Mr & Mrs T F Chon

Elmhurst Residential Home

Inspection report

7 Queens Road
Enfield
Middlesex
EN1 1NE

Tel: 02083663346

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 29 March, 12 and 17 April 2018 and was unannounced. At the last inspection in July 2017, there were two breaches of legal requirements about staffing levels and activities. Although staffing levels had improved since that inspection, we found neither requirement had been fully met. We also found additional breaches of regulations.

Elmhurst Residential Home is a residential home for up to 34 people with dementia. There were 19 people in the home at the time of the inspection.

The home had a registered manager. 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 home is run.

Elmhurst Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home was extended in 2017 from 14 people to accommodate up to 34 people. There were suitable facilities for people using wheelchairs including assisted baths, wet room and a lift.

There was a failure to provide safe care to some people as there was insufficient information about two people's medical conditions and some people were not being given their medicines safely as prescribed. The food was fresh and well presented but some people who were at risk of poor nutrition were not receiving enough support with and monitoring of their nutrition.

The governance of the home (by the registered manager and the provider) was not effective as they did not find and act on the concerns we found and some confidential information was not stored securely. They had also not notified us of events they are required to tell us about by law.

Relatives said they felt welcome and were generally positive about the service although some said they would like to see more interaction and activity. They said any concerns were listened to and acted on. Staff received training but did not receive regular supervision where they could discuss their work. Staff were happy working in the home.

There were risk assessments in place to help keep people safe in the home but some were not up to date. Staff knew how to recognise signs of abuse and how to respond.

Although staffing had increased since the last inspection there was no systematic way of assessing how many staff were needed on duty to meet people's needs as the provider did not use a dependency tool.

The registered manager, provider and staff were kind and caring and formed good knowledge of people's individual needs. Some care plans were of a good standard and reflected people's needs and wishes about their care. Others, especially for people who had stayed temporarily in the home, did not contain enough information for staff to provide good person centred care meeting all their needs. Some plans had not been reviewed regularly to ensure they were up to date.

People had good support with seeing the GP and other healthcare professionals when required. The standard of cleanliness throughout the home was very good.

There were six breaches of legal requirements found at this inspection. Two were continued breaches from the previous inspection as the provider had not improved the quality of activities and had not developed a system for assessing people's needs in order to ensure enough staff were available on duty. The other breaches were about safe care and treatment, meeting nutritional needs, failure to report significant events and ineffective governance.

You can see what action we told the provider to take at the back of the full version of the report. However, full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. There was no recognised system for determining how many staff should be on duty in order to meet people's needs.

Some risk assessments did not reflect current risks to people's health and safety.

Medicines were not being managed safely and some people were not getting their medicines as prescribed.

Staff knew how to identify abuse and the correct procedure to follow to report abuse. Pre-employment checks had been carried out to ensure staff members were suited to work with vulnerable adults.

The service was clean.

Is the service effective?

Requires Improvement

The service was not consistently effective. Although the food was fresh and well cooked, some people's dietary needs were not met and there was inadequate monitoring of food and fluid intake for those people who were at risk of dehydration and/or poor nutrition.

Staff had training but had not received enough training and supervision.

People's weights were monitored regularly. Staff supported them with maintaining their health and seeing healthcare professionals.

Is the service caring?

Requires Improvement

The home was caring. Staff treated people with respect and dignity. People were encouraged to be independent.

Staff had a good knowledge and understanding of people and their preferences.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Although some people had a personcentred care plan reflecting their needs and wishes, others had basic plans that did not reflect their needs. There was a limited programme of activities that people had not been consulted on and was not responsive to their needs.

Is the service well-led?

Requires Improvement

The service was not well led. The registered manager and provider had a good relationship with people and their relatives but the governance of the home was not effective.

The provider had not found and addressed the concerns we found about medicines, mealtimes, care plans and risk.

Confidential information was not stored securely.

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

The inspection took place on 29 March, 12 April and 17 April 2018 and was unannounced.

The inspection team comprised one inspector, an expert by experience and a pharmacist specialist (17 April). An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed all the information we held about the provider including notifications, complaints and safeguarding alerts.

We spoke with fifteen people living in the home to seek their views on the service provided. We met with two of their relatives and friends. We talked to the registered manager, deputy manager, a senior care assistant, two care assistants and one of the joint owners of the home. After the inspection we spoke with six people's relatives on the telephone to ask their views.

We carried out pathway tracking, where we read all the care records for a person and checked whether they were being provided with the care they had been assessed as needing. This included reading the needs assessments, care plans, risk assessments, health records and daily records of care provided for six people.

We observed staff interaction with people, activities, part of six mealtimes and medicines administration. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people when they may not be able to tell us themselves.

We looked at staff training and supervision records for the staff team, three months staff rotas and the staff files for three staff including their recruitment records. We looked at 16 people's medicines administration records. We also looked at records of staff meetings, quality monitoring records, medicines adults, fire safety

records and health and safety records relating to legionella, maintenance and servicing of equipment. We read the fire risk assessment for the home.

We also looked at records of activities taken place, the activities programme since the last inspection, menus, food and fluid monitoring charts, weight monitoring records, complaints, accidents, incidents and safeguarding records.

We met the local authority Care Home Assessment Team nurse during the inspection and we asked the views of the local authority commissioning and quality assurance teams.

Requires Improvement

Is the service safe?

Our findings

Although most people had up to date risk assessments addressing risks to their health and safety such as falls, nutrition, smoking and going out., the service did not always address the risks to people's health which left them at risk of receiving unsafe or inappropriate care. One person had a serious diagnosed medical condition. There was no mention of this medical condition in the person's care plan and no risk assessment for the condition. Health records showed that the service had called the GP to visit this person on two occasions in January 2018 as they were unwell but there was no record that they informed the GP of this person's medical history. We spoke with the person who told us they did not believe their diagnosis was correct so they decided not to follow recommended medical advice. Their file recorded that they had dementia and did not have capacity to make decisions about their care. There had been no capacity assessment regarding this medical condition. This had also not been carried out when we returned on 12 April 2018. We advised that the provider seek medical advice from the GP but two weeks later the second day of our inspection this had still not been done. This left the person at risk of harm.

We read the care file for another person with complex health needs. Their risk assessments were dated November and December 2017 and had not been updated since then. There was no risk assessment in place to detail current risks and to advise staff how to mitigate these risks to the person's health. Their care plan lacked information. There were three sentences written under the heading "medical condition." The assessment carried out by the local authority stated that they had two complex medical conditions both requiring high risk and complex medicines regimes and there was no information recorded about these regimes nor the symptoms of the conditions and what support staff needed to provide. This left the person at risk of receiving inappropriate or unsafe care.

Medicines were not managed safely as prescribed. Two people were prescribed steroid inhalers for the treatment of asthma to be taken twice a day and staff were only giving them their inhaler once a day. The registered manager could give no explanation for this. One of the two people had a chest infection and we had to intervene to tell staff to inform the GP of this error and to start giving the inhaler as prescribed and stated clearly on the box and medicines chart. Five people were prescribed regular topical emollient creams to be administered two or three times a day but they were only given once a day. There was no explanation given for this error. Failure to give medicines as prescribed put people at risk of health conditions worsening.

One person was being administered their medicines covertly (without their consent crushed in food). A specific mental capacity assessment for this task had not been completed to determine whether the person could consent to this. Although a GP had agreed to giving medicines covertly to this person, no best interest process or meeting had taken place and no planned reviews were documented or scheduled to ensure the ongoing appropriateness of covert administration. The only document staff had was agreement from the GP. They had not consulted a pharmacist to see if the medicines were suitable to be crushed. Staff told us all medicines were being crushed and administered in food or water. Three of the medicines were clearly labelled with the warning "do not crush." Staff had not consulted a healthcare professional for advice on how to safely administer the medicines covertly. No policy was in place at Elmhurst Care Home to support the covert administration of medicines. This practice put this person at risk of harm.

Another person was prescribed a high-risk medicine requiring frequent monitoring. The medicine was not signed on seven occasions in a three-week period and when we counted the tablets on 12 April 2018 to see whether the seven doses not recorded had been given, we found extra tablets which could not be accounted for. Staff had not recorded how many tablets were received in the home and the registered manager could not explain why there was an excess stock of this high risk medicine. This meant the provider did not have an effective system to ensure stocks tallied with records, and placed people at risk of not getting medicines as prescribed. Care plans contained no information about medicines. There was no guidance in place for staff to use to decide when it might be appropriate to administer "when required" medicines and some people were not able to explain their requirements which left one person at risk of being in pain.

Weekly audits of the medicines administration records were undertaken by the registered manager on 19 February, 27 February, 6 March and 25 March 2018. The records of these audits however, these failed to identify and act on any of the errors detailed above.

The above amounts to a breach of Regulation 12 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection the home was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A formal needs analysis had not been carried out to calculate staffing levels and staff had not been deployed effectively.

We found staffing levels had improved since the last inspection. There were now three care assistants on duty instead of two. The number of people living in the home had increased from 12 to 19 and five people did not receive staff support with their personal care. The registered manager worked Monday to Friday and there was a cook, cleaner and activity coordinator. Staffing at night had increased from one awake and one asleep on call to two staff awake on duty. Staff felt that currently the staffing level was adequate though said that a few months previously they had more people in the home and had struggled to meet their needs.

Relatives told us they thought there were not enough staff on duty. They told us,"Times when I go I don't see enough for the type of patients they have. I think there should be more than two or three, just in case. When we first went there were always a full amount of staff." and, "[The care is] OK. It's not good. They need more staff. There doesn't seem to be much interaction. They're clean, they feed them and they have drinks." Another visitor said, "They need more staff. They are constantly in the corner doing paperwork." At the previous inspection the provider told us that the cook supervised people in the evening but was not trained to do so. At this inspection they said the cook did not have to supervise people any more and their work was solely cooking and interacting with people to check their dietary preferences.

The registered manager helped with providing care. When the registered manager was on leave there was no extra support provided. On the first day of the inspection both the registered manager and activity coordinator were on leave but there was no extra cover provided. The deputy manager was carrying out manager duties whilst also on shift as one of the three care staff on duty.

The staff rota was poorly kept and not an accurate reflection of the staffing provided at the home. In the month of March 2018 there were five occasions where the rota indicated one night staff on duty and three occasions where there were no night staff recorded plus occasions where there were only two staff recorded to work in the evenings. The provider told us that staffing was never below three during the day and two at night and staff confirmed this but the rota did not.

We asked if a formal needs analysis had been completed to calculate staffing levels according to people's dependency needs. The provider had told us they would do this at the previous two inspections but had not done so. On the first day of the inspection this had not been completed. On the second day of the inspection the registered manager gave us a dependency tool which the provider had used to calculate staffing requirements. This document was not completed correctly and we were unable to understand it. The provider was unable to explain how they had calculated the staffing requirements of people in the home. Therefore, although the provider had increased staffing there were five people in the home who did not receive staff support with personal care and with current people in the home there were no staffing problems evident, it was not possible to confirm that there were enough staff to meet people's assessed needs as there was no system in place for doing so.

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

Personal Emergency Evacuation Plans (PEEPs) had been completed for people living at the home which contained information on how to evacuate people and the level of support people required to evacuate the building in the event of a fire. Regular evacuation drills had been carried out. An emergency grab bag containing the PEEPs, staff rota, torch, a high visibility jacket and next of kin details was available and the content checked weekly to ensure it was ready to use at any time.
Premises safety checks had been carried out. We saw evidence that demonstrated appropriate gas and electrical installation safety checks were undertaken by qualified professionals. Checks were undertaken on portable appliances and lifts to ensure people living at the home were safe.

People were protected by appropriate infection prevention and control practices. Communal rooms and bedrooms were very clean and tidy. Staff used gloves and aprons when providing personal care. People told us they were satisfied that the home was hygienic.

Staff and the registered manager were aware of their responsibilities in relation to safeguarding people. Staff could explain signs of abuse and who to report abuse to.
The home followed safer recruitment practices. We checked five staff records and these showed that relevant pre-employment checks such as criminal record checks, references and proof of the person's identity had been carried out when recruiting staff.

Relatives told us they thought their relative was cared for safely at the home. Comments included; "You can sleep at night. I'm confident [my relative] is safe." And, I can visit at any time so there is the element of surprise…. There are always staff in the main lounge keeping an eye out." Another relative said that their relative much safer in the home as they had fallen over at home and this had not happened since they moved to this care home.

We asked the provider for an example of where they had learned and made improvements after something went wrong. They told us that they had recently made improvements after a safeguarding alert regarding a person sustaining pressure ulcers whilst in the home. They had acted on the recommendations of the safeguarding social worker and started completing body maps when a person came to the home and left the home so that they could be sure they were able to spot any skin conditions which put the person at risk.

Requires Improvement

Is the service effective?

Our findings

People were not always supported with their nutritional needs. On the first day of our inspection we saw that one person did not eat any lunch nor have anything to drink. They said they were unable to eat the food (sausage) due to having no teeth. This person's care records showed that they had been assessed by a dietician for weight loss and remained underweight. The dietician's written advice stated that staff were to fortify their meals. The advice also stated that they be given prescribed supplements twice daily and be provided with milk and high calorie puddings between meals. There was no written evidence of this advice being followed. Staff members explained that the person did not like to eat much but did like Weetabix, crisps and ice cream. No alternative food and no drink were offered to this person at lunchtime. At teatime this person was given quiche, tomato, cucumber and lettuce which they did not eat. They had yoghurt for dessert but no other food was offered despite them having eaten nothing since breakfast. Staff said this was a normal pattern for this person and did not attempt to offer any snacks or foods they were known to like. This was a failure of provide suitable nutrition and hydration to sustain a person's health. This person's weight chart showed they were consistently losing weight since January 2018. The registered manager had not contacted the GP or dietician about this further weight loss.

The registered manager started a new food and fluid chart for this person on 29 March 2018. This was inspected on 12 April 2018. We found this was not always being completed and we found several gaps in recording. Charts showed the dietician advice had not been followed. There was no chart for the first week of April. We found another person who had a food and fluid chart that was not completed for 5 days in April. This failure to monitor a person's food and drink intake and to provide a diet in accordance with a dietician's advice put them at risk of malnutrition.

At lunchtime staff gave people a glass of water or squash. The glass held approximately 150ml of liquid. No jugs were available on the tables for people to help themselves to more drinks. Some people were not able to ask for more to drink and none was offered by staff. At the evening meal on 29 March 2018 there were no drinks on the table. Staff did not give people a drink with their meal. Staff gave drinks to those who asked for one. People were offered hot drinks after the meal but no water or squash with the meal. This was a failure to ensure people's hydration needs were met.

A staff member supported a person who needed help to eat their meal then left the dining room at each meal. Although staff came in and out of the dining room with plates of food and drinks for people no staff member sat down with people to encourage them to eat and drink well. This left people at risk of not receiving the support they needed to eat and drink enough. We discussed the lack of staff in the dining room with the provider and registered manager who said that the staff member giving medicines supervised the dining room at the same time. This was inappropriate as this staff member was required to concentrate on safely administering medicines.

On 12 April one person was eating in the lounge without supervision. We noted that they were eating baked beans with their hands and their face and hands had sauce on. A staff member said that was the way the person liked to eat as it was appropriate in their culture. Baked beans were not suitable to eat with the

hands. When staff at our request gave the person a spoon they continued to eat the meal with their spoon. This was a failure to support somebody to eat.

Two relatives said that the person's cultural food preferences were not met. There was a four-week menu and this showed little evidence of different cultural foods to reflect the tastes of people living in the home and there was no record kept of the meals cooked each day.

The above amounted to a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw meals were fresh and attractively presented. People's comments about the food provided included, "Ok", The food is alright."And, "The food is alright. I get it three times a day." One person said they didn't eat much but that they liked soup and toast and were given this every day. "We saw this to be the case. Relatives gave mostly positive feedback about the meals; "There's a west Indian chef. He asks [my relative] what she wants and he provides it. He will cook food that she likes.", "[My relative] eats proper meals: breakfast, lunch and supper. She enjoys her food. She takes time to eat and they are very patient."

At the time of the inspection staff were attending refresher training in medicines administration and prevention of pressure ulcers. Although staff individual files seen showed they had completed mandatory training we were not able to confirm that all staff had completed all required training. The training record sent to us was not up to date so we could not be assured that all staff had completed mandatory training. The registered manager told us that dates had not yet been booked for outstanding training but that they planned to do this soon after the inspection. Staff were not up to date with first aid training. Staff supervision was not taking place regularly for all staff. One of the reasons for this was that the deputy manager was expected to supervise a number of staff when they had no management time allocated to do so. A failure to ensure staff were suitably trained and supervised put people at risk of not receiving effective care. The registered manager informed us they had planned dates for supervision for staff and made immediate improvements when we raised this concern.

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

Each person moving to the home had their needs assessed by either the registered manager or the provider. Most of the assessments were then used to write people's care plans though we found an example where information in the assessment was not included in the care plan. We addressed this with the registered manager and provider.

Staff supported people to see healthcare professionals including GPs, chiropodist, district nurses, consultants and opticians. The service encouraged relatives to go to appointments with people but staff escorted people to their appointments if they needed to. A relative told us that the staff always contacted them if their father was unwell and discussed what action to take. Other relatives said that staff called the GP promptly when a person was unwell. Outcomes of the visits were recorded on people's individual records along with any letters from specialists. We observed health and social care professionals visiting the home. Each person's file contained a record of healthcare appointments so that they had history of their health and what action had been taken. The week before the inspection an optician had visited the home to carry out eye checks for those who wanted one.

The home had suitable adaptations assisted baths, wet rooms and a lift. The garden was not accessible to people as the provider had temporarily blocked it off for building purposes but there was a decking area

where people could sit outside.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 home was working within the principles of the MCA. People's files contained record of whether they had a DoLS and capacity to make decisions about their care and the provider requested a professional to come and assess a person's capacity if there was a complex situation. There was a record in people's files that they consented to being provided with care. Staff told us that they asked for consent before providing care and support to people. People told us that staff asked them for consent before they provided personal care. We observed staff asking people for their consent.

Requires Improvement

Is the service caring?

Our findings

The overall feedback about whether the service was caring was positive. One person said they would score the home "9 out of 10." One person told us; "The carers are very pleasant. Quite good at their job. When they speak to one of the patients they speak in English and use lovely words… "It's a nice place, this is."

Another said, "They look after me sometimes… Some care is good, some is bad." Two people said they felt that staff didn't spend enough time with them and they felt isolated. Two others who were in the home temporarily said they didn't feel cared for or well supported but felt some staff were kind and caring.

The registered manager said that staff always tried to keep people happy and that they encouraged staff to hug people where a person wanted this.

We observed staff acting in a caring way to people. They chatted and laughed with them. Staff also offered emotional support to people who needed it. We saw staff listening to people and giving two people a hug. The provider had a good relationship with people and they were happy to see her. We saw other staff interact positively with people. Staff showed they knew people's individual needs well.

The last residents' meeting was in February 2017 so there was no regular opportunity for people to get together as a group, to express their views and be actively involved in making decisions about their day to day lives in the home. People did not raise this as a concern to us. People's own views on their care were not always reflected in their written care plans. Four people said their wishes were not acted on.

One relative said that the service had helped a couple to be together in the home. They said that staff, "put themselves out more than they had to" and helped the couple to share a room and listened to relatives' views. Another relative said, "The staff are very patient. [My relative] is very slow at walking and they let her go at her pace and there is one person there to help and guide." A relative told us they had been involved in reviewing the care plan a few times. Another said, "I think the care is pretty good. "I think they are very helpful. They do talk to me about [my relative] if there is anything they are worried about e.g. not wanting to wake up in the morning sometimes. The staff are OK; understanding as well. I think [my relative] is happy [living at the home]. Before her dementia became worse she would say she was happy living there."

Relatives said there were no restrictions on visiting, they could visit any time and felt welcomed. One visitor said, "I like that they have an open-door policy that you can visit when you like." We saw relatives and friends arriving to visit during the inspection and staff talked to them to let them know how their relative was that day.

People's privacy and dignity was being maintained in their day to day lives. We saw staff were discreet when they assisted people to go to the toilet. One person told us, "They do whatever you need. They always ask permission. They don't just barge into your room. They always knock first and then they enter. They let you do what you can yourself; if you can't do it you tell them like., If I was in my room and I was stuck I would press the buzzer which goes straight to the command centre and someone would come straight down."

Staff supported people to be independent as much as possible. Where people could care for themselves, for example take a shower without help, they were encouraged to do so. There was a small kitchen area where people could store their own personal food and drink items and use them whenever they wanted.

Care plans did not fully address people's preferences relating to their culture or religion. Care plans contained sentences such as; "to support and encourage [name]'s wishes according to his religious and cultural needs" without specifying what these needs were. People came from a variety of cultural backgrounds but this was not reflected in the menu, music, TV programmes, activities or environment. We discussed this with the registered manager who said they were planning to improve this. They said they were going to display flags from the countries people came from and purchase appropriate music as well as provide more culturally diverse foods.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection there was a breach of regulation about person centred care as there was a lack of activities for people to engage in to be able to keep up with their interests. We found there had been little improvement since the last inspection. The provider had employed a new activities coordinator but they were away for a few weeks on the first day of the inspection and no arrangements were in place for people to have any activity during the day while they were away.

The activities coordinator returned to work for the second day of the inspection and we saw that they engaged with people in a responsive and kind way. We looked at the available records of activities taken place since the last inspection. This showed a group of five people usually took part in daily activities of seated exercises, seated ball games, art, puzzles and cards. People told us they wanted to do something during the day but would have preferred other activities. Two people said they took part in the exercises every day and enjoyed it but did not think the exercises were appropriate for them. We saw one person completing a children's puzzle. When we asked the registered manager and provider about the appropriateness of activities in place they said they had not devised a programme of activities with the activities coordinator and were not aware whether the exercise programme was appropriate. This was a failure to be responsive to the needs and preferences of individuals in the home for support to follow suitable leisure interests. Relatives told us they did not see activities taking place. Where people told us of their interests/hobbies they said they were not supported to maintain their interest once they moved to the care home.

One person told us, "You don't get much chance to talk to the staff. I don't think they're encouraged to anyway. They bring them down, feed them, make them walk into that room and put them in seats with no stimulation." Four people told us they were very unhappy at the home and felt very isolated and did not feel their wishes were being met. With their agreement we passed their concerns to social services so that a social worker could come to visit them.

A relative said, "There's not enough activity for [my relative] to do, it could be better. It would be good for the clients to be engaged a bit more instead of watching telly. I saw a sing song once which people liked." Two other relatives said they were concerned about a lack of interaction from staff who they thought could spend more time with people talking and engaging in interesting activities. We carried out periods of observation during two days of the inspection and saw that the majority of people had limited attention from staff and there was little stimulation for those people.

Care plans varied in format and content. Some people had comprehensive care plans reflecting their needs and wishes but others had a brief format that did not contain enough information about their needs. The registered manager said that when people stayed temporarily in the home they had a shorter care plan and if they then moved in permanently the care plan may not change. There was no evidence in some care plans that the person had been involved in expressing their wishes and needs. This meant people were at risk of not having their needs known and met.

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

There was a written life history for people so that staff could understand their history and background and use the information to talk to them. A priest visited one person weekly at their request and one person went to church independently.

The service had a complaints procedure and clear policy on handling written and verbal complaints. There were no recorded complaints since the last inspection. Relatives said that the registered manager was responsive if they had a concern and would listen to their suggestions and act on them. Two people said they would talk to the registered manager if they had a concern and they thought the registered manager would respond.

There were end of life plans in place, which included people's preferences with people's preferred funeral arrangements, family members to contact and where would they like to stay during the final stages of their life. The home had the support of healthcare professionals to advise and support when they were caring for a person at the end of life. A Do Not Attempt to Resuscitate (DNAR) Order was in place in people's files where this was appropriate.

Requires Improvement

Is the service well-led?

Our findings

The governance in the home was not sufficiently robust. There was a lack of oversight of risks to the health and safety of people living in the home and staff working there.

Medicines audits were ineffective. Despite the registered manager undertaking regular audits there were medicines errors and some people were not receiving their medicines safely as prescribed. This put people at risk of harm.

We saw staff carrying plates of hot food up the stairs from the kitchen in the basement to the dining room on the ground floor. This practice was not safe and staff were at risk of falls and burns. This practice also had an impact on the mealtime experience as meals were not served at the same time. Although there was a dumbwaiter available to use, staff were not using it. There was no risk assessment in place for the practice of carrying plates of hot food upstairs. This was a failure to assess and mitigate risks to the health and safety of people and staff working in the home.

We noted different formats of risk assessment and care plans in people's files. On the first day of the inspection the files were disorganised and these were better organised by the second day of the inspection two weeks later. However, some care plans had not been reviewed for six months to see if they still reflected a person's current needs. One person had complex health conditions but their care plan had not been reviewed since November 2017 so it was not possible to ascertain whether it was up to date. There was no system in place for regularly reviewing care plans with people. The registered manager said they intended to do this.

Despite there being a breach of Regulation 18 – Staffing, at the previous two inspections due to the provider's failure to introduce systematic way of assessing staffing needs, this had still not been complied with. Although staffing levels had been increased there was no assessment in place to determine whether staffing levels were sufficient. The home had fifteen vacancies at the time of the inspection so it was a concern that there was no system in place to assess when staffing needed to be increased again. The provider completed a dependency tool after the first day of the inspection which showed a lack of ability to follow a dependency tool. The instructions were not followed, it was not completed correctly and they were unable to explain it.

There was no management oversight of mealtimes and the monitoring of nutrition for those people at high risk of poor nutrition. Records of food eaten were not accurately kept and staff were not asked to support people to eat at mealtimes.

People's confidential records were not always stored securely. On 29 March 2018 people's confidential files were not stored securely. These were in the registered manager's unlocked office on top of a cupboard and on a shelf. Some files had labels on the spine saying "DNAR" – Do not attempt to Resuscitate. These files were in a cupboard on 12 April but this was due to the inspector's intervention who asked the provider to lock them securely away. On 29 March 2018 there was a piece of paper fixed to the kitchen wall with sticky

tape which recorded people's names and the contact details for their next of kin. This confidential information was accessible to the cook and to anyone who entered the kitchen. There was no reason for confidential information to be displayed on the kitchen wall. The provider removed this immediately when we pointed it out.

There had been no residents' meeting for a year so there was limited opportunity for people to be engaged in the planning of their day to day lives and suggest improvements in the service. The registered manager planned a meeting for shortly after the inspection. Relatives' meetings were also infrequent and the registered manager said they would arrange one shortly after the inspection. Relatives said that the provider, registered manager and deputy manager all responded to any concerns they had and engaged with them individually.

The above amounted to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The registered manager told us the home had a person centred culture. They said they encouraged staff to treat each person as an individual. They demonstrated a caring approach. Relatives said that the registered manager and deputy manager were responsive and good at keeping them informed of any changes affecting their relative. Staff were happy to work at the home.

The registered manager and the provider told us they were committed to continuous learning and improvement in the home. The registered manager said they had plans to update all records and to personalise all bedrooms this year. The provider said they would spend more time based at the home to support improvements in the areas that we identified. Both demonstrated a commitment to learning and improvement. The provider carried out audits and was aware that improvements were needed.

The provider and registered manager worked alongside professionals such as the district nurse, community matron and local authority and acted on the recommendations the professionals made. Examples of this were the creation of a second lounge, buying a sluice and updating staff training in medicines recently. Professionals said that the registered manager was caring.

The registered manager and provider had not notified us of events which they were required to notify us of by law. This was a breach of Regulation 18 of the Care Quality Commission Regulations 2009.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents There was a failure to notify the Commission of notifiable events, specifically two safeguarding alerts and a serious injury.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider did not ensure that appropriate activities for people's age, abilities and interests were organised and provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was no system in place for determining staffing needs and staff were not receiving regular supervision.

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 There was a failure to properly assess the risks to the health and safety of two people receiving care or treatment and do all that was reasonably practicable to mitigate the risks to them. There was also a failure to ensure proper and safe management of medicines.

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs There was a failure to meet some people's nutritional and hydration needs.

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The governance systems in place failed to effectively assess, monitor and mitigate the risks relating to the health, safety and welfare of people. There was also a failure to securely store confidential information.

The enforcement action we took:

warning notice