Avens Care Homes Limited

Prestbury Court Residential Home

Inspection report

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Date of inspection visit:
18 August 2017
22 August 2017
23 August 2017

Date of publication:
07 December 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Prestbury Court Residential Home is a care home without nursing, providing care and accommodation for up to 48 people. People living at the service were older people, some of whom were living with significant dementia or long term health conditions. At the time of the inspection there were 31 people living at the service.

There was no registered manager for the service. 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. An acting manager had been appointed in May 2017 and was in day to day control of the service.

This inspection took place on 18, 22 and 23 August 2017. The first two days of the inspection were unannounced. The service was last inspected in October 2016 when it was rated overall as Good, with the key question 'Well-led' being rated as Requires Improvement. Prior to the inspection in October 2016 the service had been inspected in December 2015 when we found significant improvements were needed. At the inspection in October 2016 Improvements had been made. However, at this inspection in August 2017 we found the improvements had not been sustained.

We carried out this inspection because we had received information that three safeguarding alerts had been made to the local authority in August 2017. The concerns had been raised about the care people received at the service. The local authority's safeguarding team and commissioners were investigating the matters and working together to keep people safe.

The overall rating for this service is 'Inadequate' and the service was therefore placed in 'special measures' and enforcement action was considered. However, since this inspection the provider has applied to de-register Prestbury Court and asked for support from the local authority to help people move to other care services.. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

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

We found the provider had not taken sufficient action to ensure people received safe and high quality care from well trained and competent staff. The quality monitoring systems were not effective and failed to identify and address the concerns we found at this inspection. The acting manager had been working with the local authority's Quality Assurance and Improvement Team (QAIT) since May 2017 and a Service Improvement Plan (SIP) had been produced. Some work had been completed on the SIP. However, the report from the visit by QAIT on 2 August 2017 identified a quality assurance system needed to be reinstated, monitored and maintained.

People were not protected from risks to their health and safety. Risks associated with people's specific health needs were not always identified or acted upon in a way that reflected the urgency of the situation. The gates fitted across some people's doors were at a low height and there was a risk that people could fall over the gates. Risk assessments did not always contain sufficient detail to help keep people safe. There was no clear care plan or risk assessment to support staff in understanding the needs of people with diabetes or epilepsy.

People were not supported to receive their medicines safely. Staff did not have a full understanding of what people's medicines were for or when people might need additional medicines, for example for pain relief.

People were not supported by sufficient staff at all times. However, involvement of the local authority's safeguarding and commissioning teams had reduced the risks associated with this.

People were not supported by staff who received sufficient induction and supervision to ensure they were competent to meet people's needs. Staff had not received recent relevant training to support people living with dementia, diabetes or epilepsy.

People were not always supported to receive sufficient food and fluids. There were concerns that staff had not made sufficient attempts to encourage one person to eat resulting in significant weight loss. When the weight loss had been identified professional advice had been sought and the person's weight had increased. Fluid intake was not always recorded to ensure people remained hydrated.

People did not always receive care that was respectful and promoted their independence, privacy and dignity. We heard some staff talking about people in front of other people, breaching their confidentiality. We saw one member of staff assisting two people to eat at the same time, while also supervising other people who were eating independently.

People were placed at risk of not receiving the care and support they required to meet their dementia care needs. Staff did not always address people living with dementia by name when they spoke with them or ensure they made and retained eye contact with them. Care plans did not contain sufficient detail for staff. There were no instructions on what form reassurance should take in order to help people who became

anxious due to short term memory problems. Care plans did not identify and plan to meet people's social care needs. People's records did not always contain up to date and accurate information about the care they received. People did not benefit from an environment that supported those living with dementia.

People were not supported to have maximum choice and control of their lives and staff did not always provide care in their best interests; the policies and systems in the service did not support this practice.

People were supported to receive regular visits from healthcare professionals.

Complaints were well managed. One relative told us they felt able to raise any concerns they may have.

People and their relatives were supported to be involved in planning their care if they wished.
People were protected from the risk of abuse, because staff had a good understanding of how to recognise and report abuse. There were robust recruitment procedures in place.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected from risks to their health and safety.

Risk assessments did not always contain sufficient detail to help keep people safe.

People were not supported to receive their medicines safely.

People were not supported by sufficient staff at all times.

People were protected from the risk of abuse, because staff had a good understanding of how to recognise and report abuse. There were robust recruitment procedures in place.

Is the service effective?

Inadequate

The service was not effective.

People were not supported by staff who received sufficient induction and supervision to ensure they were competent to meet people's needs.

People did not benefit from an environment that supported those living with dementia.

People's rights were not always upheld as staff did not always follow the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards.

People were not always supported to receive sufficient food and fluids.

People were supported to receive regular visits from healthcare professionals.

Is the service caring?

Requires Improvement

Aspects of the service were not caring.

People did not always receive care that was respectful and promoted their independence, privacy and dignity.

People were not always supported to eat in a positive way.

People and their relatives were supported to be involved in planning their care if they wished.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive.

People were placed at risk of not receiving the care and support they required to meet their dementia care needs. Care plans did not contain sufficient detail for staff.

People's social care needs were not identified and planned for.

Complaints were well managed.

Is the service well-led?

Inadequate

The service was not well led.

The quality monitoring systems were not effective and failed to identify and address the concerns we found at this inspection.

The provider had not taken sufficient action to ensure people received safe and high quality care from well trained and competent staff.

People's records did not always contain up to date and accurate information.

Prestbury Court Residential 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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We carried out this inspection because we had received concerns from the local authority about the quality of care being provided to people living at Prestbury Court.

This inspection took place on 18, 22 and 23 August 2017. The first two days of the inspection were unannounced.

The inspection team consisted of one adult social care inspector on the first and third days and two adult social care inspectors on the second day.

Before the inspection we gathered and reviewed information we held about the registered provider. This included notifications (about events and incidents in the service) sent to us by the registered provider. We also received information from the local authority's Quality Assurance and Improvement Team (QAIT) who had been working with the provider.

In order to gather information during the inspection we spoke with the acting manager, 16 staff, one visitor and nine people living at the service. We also spoke with two visiting social and healthcare professionals.

Not everyone living at Prestbury Court was able to tell us about their experiences. Therefore we spent time in the dining room on the second day of inspection and completed a Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

During the inspection we looked at a number of records including three people's care records, the provider's quality assurance system, accident and incident reports, three staff files, records relating to medicine administration for four people, complaints and staffing rotas.

Inadequate

Is the service safe?

Our findings

At this inspection we found improvements were needed in order to keep people safe.

We carried out this inspection because we had received information that three safeguarding alerts had been made to the local authority in August 2017. The concerns had been raised by the acting manager, the ambulance service and a GP about the care people received at the service. The local authority's safeguarding team and commissioners were investigating the matters and working together to keep people safe. A community nurse from the local authority was based at the service on weekdays and the out of hours community nursing team were providing support overnight and at weekends.

There had not always been enough suitably trained staff or sufficient monitoring of staff to support people safely. The provider used a specific tool to calculate the number of hours required to meet people's needs. The calculation for August 2017 indicated there were 20 people with high dependency levels, 18 people with medium dependency levels and one person with low dependency needs. At the time of the inspection one person with high dependency levels was in hospital. Rotas supplied by the acting manager showed three or four staff on duty at night and seven or eight staff on duty during the day. We had been told by the local authority they felt there was there was a need for four staff to be on duty at night. On the morning of 22 August 2017 there had been three staff on duty the previous night. The acting manager told us they had been unable to source a fourth member of staff. Staff told us staffing levels were not always enough to meet people's needs or keep them safe. One staff member told us the staffing levels we had seen on the first and second days of the inspection had not been the usual numbers and they would be reduced after the inspectors had left. There were seven or eight care staff on duty at different times of the day during the inspection. The acting manager told us they always tried to keep night staffing levels at four staff and day staffing levels at eight staff using agency staff, but it was not always possible to get agency staff to cover all the vacancies.

One person living at the service told us "There's never enough staff." The person sitting next to them said "When you write it down put down that I agree with her. No-one supports or thanks them." We saw one person living at the service assisting another person. They told us they had just removed, turned off and packed up the person's nebuliser. They told us "Every little helps the carers", and they had done this because there were no care staff about. The person having the nebuliser was being cared for in bed.

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

However, due to the involvement of the safeguarding and commissioning teams the provider had agreed to ensure that staffing levels were sufficient to ensure the safety of people. The numbers took into account the fact that new and agency staff who may be unfamiliar with people's needs were sometimes on duty.

Risks to people's wellbeing and safety had not always been mitigated effectively. Risks associated with

people's specific health needs were not always identified or acted upon in a way that reflected the urgency of the situation. For example, one person was living with a long term health condition that affected their breathing. They needed medicine delivered to them four times a day in a fine mist via a machine called a nebuliser. The person told us the tubing on their nebuliser had split, which meant it was ineffective in delivering the medicine to them. They told us this had been reported to the service's staff but five days later the issue had still not been sorted. The person told the community nurse based at the service who "sorted it out in an hour." They told us there had been "no sense of urgency" from the service and they were still suffering the consequences several days later with poor breathing control. They said "This is a lifeline for me. I can't be without it." We found the lack of action on the part of the service had led to a significant risk of harm to this person. The community nurse based at the service told us they had suggested to the acting manager they get hold of replacement masks but staff we spoke with were not aware any had been obtained. The acting manager told us they had tried unsuccessfully to obtain replacement masks. Although the person managed their own medicines in the nebuliser, there was no care plan or risk assessment in relation to its use other than whether the person was able to administer their own medicines safely. Staff did not know how often tubing or masks should be changed or how they were to be cleaned. This left the person at risk of infection and unsafe care. We saw that another person had a nebuliser that was very dirty and had a sticker to say it was due for service in December 2016. There was no evidence the machine had been serviced as required.

We looked at the care records for one person who had diabetes. There was no clear care plan or risk assessment to support staff in understanding this person's needs or how any risks to their health would be managed. The person had a record in their file stating that the occasional sweet treat would not harm them, otherwise no guidance was available. We spoke with a team leader and asked if they understood what signs they might look for if the person was becoming unwell through their diabetes. They shrugged their shoulders and said they did not know, then suggested "maybe sweating?" This did not demonstrate a clear understanding of the management of risks associated with long term health conditions and put the person at risk of poor care.

Risks to people's safety were not well managed. On the first day of inspection we saw staff serving people very hot soup. People were told the soup was hot, but some people were not able to assess how hot the soup was and were at risk of scalding. We pointed this out to senior staff, but on the second day of inspection we saw a staff member serving people steaming hot custard. We suggested they add cold cream which they did to reduce the risks of people scalding themselves.

On the first day of inspection we saw a bolt across a fire door which would hinder any evacuation. This was removed immediately. We also had concerns about the evacuation of people where safety gates were fitted across their doors. We discussed this with the local fire officer who told us they were happy with the gates being fitted providing they were easily opened if evacuation was needed. On the second day of inspection we saw the fire escape to the rear of the building was being used as storage for Christmas decorations, cardboard boxes, old sheets and tools. These were combustible items and there was a risk that the area would not be safe to use if evacuation was required. We asked the staff on duty to address this immediately, which they did. However, on the third day of inspection we saw that not all the tools had been removed. Also there were some bottles of solvents and the area had not been made safe to use in case of evacuation.

The gates fitted across some people's doors were at a low height and there was a risk that people could fall over the gates. This risk had not been assessed. On the third day of inspection we discussed this with the acting manager who agreed to assess the risks.

We saw hand dispensers of antibacterial gel had been left around the service. These would have presented a

risk if people had accidentally ingested them. The acting manager removed these as we toured the service.

Accidents and incidents were recorded and monitored by the acting manager. The time date and place of the accident or incident were recorded. However, these accidents and incidents had not been analysed in order to minimise the risk of reoccurrence. For example, one person had slipped out of their wheelchair, but there was no indication that procedures to prevent a re-occurrence had been considered or that the person's care plan had been reviewed in light of the accident.

Risks related to cross infection were not well managed. On the first two days of the inspection when we toured the service in the early morning we found the hot trolley used to serve food from was dirty, with dried food on the lid and dishes. We asked staff to clean this before people were served breakfast. The food hygiene rating for the kitchen was 4. We were told that this was mainly because the kitchen floor needed replacing. We saw this had not happened. Staff had access to aprons and gloves to help control the risks of cross infection, and we saw staff use these throughout the inspection. Staff changed aprons after providing care to people and when serving meals.

Medicines practice was not safe. Staff told us they had received training in safe medicine practice from the supplying pharmacist. However, no checks had been undertaken to ensure staff were competent to administer medicines and we saw evidence of poor and unsafe practice being carried out.

We found staff administering medicines did not always have a clear understanding of what people's medicines were for or when people might need additional medicines, for example for pain relief. For example, one person had been prescribed paracetamol for pain relief "as required". We asked staff how they would know this person was in pain. The person was very frail and living with dementia. Staff told us "We just think she is in pain." They told us the person did speak a little so "probably" would be able to say if they needed pain relief. There was no protocol for the administration of this medicine and no specialist tools were in use, such as the Abbey Pain Scale. The Abbey Pain Scale helps staff to assess the pain levels of people who are not always able to tell staff when they are in pain. This left the person at risk of not receiving appropriate or consistent pain relief.

We found that records relating to the application of topical medicines did not provide confirmation that people received these medicines. Topical medicines such as creams are prescribed to protect people's skin or to provide pain relief. Records relating to these medicines were inconsistent. This meant people may not have received their medicines as prescribed and were at risk of unnecessary discomfort.

Medicines were stored securely in the medicines storage room. However, we found two large crates of medicines on the floor, full of boxes labelled with the names of people living at the service. Staff told us these were medicines waiting to go back to the pharmacy as people had left, no longer needed them or had passed away. Medicines to be returned to the pharmacy should be logged in a book prior to them being returned. This had not happened as the service did not have a returns book. This meant there was no audit trail of what medicines were in the box and it would not be possible to check if medicines had gone missing. Some medicines, including high risk medicines were still at the service for people who had left the service some time before.

We looked at the management of medicines which needed particular precautions due to their strength or effects. The record book in relation to these medicines was not clear to understand. Staff had signed entries incorrectly, which made it difficult to audit. The record book had been audited and we eventually confirmed the correct stock was held.

We identified failures to assess and mitigate risks relating to the health and safety of people including from fire, specific health conditions, the spread of infection and medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored securely in locked trolleys. The temperature of the medicines refrigerator was recorded to ensure medicines were kept at the correct temperature to ensure they were safe to use. We spoke with a member of the staff about the length of time it had taken to do the medicines round in the morning. They told us "Meds takes as long as it takes. It is more important to get it right."

People were protected from the risks of abuse. Not all staff had received training in safeguarding people. However, staff we spoke with knew how to recognise abuse, and told us what they would do if they thought someone was being abused within the service. Staff told us they thought the acting manager would deal with any concerns they may raise. The acting manager was aware of their duty to report any incidents of abuse and had acted appropriately when they had needed to do so.

There were robust recruitment systems in place. This protected people from the risks associated with employing staff who may be unsuitable to work with people who needed help with their care. We looked at the files for three staff. Staff were thoroughly checked to ensure they were suitable to work at the service. These checks included obtaining a full employment history, seeking references from previous employers and checking with the Disclosure and Barring Service (DBS.) The DBS checks people's criminal history and their suitability to work with people who require care and support.

Inadequate

Is the service effective?

Our findings

At this inspection in August 2017 we found improvements were needed to staff training and the implementation of the requirements of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards (DoLS).

People could not be assured that staff had received training and support to enable them to fulfil their role effectively. Most people living at Prestbury Court had high dependency levels relating to living with dementia and their physical care needs.

Staff did not receive sufficient induction and supervision to ensure they effectively carried out their role. We discussed training with the acting manager who told us staff had received very little training. They told us a new training package had been purchased and staff had been registered to undertake the training, but had not yet started it. Some staff had received training which was now out of date and some had received training from previous work settings. Staff told us they had received some recent training in fire safety and moving and transferring. However, the majority of staff had received very little recent training and their understanding of the principles underpinning care was limited. For example, some senior staff were unaware of how to recognise the signs when one person who was living with epilepsy would need special assistance.

The acting manager told us that because the service was short staffed, new staff were working 'on the floor' as soon as they started and did not get a thorough induction.

The acting manager told us that they felt staff were very willing to learn, but had never been given the opportunity or support to do so. Staff told us they rarely had one to one supervision or appraisals which would have given them time to discuss any concerns or learning needs they may have. However, staff told us they felt well supported by the acting manager and that they had an open door and "you can go at any time." The acting manager told us they had begun to put a plan in place to ensure staff received regular supervision. However, they had not been able to follow this through due to other matters that needed addressing within the service.

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

People were at risk of staff making decisions on their behalf without due regard as to whether the decisions were in the person's best interests.

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.

Most people who lived at Prestbury Court were able to make day to day decisions for themselves, but may not have the capacity to make more complex decisions about their health and welfare. Some staff had received training in the MCA, but had a limited understanding of the Act. However, they did have some understanding of the principles underlying the Act. For example, one staff member told us they understood the MCA was about gaining consent from people, before undertaking care tasks. They told us "You have to ask them what they want" and "If they really need it we just have to get round them somehow – ask them if they would like a wash or a shower maybe." Another staff member said "You must never assume people don't have capacity."

We saw some MCA assessments in people's files. However, the assessments were not always personalised to the individual. For example, we saw one person had an assessment in their file regarding the stairgate on the door to their bedroom. This decision was stated to be in the person's best interests to "prevent other residents from entering her room." There was no indication as to how the decision had been arrived at or who had been involved in making the decision.

We saw one person had been prescribed medicine to be taken without them knowing. Staff did not know if there was a clear protocol or best interests decision made with regard to this person's medicines. There was no record on their file that a best interest decision had been made in relation to the covert administration of medicines. We asked a staff member why the person was being given their medicine without them knowing. They told us it was "because she won't take them." We saw the person being given their medicines in a mousse, which they ate. There had been no attempt to persuade the person to take their medicines, or explain to them what they were taking. This meant the person was not given the opportunity to take their medicines willingly and no consideration whether this was necessary.

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. The service had a locked entrance door to protect those people who would be unsafe to leave the service unaccompanied. Because of the restriction on leaving the service the acting manager had assessed 28 people as not having capacity to consent to living in a service with a locked door. Therefore they had made applications to the local authority to deprive the 28 people of their liberty in order to keep them safe. Due to the large number of applications being processed by the local authority only four authorisations had been granted at the time of the inspection. Staff we spoke with were unaware of whether any DoLS had been granted or any conditions that were attached to the authorisation. This meant people may be at risks of having their liberty denied unlawfully.

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

Assessments were being carried out where people were at risk of poor nutrition. This included different textures of food to assist people who had been diagnosed with swallowing difficulties. Information about this was available in the service's kitchen. Staff we spoke with were clear about different textures people

required in order to ensure they could eat sufficient to minimise the risk of malnutrition. However, following the inspection we received information from a visiting social care professional that one person had lost a significant amount of weight. There were concerns that staff had not made sufficient attempts to encourage the person to eat resulting in the weight loss. When the weight loss had been identified professional advice had been sought and the person's weight had increased.

Lunch on the day of the inspection was ham egg and chips. We saw people enjoying this meal very much. Some people ate with cutlery, others with their fingers, but everyone was well monitored and supported. Tables were laid nicely, with condiments and napkins. We heard and saw people being offered salt, pepper or sauces on their chips. One person said "A little on the egg and some on the chips". The staff member had to squeeze the bottle hard and they both laughed at them struggling. Staff assisted people discreetly if they spilled anything.

There was a menu displayed in the dining room and people told us they could have something else to eat if they did not want what was on the menu. Some staff told us they thought people did not always get enough to eat at tea time. However, we saw no evidence of this. People told us they had enough to eat and we heard some people refusing second helpings At tea time people had three courses, including soup and a sweet.

However, records relating to the amounts of food and fluids people received were not complete. Some people had been assessed as needing a higher level of care than others. For these people 'high dependency' record charts were kept. The charts included checks on the amounts of fluids taken and eliminated. Some charts showed people had not received much fluid, or had refused this. We asked a staff member how they knew how much fluid each person needed to take in in a 24 hour period to maintain their health. They did not know, and no assessment had been made on the charts of the amount each person needed. This meant people were at risk of poor hydration as staff were not able to effectively check how much fluid people were taking. We spoke with a member of night staff about a recent incident when there had been concerns about the lack of completion of these charts throughout the night. We asked them what they had learned from the incident and they told us "The first thing I do when I go into anyone's room now is to log the time. Then I never forget."

People files indicated they had access to healthcare services and received ongoing healthcare support from GPs, opticians and community nurses. However, community nurses were concerned that the advice they gave to staff was not always followed and this put people at risk of not having good health maintained. For example, one person had been seen by a community nurse who had recommended antibiotics be obtained. Several days after the advice had been given the antibiotics had still not been obtained. However, we were told later that the delay had not just been a result of inaction by the service, but there had also been some confusion with the surgery and the pharmacy.

The service was in need of redecoration and refurbishment. Some areas of the service including bedrooms, had a strong unpleasant odour. Bedrooms were untidy and there was debris on the floors. Curtains were hanging down and bedding was of a poor quality. Some bedrooms contained belongings of people who had left the service several months before. Corridors were narrow and the upstairs corridors were dark and poorly lit.

The environment was not well adapted to meet the needs of people living with dementia or visual impairment. Toilet and bathroom doors were identified by pictures and people had picture frames on their doors to identify their rooms. However, there was a general lack of signage to support and encourage people living with dementia to find their way around or encourage independence. For example, there were no signs indicating where to find toilets and bathrooms, the lounges or dining room. There had been no

recent audit completed to identify best practice in dementia care with regard to the environment, such as high contrast light switches, blackout blinds, visual time and season reminders, high contrast crockery and adapted cutlery.

New non slip flooring had been fitted to the lounge, shared areas and activity room. This had reduced the odour problem in these areas and provided an easier surface for people to walk on or push a frame. However it did not help people orientate themselves, such as by different colour zones for certain tasks, such as eating.

Requires Improvement

Is the service caring?

Our findings

At this inspection in August 2017 we found improvements were needed to ensure people's needs were met in a caring manner.

People's needs were not always met in a kind, caring and respectful manner and their privacy and their dignity was not always respected. One member of staff was asked to help a person who needed personal care. They told us they were due to go on their break and were reluctant to give care to the person. We then heard the staff member shouting down the corridor above the person who needed assistance that they (staff) were "Supposed to be going on a break." We heard other communication that needed to be improved. For example, we heard some staff talking about people in front of other people, breaching their confidentiality. We also saw some confidential personal care documents left on a table in an area where anyone could have seen them.

People were not always assisted to eat in a positive way. We saw one member of staff assisting two people to eat at the same time, while also supervising other people who were eating independently. The staff member was polite and caring, but was unable to give their full attention to the people they were assisting to eat. We were told there were not enough staff to ensure people who required assistance had individual attention when eating. This meant that not all people had a pleasant experience when being assisted to eat.

However, we also saw some positive interactions between staff and the people they cared for. For example, we observed a member of staff helping a person to eat in their bedroom. They were sitting by their side chatting to the person, although the person did not respond. We heard them discussing flowers in the person's room with them. They told us the person was a really keen gardener, and said "You must have green fingers" and stoked their hand. They pointed to photographs of person in their garden and a book on National Trust gardens in their room. The member of staff tried really hard to involve the person in the experience of eating their meal, and make the experience a positive one.

We also heard a member of staff gently encouraging a person to leave the dining room to sit in the lounge. The person was reluctant to move and the staff member tried various distraction techniques in order to encourage the person to move. The staff member left the person sat in the dining room, but kept coming back until the person agreed to move. The staff member told us they wanted the person to move as they were concerned about them sitting on a hard dining chair for a long period of time.

When we spoke with staff individually they spoke positively about the people they cared for. One member of staff told us they wanted to make things nice for the people living at the service. Another told us "I love them (people) and want to help as much as I can."

There was some evidence that people or their relatives had been involved in planning their care. For example, care plans contained some signatures signifying consent to receive care and some details of discussions around how people wanted to receive their care. We spoke with one relative who told us they had reviewed their relation's care plan and had been asked if there was anything else they felt needed to be

included.

We saw that the service had received many compliments from relatives. One relative had written "Thank you to everyone who made such an effort to help mum settle in."

Requires Improvement

Is the service responsive?

Our findings

At this inspection in August 2017 we found people did not always receive person centred care that was responsive to their needs. Many of the people living at Prestbury Court were living with dementia and 20 people had been assessed as having high dependency care needs.

The majority of staff had not received training in caring for people living with dementia. This meant that people did not always receive care that was responsive to their dementia care needs. For example, staff did not always address people living with dementia by name when they spoke with them or ensure they made and retained eye contact with them. People were prevented from doing things such as walking to the dining room, without any explanation of why they could not do this. For example, one person was being cared for in their room because of a particular healthcare concern. The person wanted to leave their room and go into the dining room. Two staff made no attempt to distract the person and encourage them to stay in their room. They just kept telling the person they could not go into the dining room. This caused distress to the person and other people around them. Another member of staff came along and spoke calmly with the person who was eventually encouraged back to their room. One member of staff told us they had personal experience of supporting a person living with dementia and could understand their needs and empathise with them. However, they had not received any training at the service.

Staff told us that they did not always have time to ensure people received care that was responsive to their personal care needs. In particular they said they did not always have time to ensure people were taken to the toilet in a timely way. One staff member told us "We are relying on the pads more than we should do" and not changing people sufficiently when they were wet."

People's care records did not include sufficient information on how to support people living with dementia take full advantage of the skills and strengths they maintained, or how to address distressed or risky behaviours. For example, one care plan indicated the person had short term memory problems. Their care plan stated "Staff to monitor and offer assistance if I appear confused or struggling with something." There were no instructions on what form the reassurance should take in order to help the person. Information on how the person communicated indicated they may "walk off" when staff were speaking with them due to their short attention span. The care plan stated staff should speak clearly and give the person time to process information, but did not give any instructions on how to support the person to maintain their interest and prevent them walking away.

One person had been receiving individual support because of aspects of their behaviour that meant they may become violent. This individual support had recently been stopped as they had become more settled within the service. There was no evidence on the person's care plan as to how to manage the person's behaviour if they became violent. One staff member told us they had not received any instructions on how manage the person's behaviour. They told us "Us light blues' (care staff uniform colour) don't get told much." This meant people were at risk of not receiving care that was responsive to their needs and also placed staff and other people at risk.

Care plans did not consider people's social care needs and there was brief information on people's life histories, such as who was involved with their care. Personal life histories capture the life story and memories of each person and are important to help staff deliver care responsive to their needs. They enable the person to talk about their past and give staff an improved understanding of the person they are caring for. There was no information on people's care plans that indicated any hobbies or interests they may have had or would like to participate in.

Care plans did contain some information on people's catering preferences, such as what they liked to eat and where they preferred to eat. However, some of this information was confusing. For example, one person's catering preference notes said they liked to eat in the dining room with other people, but information about their routine indicated they wanted their breakfast in their room. Care plans had been reviewed regularly but had not identified the gaps noted above.

The acting manager had been working closely with the local authority's Quality Assurance Improvement Team (QAIT) on improving care plans and had developed a 'summary' of the care plans. This was so staff would have basic information about people's needs available to them without having to read the full care plan. However, the acting manager had not had time to develop the summaries to ensure they were person-centred. Daily care records were not always fully completed to show the care that people received. For example, the daily records for one person showed they had been checked by staff at 8.30am when they were asleep in bed. There was no further record until 2.15pm when it was recorded they had had a settled morning. The failure to record the care given meant the provider could not be assured people received personal care as detailed in their care plans.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see some responsive care taking place. For example, one person was unhappy being supported by some of the service's staff to maintain their hygiene. Staff had identified which staff the person preferred support from and they were delegated to support them. This helped reduce the person's anxiety. We saw the person was happy to consent to receive care from the particular staff member. One staff member told us how they had arranged for a hearing check for one person. The person had not been speaking with staff, but following the hearing check, aids had been obtained and the person was communicating more effectively.

An activities organiser was employed by the service and we some good one to one interactions between the activities organiser and people living at the service. We also saw people taking part in group activities in the activity room, these included word games and crafts. There were samples of people's art and craft work displayed around the service. An electronic care planning system had started to be used, but had not been fully implemented. The acting manager told us that the system was only used to record activities that had taken place, but the system had stopped being used in August 2017 and no records of activities had been recorded since then. This meant there was no evidence recorded of activities having taken place. There were no care plans to ensure people had the opportunity to take part in meaningful activity.

The activities organiser told us they had planned a 'family' day, where people's families could meet and enjoy a fun day socialising with their relatives. However, the majority of the one to one support we saw between staff and people was task based. For example, when people were receiving personal care.

There had been some meetings held for people living at the service where people were able to discuss activities, food and any concerns they may have. However, no meetings had been held since November

2016.

There was a complaints policy and procedure for the service. However, the policy had not been reviewed since April 2016. This meant people may not have the most up to date information about who to complain to. We looked at the way complaints were managed within the service. We saw there had been two complaints received during 2017. Both complaints had been fully investigated and responded to by the acting manager. The acting manager had asked that the complainants respond to them if there were any further concerns, which there were not. One relative we spoke with said they felt able to raise any concerns they had with staff and that they would be dealt with.

Inadequate

Is the service well-led?

Our findings

The service was inspected on 18, 22 and 23 August 2017. The service had previously been inspected in October 2016 when it had been rated as Good overall, with the key question well-led being rated as requires improvement. At this inspection in August 2017 we found improvements that had been made at the previous inspection had not been sustained.

The overall rating for this service is 'Inadequate' and the service was therefore placed in 'special measures' and enforcement action was considered. However, since this inspection the provider has applied to de-register Prestbury Court. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

We carried out this inspection because we had received concerns from the local authority about the quality of care being provided to people living at Prestbury Court. Safeguarding alerts had been made about incidents that had occurred within the service. During this inspection we found systems were not robust and the service was not well led.

The provider's systems to monitor and improve the quality of care had failed to identify and address the many issues we found during this inspection. During the inspection we identified a number of concerns and six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because aspects of the service were not safe, were not well-led and did not provide effective, responsive care.

The providers visited regularly and we saw a record of visits made by them, the last of which had been completed in August 2017. However, these visits had failed to ensure the health and safety of people living at the service. For example, equipment one person needed to maintain their health had not been maintained. Staffing numbers were not always sufficient to meet people's needs. Risks to people in relation to diabetes and epilepsy were not identified and managed in order to mitigate the risks. This meant people living with these health conditions were at risk of not receiving appropriate care. Fire evacuation routes were not clear from combustible material and the environment was not suitable for people living with dementia. Gates used to prevent people going into other people's rooms had not been risk assessed and there were no best interests decision made in relation to the use of the gates. There was no analysis of accidents and incidents in order to minimise the risk of reoccurrence. Staff were not sufficiently supported or trained to perform their role effectively. A new training package had been purchased and staff had been registered to undertake the training, but had not yet started it. Staff were not always respectful to people or responsive to their needs. People were at risk of not having decisions made in their best interests as staff had a limited understanding of the Mental Capacity Act 2005. People's care plans did not give staff sufficient information on how to meet their personal and social care needs.

We saw records that showed some checks had been made on bedrooms to ensure they were clean and tidy and that call bells were working. However, these had not been completed since April 2017. The record made by the provider indicated call bells had been checked. However, the records made by staff did not confirm

the checks had been completed. The provider's records also showed care plans were being reviewed, but not audited and that medicine audits were overdue.

There was no registered manager in post. The acting manager had been in post since May 2017. They had not applied to register as the provider was intending to appoint another person as permanent manager. They told us that when they had taken on their role, there were no quality assurance systems available to them. This meant they had had to put systems in place. The acting manager told us that there had been a number of pressures on them, including a high turnover of staff, that had limited the time they had available to work on the quality assurance systems. They told us they felt unable to plan and look to improve the service because they were having to continually monitor and support staff who had received very little training. As a result of this they were being supported by a Quality and Compliance lead who had been appointed by the providers. They were supporting the acting manager to draw up an action plan to ensure there were systems in place to improve the quality of the service.

The acting manager had been working with the local authority's Quality Assurance and Improvement Team (QAIT) since May 2017 and a Service Improvement Plan (SIP) had been produced. Some work had been completed on the SIP. However, the report from the visit by QAIT on 2 August 2017 identified a quality assurance system needed to reinstated, monitored and maintained.

The provider introduced a risk into the service by not following the service's procedure in relation to falls. They did not close a gate that was in place to prevent people from falling down a set of stairs. Due to their action one person fell down the stairs. Following the fall the provider failed to take appropriate action and this incident is being investigated by the police.

The provider had failed to establish and operate effectively systems and processes for monitoring the quality of care being provided, mitigating risk and to maintain an accurate and complete record of the care and treatment provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the incident the provider did not act in an open and transparent way. They did not provide reasonable support to the person who was injured. Also they failed to provide an account which included all the facts the provider knew about the incident. Following the incident the acting manager submitted a notification to us that included all the relevant facts.

The provider failed to act in an open and transparent manner, to provide reasonable support and provide truthful information when things went wrong. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received conflicting information from staff about how well staff worked together. Some staff told us they did not always feel involved and others that staff did not always carry their weight and do their job correctly. Another staff member told us there was little positive team work. One told us the problem with the service was "It needs a really strong manager and a bit of money spending on it." However, another staff member told us the team worked well together and that it was a happy place to work. Staff told us they felt well supported by the acting manager. Staff said that while the acting manager was very busy, they still found time to support them.

Some staff told us they did not feel involved in the running of the service and were not always kept informed about people's needs. However, staff were keen to do their jobs and told us they enjoyed caring for people. One staff member told us "They (people) are all so lovely." All staff told us they felt there had not been

enough staff to enable them to care for people as they wished.

The acting manager had notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive care and treatment that met their needs and reflected their preferences. Regulation 9 (1) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff did not act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. Regulation 11 (1) (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate, support, training and supervision to enable them to carry out their duties. Regulation 18 (2) (a). There were not always sufficient numbers of staff employed at the service. Regulation 18 (1).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use service and others were not protected against the risks associated with their health and welfare. Regulation 12 (2) (a) (b).

The enforcement action we took:

The provider de-registered before enforcement action was finalised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had not been effectively operated to assess, monitor and improve the quality and safety of the service. Regulation 17 (2).

The enforcement action we took:

The provider de-registered before enforcement action was taken.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider had not acted in an open and transparent way in relation to care and treatment provided to people in carrying a regulated activity. Regulation 20(1)

The enforcement action we took:

The provider de-registered before enforcement action was taken.