "My sister asked for some paperwork and the manager was 'huffing and puffing'." Another relative we spoke to told us they had previously made a complaint about the service but felt it had not been dealt with appropriately by the registered manager.

The feedback we received from staff in relation to the management team was mixed. Comments included, "Management is good, I'm not afraid to go to the manager to air my opinions" and "I find [registered manager] approachable." Another member of staff told us, "I'm not sure about going to the deputy manager, I'm not sure they would deal with things confidentially. I think [registered manager] is a good manager. I think they're too friendly with the staff sometimes, you have to have a line but yes they're lovely."