Deepdene Care Limited

Prema Court

Inspection report

Clifton Court
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Prema Court (formally known as Clifton House and Brook House) on 4 and 5 October 2018. The first day of the inspection was unannounced. This meant the service did not know we were coming.

Prema Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Prema Court is owned and operated by Deepdene Care Limited and is registered with CQC to accommodate up to 44 people. At the time of this inspection, 33 people were living at the service with enduring mental health needs.

Accommodation is arranged over two units; Clifton House and Brook House, which were formally registered as a hospital. In April 2017 the provider made changes to their registration and service delivery, as Clifton House incorporated Brook House Hospital as part of their registration. This location is now called Prema Court. Brook House is a specialist unit within Prema Court providing nursing care and rehabilitation support for up to 12 adults experiencing high and complex mental health needs.

Our last inspection of Clifton House took place on 11 and 12 July 2016, when we rated the service good, with the well-led domain rated requires improvement.

At this inspection we identified seven breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. We also found a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We have made three recommendations.

You can see what action we told the provider to take at the back of the full report. We are currently considering our options in relation to enforcement in response to some of the breaches of regulations identified. We will update the section at the back of the inspection report once any enforcement work has concluded.

The service had a registered manager who had been in post for over seven years. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was also supported by a deputy manager.

The premises were not maintained to a safe standard. During our tour of the premises we found the fire exit in the dining room was open, which led to an unsecure garden area, this potentially compromised people's safety. A small number of people were under restrictions and were not free to leave the home independently, however the fire exit leading to an unsecure garden meant the provider could not assure people's safety.

We noted some areas of the home that would benefit with being refurbished or re-decorated. The décor around the home appeared tired; the paintwork was scuffed and the carpets in high traffic areas of the lounge and downstairs corridor were showing signs of wear and discoloration. We discussed this with the registered manager who acknowledged our observations, but did not provide assurances that the home would be refurbished going forward.

The management of medicine was not always safe which put people at risk. The records about the stock and administration of medicines were kept electronically. When audits were done using these records they did not evidence that medicines were always administered as prescribed or could be properly accounted for.

Staff were not always working within the principles of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Information about people's care was not always being communicated effectively between staff.

The home did not comply with either the Mental Health Act 1983. We found there was an inconsistent approach detailing people's Community Treatment Orders (CTO's). We found several CTO's that had expired and the provider had not been proactive at making sure these orders were still relevant.

Care plans were not always detailed and lacked guidance around people's diagnosis. The service had not ensured people's care plan reviews were clearly signed by the person to confirm their involvement. Action to fully meet the accessible information standard were not always in place to provide assurances people's communication needs would be met.

There was a robust recruitment processes, safe levels of staff that were always maintained, and staff protected people from the risk of abuse. There was a business continuity plan in place for staff to follow in the event of an emergency.

We received mixed views on the food and found the dining experience could be improved. People were supported to maintain their health and had access to health care professionals.

People told us staff were caring. We found that staff had a good understanding of people's likes and preferences. However, we observed staff not always taking the opportunity to interact outside of providing support with a task.

Everyone we spoke with was happy with the activities and events provided.

Before people moved in to the service a full assessment of their needs took place. However, we found the provider did not complete this process for one person.

Complaints were recorded and responded to. People were supported with their health needs and had access to a range of health care professionals.

There was a lack of systems to monitor and improve the quality of the service. We found governance systems were incomplete and not sufficiently robust to ensure best practice was followed and compliance with regulations.

The overall rating for this service is 'Inadequate' and has been placed into 'special measures.'

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

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

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?

Inadequate

The service was not safe.

Medicines were not all managed effectively.

The premises were not maintained to a safe standard. We found the fire exit in the dining room was open, which led to an unsecure garden area.

We noted many areas of the home that needed refurbishment. We found stairs carpets were stained and the curtains in some people's bedrooms needed cleaning or replacing.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider was not meeting the requirements of the Mental Capacity Act 2005.

People had mixed views about the food at the service.

Staff received an induction, training and appraisal to help them to support those who lived at the home. However, the provider needed a better overview of when staff training updates were due.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff interactions were caring, but were often task orientated.

Staff did treat people with dignity and we did see occasions where staff were kind and attentive.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records, including those relating to identified risk, were not always complete, accurate or updated when people's needs

changed.

People were positive about the activities on offer.

Suitable arrangements were in place for the reporting and responding to complaints.

Is the service well-led?

Inadequate

The provider did not have effective systems and processes in place to monitor and improve the quality of service provided.

Robust systems had not been implemented to mitigate risks and the management of the home did not adequately support staff to deliver safe care.

Notifications about authorised DoLS had not been made to the CQC as required.

Prema Court

Detailed findings

Background to this inspection

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

The inspection was unannounced and was undertaken on 4 and 5 October 2018. The inspection team consisted of two inspectors, a medicines inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Due to the timeframe in which this inspection was completed, a Provider Information Return (PIR) was not requested to support us with our inspection planning. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, we reviewed information we already held in the form of statutory notifications received from the service, including safeguarding incidents, deaths and serious injuries.

We contacted Trafford local authority, and Healthwatch (Trafford) to obtain their views about the quality of this service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. All of the comments and feedback received was reviewed and used to assist and inform our inspection.

During the inspection we spoke with 14 people who lived at the home to seek their views. We spoke with 11 members of staff including five care workers, two senior care workers, the nurse on duty, the registered manager, deputy manager, and the activities coordinator. We spoke to a health professional who visited the home regularly.

We spent time looking around the home at the standard of accommodation. This included the communal lounge and dining areas, bathroom facilities, the kitchen, laundry and a number of people's bedrooms. We carried out observations in communal areas of the service. We looked at five care records, a range of documents relating to how the service was managed including medication records, three staff personnel files, staff training records, duty rotas, policies and procedures and quality assurance audits.

Inadequate

Is the service safe?

Our findings

We found the premises were not secure which meant vulnerable people were at risk of leaving unnoticed and potentially coming to harm. A small number of people who live at Prema Court had been assessed as requiring locking systems on the exit doors to keep them safe and to protect them from harm. We saw records that confirmed one person who lived at the home was not free to leave due to their vulnerability and being subject to a Deprivation of Liberty Safeguards (DoLS). We received a statutory notification from the provider in August 2018 which indicated the Police were called due to this person leaving the home unwitnessed, as they left via the emergency exit in the dining room. This person was safely found by the Police shortly after. However, during our tour of the premises we found the fire exit in the dining room was open, which led to an unsecure garden area. This unsecure garden area had a second small smoking area, located close to the car park at Prema Court. This meant people at the service could leave if unwitnessed by staff. We were told by a member of staff that people living at the service frequently used the fire exit as a short cut. We saw this risk had not been dealt with appropriately by the management team and no risk assessments were in place. This placed people at risk of harm as the provider failed to promote the safety of those who lived at Prema Court.

During the inspection, the registered manager introduced signage and 15-minute checks to remind people and staff not to use the fire exit, unless there was an emergency. Shortly after the inspection the registered manager informed us the provider had an engineer at the home to assess the unsecure garden area to have this section fenced off.

The management of medicines was not always safe which put people at risk. We found concerns about the safe management of medicines for all 12 people whose records we reviewed.

We found medicines management policies and procedures were in place dated July 2018. Although staff had access to information about medicines, the medicines policy was not always being followed by staff and aspects of the policy needed updating.

The records about the stock and administration of medicines were kept electronically. When audits and checks were done, using these records did not evidence that medicines were always administered as prescribed or could be properly accounted for. When discrepancies in the amount of medicines that should be in stock for people and the actual stock in the home were found, no investigations were made to find out why the discrepancies had occurred. Furthermore, the medicines policy made no reference to the use of the electronic system of medicines management. The policy still referenced that the service was using a paper based system. This meant the provider did not have a robust policy and procedure in place that guided the staff team around the use of the electronic medicine system and in terms of how the provider was to undertake audits of the medicines at the home.

Two people were prescribed medicines that were to be given "when required" for agitation. However, there was no guidance for staff to follow so they could determine under what circumstances to give these medicines to ensure they were given safely and consistently. We asked the registered manager why "when

required" guidance was not in place, the manager told us this wasn't used due to the electronic medicines system.

Another person was prescribed pain relief where there was a choice of dose. No information was recorded to guide staff when to choose the higher or lower dose to ensure the pain relief was given safely. This meant there was a risk staff did not administer people's medicines in a consistent manner.

One person needed to be given their medicines covertly by disguising them in food or drinks. Information from the pharmacy was available indicating how the medicines could be given for all but one of their medicines. This meant that one medicine may not be given safely. There was also no evidence that this guidance was being followed and there was no practical guidance as to how each individual medicine was given to the person.

We looked at one person's hospital discharge which listed all their medicines and the times they should be taken. When we looked at the times one of their medicines was given it did not match the prescribed times on the discharge document. No evidence could be found to show that any changes had been made to the dose times following their discharge from hospital. If medicines are not given at the times they are prescribed they may not be effective in relieving the symptoms they were prescribed for.

We saw that three people were prescribed medicines that must be taken before food. We saw that all three people were given these medicines at the same time as their other medicines, which must be given with or after food. If medicines are not given at the correct time regarding food they may not work properly.

The records showed that three people missed having one or more of their medicines for up to three days because they were "awaiting delivery from the pharmacy". If people miss having doses of their prescribed medicines their health could be placed at risk of harm. We found records were not being done to check the temperature of the room. The temperature is important as it can affect the fitness for use of certain medicines.

Staff with responsibility for medicines understood the processes for ordering, storage and disposal of medicines. Staff with responsibility for administering medicines had been trained in medicines administration and management; however, the registered manager informed us that the five nurses employed had not received their annual medicines competency observation. Observations of staff competency help to ensure staff are competent in their roles and understand the provider's medicines policies and practices. Not all staff had been assessed as competent to administer medicines.

Most medicines were stored securely and safely however unwanted waste medicines were not stored properly. The bins containing the waste medicines were not locked away as advised in the current National Institute for Health and Care Excellence(NICE) guidance to prevent misuse of medicines. We also found an oxygen cylinder in the medicines room was not secured or chained to the wall, the Health and Safety Executive guidance 'Oxygen use in the workplace' states; cylinders must be chained or clamped to prevent them from falling over.

The above matters in relation to the environment and medicines are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we pointed out that the service had out of date electrical installation conditions certificate at Brook House and a re-inspection was due in October 2017. Although the regulations of the Electricity at Work Regulations 1989 do not require electrical testing to be carried out, it is required in law

that providers must ensure the homes entire electrical systems are safe at all times. Regulation 4(2) of the Electricity at Work Regulations 1989 states: "All systems to be maintained so as to prevent, so far as is reasonably practicable, danger." This meant the provider had not taken the timely action in arranging the next electrical installation conditions inspection to ensure best practice was followed and adhered to. The registered manager provided us with an email giving assurances that the electrical installation conditions inspection would be completed on the 8 October 2018.

We found the premises and equipment was not always maintained appropriately to keep people safe. At our last inspection in July 2016 we were encouraged to see that the provider had made a number of positive changes within the home, such as the introduction of new bathing facilities on the first and second floor and we found the kitchen had been upgraded in terms of cookers, ventilation and gas safety equipment. We were assured by the registered manager the home was planning a number of refurbishments to ensure the building was fit for purpose and able to meet people's needs.

Although the service employed a maintenance staff member, we found that this was not effective at the service. During our tour of the premises at this inspection we noted that various appliances and facilities were known to be broken but had not been fixed in some time. We found an unused fridge and washing machine being stored within the service, which the registered manager told us were not working and due to be taken away. We found two old sofas that were due for the tip being stored close to the smoking area, which were covered in cigarette stubs and in poor condition due to the weather. A staff member raised this with us, as some people would sit on the sofas, and they felt this was not dignified. We found the shower room on the second floor was not working, which meant people had to use the other bathing facilities within the home. It was not clear when this would be fixed, due to no record of this in the managers audits. We found a number of window handles in communal areas were broken off which meant that the windows could not be opened. The registered manager told us that this had been reported previously, but did not know why it had not been addressed.

Furthermore, we found the outdoor yellow clinical waste bin was unlocked, and visible from the main road. We brought this to the registered manager's attention who told us the lock was no longer working on the bin. The registered manager said they would order a new clinical waste bin, however we found the provider had not considered the significance of ensuring this always remained locked when not in use. The Department of Health guidance states that: "Where the waste is stored for any period (that is, up to 24 hours), it should be stored securely and access should be restricted to authorised and trained personnel." The provider had not taken reasonable steps to ensure the clinical waste bin was stored securely.

As the environment had not been well maintained which did not promote safe care this is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at systems in place to ensure the environment was clean and to reduce the risk of outbreaks of illness and infection.

We saw that the service had an infection control policy and procedures. These gave staff guidance on preventing, detecting and controlling the spread of infection. They also provided guidance for staff on effective hand washing, disposal of contaminated waste and use of personal protective equipment (PPE) such as disposable gloves and aprons.
During the course of our inspection we toured the premises and found in general the environment to be of a satisfactory standard of cleanliness. However, infection control practices could have been better in some areas. For example, we noticed the small communal kitchens had not been cleaned fully with cooking equipment left on chairs.

Emergency plans were in place at the home and systems and equipment had been serviced in accordance with manufacturers' recommendations. However, the home had no records of fire drills that had taken place in Clifton House. Staff we spoke with could not recall the last fire drill they took part in. One staff member said it was over a year ago. We advised the registered manager of our findings who told us they would organised a session to show staff how to use the evacuation equipment. We noted the last fire drill undertaken in Brook House was in April 2017.

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. There was guidance and policies available to remind staff of the correct procedures and who to contact if they suspected abuse.

We observed that there were enough staff to meet people's needs throughout the day. The registered manager told us that they used bank staff or staff picked up overtime to cover any shortfalls on the rota due to sickness or vacancies for permanent roles. We checked the rotas and found that there was always the safe level of staff on duty.

Comments from staff included: "I feel we have enough staff on duty, in the past we struggled but the staffing levels are fine now" and "We very rarely use agency staff, we have a good team and comfortably support people."

Risks to people at the home were regularly assessed and reviewed. General environmental and specific risk assessments were completed. We found risk assessments in place in the electronic care plans we reviewed around mental health, physical health, maintaining a safe environment, social well-being, moving and handling, and other aspects of personal care.

We looked at the records of three newly recruited staff to check that recruitment procedures remained effective and safe. We found prospective new employee's completed application forms and the information provided included a full employment history and pre-employment checks had been carried out. These included Disclosure and Barring Scheme (DBS) checks, health clearance, proof of identity documents, including the right to work in the UK, and two references, including one from the previous employer. The DBS helps employers make safer recruitment decisions and aims to prevent unsuitable people from working with vulnerable groups.

Accidents and incidents that took place in the service were recorded by staff in people's records. Such events were audited by the registered manager. This meant that any patterns or trends would be recognised, addressed and the risk of re-occurrence reduced. Records showed actions had been taken following these audits to help reduce risk in the future. For example, the needs of a person had increased to a level where the registered manager had agreed with professionals the placement was no longer safe. The registered provider worked with the person and family as well as professionals to seek a more suitable placement.

Requires Improvement

Is the service effective?

Our findings

Prema Court is arranged over two units; Clifton House and Brook House, which was formally registered as a hospital. In April 2017 the provider made changes to their registration and service delivery at Clifton House incorporated Brook House Hospital as part of their registration.

During the inspection we found little evidence to suggest Clifton House and Brook House were now one location 'Prema Court'. Signage around the building still advertised both services as separate entities and the registered manager was not clear in terms of the care model the provider was delivering to people, as we found both client groups assessed needs were similar. The provider's statement of purpose indicated Brook House is a specialist unit within Prema Court providing nursing care and rehabilitation support for adults experiencing complex mental health needs, including those with forensic histories, and Clifton House is a service specialising in adults experiencing severe mental health needs who currently need ongoing extensive support, which may not be available in other environments. In discussion with the registered manager, they told us both services are very similar and currently there was not a clear distinctive care model in place. The registered manager acknowledged aspects of the building had not been changed over to make the people and visitors aware the service was now called Prema Court.

We recommend the registered provider reviews the service delivery model at Prema Court to clearly set a defined structure of the service.

We noted many areas of the home, particularly in Clifton House needed refurbishment. For example, stairs carpets were stained and the curtains in some people's bedrooms needed cleaning or replacing and some communal chairs needed replacing due to rips in the cushions. We noticed areas around the home would also benefit from re-decoration. The décor throughout the home appeared tired; the paintwork was scuffed and the carpets in high traffic areas of the lounge and downstairs corridor were showing signs of wear and discoloration. We discussed this area with the registered manager who acknowledged our observations, but did not provide assurances that the home would be refurbished going forward and there was no planned programme of refurbishment in place.

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

People can only be deprived of their liberty so that they can 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). During this inspection we checked to see if the service was working within the principles of the MCA.

Staff we spoke with did not have a clear understanding of MCA and DoLS. The staff we spoke with were not

clear who had a DoLS in place. One staff member told us, "I believe DoLS is about whether we think someone is being abused." Another staff member told us, "I have a rough idea about DoLS, but I would be guessing to be honest, which of the resident had one in place." We found this was particularly concerning, considering the service supports people with enduring mental health.

We viewed the a DoLS tracker which detailed people's DoLS status and applications to the local authority. However, we found the DoLS file was in a poor state and not easy to navigate. We spent time looking at people's DoLS applications and were generally satisfied the appropriate DoLS were being applied. However, we found one person who had been at the service just under four weeks had not yet received a mental capacity assessment by the provider, even though the staff team felt the person lacked mental capacity to make certain decisions, such as leaving the home independently. We found no DoLS application had been made within the four weeks the person had been at the home. We asked the registered manager why there had been a delay, which they could not answer.

Some of the people using the service were restricted by provisions under the Mental Health Act 1983 (amended in 2007) (MHA), such as Community Treatment Orders (CTO). CTOs enable people to live under supervision in the community. A CTO is part 17A of the Mental Health Act; this allows people to leave hospital and be treated safely in the community rather than hospital.

We found the management of people's CTO's were poor and needed urgent action from the provider to resolve. We were informed by the registered manager the service had a separate file which detailed people's CTO's. We viewed this file and noted four people who were subject to a CTO at Prema Court. However, we found the paperwork confirming people's conditions had all expired or did not clearly reference when the CTO was due to expire. For example, one person's CTO had expired in February 2017, but the care staff and management team were telling these people their CTO's were still in place. The provider introduced a form called 'record of patient' rights MHA 1983 amended 2007' in which people were notified of their rights under the section of the mental health act. Although this was good practice, we found this process was fundamentally flawed, due to the service and people not having a clear idea if their original CTO was still in place. We were provided with a thread of emails which provided some assurance the home had asked for updates. However, the process for ensuring people's rights were protected were not robust and did not protect people or act in accordance with the Mental Capacity Act 2005 or Mental Health Act 1983. During the inspection we spoke with one person who made us aware their CTO had expired and they were concerned that the paperwork was no longer current. They told us, "I am not happy to be honest, the home is expecting me to sign my CTO when I know for a fact the CTO is out of date."

We also found that there was an inconsistent approach detailing people's CTO's in their care plans to ensure staff are aware what the conditions or restrictions were and how they should be supported to meet them.

The home advertised in the reception area the support of an independent mental capacity advocate (IMCA) when a person needed support with a specific decision. However, we found the provider missed the opportunity to provide people with this level of support. We asked one person whose CTO had expired if they felt supported or were offered the opportunity to have advocacy support. They told us, "Maybe in the past, but at the moment it's just me dealing with it and nobody here has a clue about the section I am on. It would be good to get some help with this, it's making me very upset."

This was a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the most recent local authority food hygiene inspection of Prema Court, the service was awarded a food

standards agency (FSA) rating of 'one star' which meant major improvement necessary. We discussed with the registered manager why the home received such a poor rating. We were told, this was due to poor basic food hygiene practices on the day of inspection from the previous home chef. The provider replaced the chef and the inspectors from the FSA revisited and the registered manager said they were satisfied that the appropriate action had been taken to ensure the cleanliness of the kitchen and recording keeping was improved.

During the inspection we observed the lunch time experience on Brook House. Whilst Brook House did have a commercial kitchen, staff told us this was no longer operational and meals were prepared in the main building and then brought over to Brook House in a heated trolley. It was then the responsibility of care staff to serve the meals and then clean-down after mealtimes.

Five people who used the service were seated in the dining room and we were told by staff the other people had either gone out or had chosen to eat in their room. Each person seated in the dining room was eating a jacket potato with a filing of either baked beans and/or cheese; we did not observe an alternative choice being offered. We also found cold drinks were not provided at mealtimes. Two people who used the service told us they purchased their own cans of pop to consume at mealtimes, otherwise they told us they would go without. We saw an area had been made available in the dining room for people to make their own hot drinks, but this system was reliant on people being sufficiently independent to make a hot drink without support.

We noted the menus displayed in communal areas were dated spring/summer 2016 and no up-to-date menus were displayed or available at the table. However, information was displayed regarding breakfast options which mainly consisted of cereal and/or toast during the week, with a cooked breakfast option only available at weekends. People who used the service told us they had no idea what the lunch and evening menu looked like and that they were simply told on the day what they would be having. Comments from people included, "We're offered little to no choice, we get what's given to us."; "I've complained about the food and raised it at residents' meetings but nothing is done. The quality of the food is awful."; and, "Those people who are allowed to go out alone are lucky, it means they can eat out, I'm stuck here so have to put up with it."

We found the overall mealtime experience was poor and the needs of people with additional dietary needs were not being met. The service viewed mealtimes as a task rather than an experience to be enjoyed by people who used the service that sought to promote good health, nutrition and well-being.

This is a breach of Regulation 14 of the Health and Social Care Act (Regulated Activities) Regulations 2014 with regard to meeting nutritional and hydration needs.

The registered manager did not have effective systems in place to monitor training to ensure staff had up to date training. On the first day of inspection the registered manager advised that the training matrix was stored over two matrices, which contained staff who had left the service and had not been fully updated. We provided the registered manager an opportunity to ensure the service updated the matrices fully to establish a clearer picture of what training was outstanding.

Shortly after the inspection we were provided with an updated matrix and we were assured that the majority of staff had completed key training, but some of the training was overdue in terms of when the provider sets their own refreshers courses or online training for staff to complete. The registered manager told us they often remind staff, but acknowledged better management of the training was required.

We looked at the induction process used by the service for new staff. The home's documentation included the Care Certificate, which came into being in April 2015. The Care Certificate is a set of induction standards against which the competency of staff who are new to health and social care can be assessed.

Supervision records were evident on the staff personnel files we saw, which showed structured sessions had been held at intervals. This enabled staff to periodically discuss any concerns, training needs and personal development with their line manager. However, the supervision form was generic and lacked individualisation.

Assessments of people's needs were completed before they moved into the service. This was done to ensure that the service could meet their needs. Before people moved in they were also encouraged to visit the service, look around and meet the other people currently using the service. This ensured people had a good understanding of how the service operated before choosing to move in. It also gave people an opportunity to observe staff interacting with people and gain an understanding of how the service operated, its rules and procedures. However, we found the service failed to complete a pre-admission assessment for one person who was urgently admitted to the home. Although, this was understandable the service still should have ensured a detailed assessment was undertaken to capture the person's requirements.

We recommend the registered provider reviews their pre-admission assessment process to ensure a detailed person-centred approach is undertaken to safely capture people's assessed needs.

Requires Improvement

Is the service caring?

Our findings

We found that although people made positive comments about staff, the staff were not supported by the provider to deliver a wholly caring service. Due to the shortfalls we found at the service, the ability of staff to provide a holistic approach to people's care needs was constrained due to ineffective medicines systems, the environment not always being safely secured to minimise risk and ineffective governance and leadership. This meant that people were not always at the centre of the care they received.

We observed that staff were kind and caring when interacting with people, but did not always take the opportunity to interact outside of providing support with a task. For example, after the lunch time service, we observed two care workers in the kitchen cleaning. This took them away from providing support to people. We observed one person telling the two staff members they felt anxious and asked to speak to one of the staff. The person was redirected away from the kitchen because staff were busy cleaning. We went and sat with the person and talked to them for 15 minutes. The person's care plan detailed they require additional 1:1 support due to levels of anxiety. We provided feedback to the registered manager who informed us this was disappointing to hear and the staff will be spoken to, as this poor practice was not acceptable.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Person-centred care.

People were supported and involved in planning and making decisions about their care. We saw that where they were able to, people had been involved in the development of their care plans, however we found these had not always been signed by the person. The registered manager told us this was an area the home was going to focus on going forward. People were also able to take part in resident's meetings which included them in decisions about the way the home was run.

Staff we spoke with demonstrated a good knowledge of people's personalities and individual needs and what was important to them. Through talking to staff and members of the management team, we were satisfied care and support was delivered in a non-discriminatory way and the rights of people with a protected characteristic were respected.

Protected characteristics are a set of nine characteristics that are protected by law to prevent discrimination. For example, discrimination based on age, disability, race, religion or belief and sexuality. However, to fully embed the principles of equality, diversity and human rights we recommend the service consults the CQC's public website and seeks further guidance from the online toolkit entitled 'Equally outstanding: Equality and human rights - good practice resource.'

People spoken with confirmed that they were given privacy, respect and dignity. Staff were seen to provide appropriate care and support in a timely manner during the two days of our inspection and were observed to knock on people's doors and wait for a response before entering people's bedrooms. Likewise, when personal care was needed, this was given in privacy either in the person's own room or bathrooms.

Personal and confidential information relating to people who used the service was kept secure. This included hard copy files being stored securely in lockable cupboards and information held electronically was password protected with only relevant people having authorisation.

Requires Improvement

Is the service responsive?

Our findings

Since our last inspection the provider had purchased a new electronic based system for care and support planning. The new system enabled staff to input information against a variety of key topic areas which created both a summary care plan and extended care plan. However, we found the electronic care plans were predominantly clinical and task based in nature and lacked any meaningful person-centred information. For example, each care record contained a profile page with sub-headings for topics such as 'my daily routine' and 'my preferences', 'likes and dislikes.' In the care records we viewed we found such information to be very limited.

Additionally, insufficient information was recorded to indicate whether or not a person had chosen to not share this type of information with staff. Linked to this, we also found insufficient evidence to demonstrate how people who used the service and/or their lawful representative had been involved in the care planning process. This included evidence to demonstrate who had participated in reviews or evaluations of care.

Despite the provider now using an electronic based system for care planning and support, we found paper based records were still maintained and information was recorded and stored across a variety of systems. This meant eliciting the most up-to-date and relevant information concerning a person's care and support was difficult. For example, one person who used the service was subject to a Community Treatment Order (CTO) but the actual order was not visible to view via the electronic system. We asked a nurse about this and we were told the information was held in a separate paper based file in the office. However, the CTO was not present in the file. Later it emerged despite the CTO being current and still relevant, it had been filled in an archive. We spoke with the deputy manager about this and we were told not all staff were competent and experienced users of information technology, including how to scan documents to the electronic based system, which meant paper based records were still maintained for many aspects of care and support planning.

A further example of poor care planning included, a person who was deemed by the provider as being at risk of eating and drinking. We looked at this person's care plan which indicated they were on a 'soft diet', however the section called 'nutrition and hydration' had not been completed. We did find some limited information captured in this person's care plan sub headed 'Physical Health and Risk Assessments' which indicated they liked foods such as milkshakes, ice cream and bananas. The registered manager told us the home had little information on this person due to taking on their care package as an urgent admission. We found this person had been at the service just under four weeks, and we would have expected much more personalised information recorded in this time. We found the provider had not been proactive at ensuring this person's needs were appropriately assessed to ensure they were receiving person centred care. We found no decisive action had been made by the registered manager to ensure this person was seen by their GP, or to establish if a referral to the SALT (Speech and Language Therapist) was required. This meant that the correct level of support required by this person was not assessed or documented, to ensure care staff would understand how to meet their needs.

Additionally, we found the registered manager was not aware of June's 2018 NHS patient alert in relation to

resources to support safer modification of food and drink. The service had not been not proactive at ensuring they were following best practice.

We asked the registered manager what actions they had taken to meet the accessible information standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information they can access and understand, and any communication support they need. They told us if people required information in large print for example, this could be arranged for them. Whilst we saw care plans were in place for people's communication needs, we did not see how this had been extended to assess what format people would require information in. For example, information such as the complaints procedure and their care plan to facilitate their involvement in it. We noted one person had a learning disability and we found the provider had not been proactive at ensuring this person's care plan was in a format they understood.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Person-centred care

At previous inspections we found people did not have aspirational care plans which set out their goals and ambitions in terms of rehabilitation and recovery or what the next step was in terms of accommodation and personal independence. At the last inspection we found the provider had made progress and developed their care plans and approach to meeting people's aspirational goals.

At this inspection we found the service was steadily making improvements in this area, but better recording of people's outcomes were required. We were informed by the registered manager a small number of people since our last inspection have moved on from the service to living independently with minimal support in the community. We viewed one person's care plan who had been identified for a potential move to supported living accommodation. We found this person's care plan contained a section about their aspirations in terms of moving on, and what they needed to do to reach this outcome. We were informed by a care worker this person had done very well, but was struggling with their cooking skills. We asked had the staff been recording the person's progress in terms of establishing if they were improving in this area. We were told there was a form, but staff were not always completing this and we found from the electronic care planning system we viewed there was not a clear audit trail. We discussed the importance of having an appropriate recovery model in place with the registered manager to clearly record people's progress. The registered manager acknowledged this was an area that better recording was needed.

The activities coordinators continued to focus on providing group activities and one-to-one sessions for people. These sessions consisted of: art and crafts drop in; good mood food drop in; baking group; coffee mornings; one-to- one cooking sessions and on average a monthly organised trip out. People told us they received a weekly planner of activities and a list of trips outside the home. One person told us, "The trips out are good, I like the trips to the snooker halls."

We spent time with the activity coordinator and found them to be enthusiastic and committed to providing meaningful activities for people. An activities planner was seen displayed on several walls around the service. One staff member, told us "Motivating the residents can be hard, but those who want to take part there is always something taking place." We found activities for those people who didn't always engage was lacking, we observed one person in Brook House regularly approaching staff for interaction, but we found staff did not always take time to engage with this person fully.

On each of the floors in Clifton House there was a satellite kitchen which we were told people could access to make themselves drinks and snacks if they wanted to and to learn independent living skills such as

cooking. The activities coordinators supported people to develop these skills. One of the activities coordinators told us, "We are always trying to encourage the residents with their cooking skills. We will give the resident a budget of £10 from petty cash to buy ingredients in the shop and we will check they have budgeted correctly and observe them cooking the meal. Some of the residents are making good progress."

We found meetings were held for people using the service and/or their relatives or representatives every month. These meetings predominately looked at the activities that were taking place.

At the time of our inspection there was no one receiving end of life care. At the last inspection we found there was not a designated section incorporated within the care plans that discussed people's wishes for their end of life care. At this inspection we found people's end of life care choices were now recorded in their assessment of need. The registered manager confirmed a section would be included within the care plan to ensure this area was clearly evidenced.

The service had a complaints policy and this was distributed in the service user guide. Since the last inspection, a log of complaints was in place. The registered manager had received one complaint which was investigated and the action that had been taken was clearly recorded.

Inadequate

Is the service well-led?

Our findings

The home had a registered manager who had been in post for over seven years. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. The registered manager was also supported by a deputy manager.

Staff told us they felt well supported by the registered manager, but felt the morale within the home was very low. Comments included, "[Managers name] is doing his best, but I don't believe we are properly supported by the owners. You only need to look around, the homes décor is in a right state", "I love my job, but not sure how long I can remain here. The owners will not allow the staff to book any annual leave until we get the shifts covered. I have never had this problem before, now I feel like I can't use my leave", "This home could be so much more, not sure if it's a money issue, but sometimes I am embarrassed how the building has deteriorated" and "The manager is good, but some staff take advantage of his nice side and I have observed poor practice by certain staff, but don't feel confident approaching the manager because he is friends with some of these staff members."

During this inspection we looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems that help registered providers to assess the safety and quality of their services. This ensures they provide people with a good service and meet appropriate quality standards and legal obligations.

The number of shortfalls that we found during this inspection indicated quality assurance and auditing processes had not been effective, particularly in areas such as medicines systems, care planning, mental capacity act, and health and safety. We found these checks had been completed inconsistently and did not pick up on the issues found at this inspection. For example, we found the registered manager kept an audit of the care plans they viewed and amended, however these audits did not capture any of the shortfalls we found during this inspection.

We also viewed the registered manager's monthly environmental, and health and safety audits. We found these audits looked at the cleanliness of the home and the general maintenance. The most recent audit completed in October 2018 made reference to aspects of the home that needed replacing, such as carpets. The audit recorded the following, "The flooring in Clifton's office requires changing, this has not been changed for 15 years plus, also the carpet on the main stairs is badly worn, it is not a risk but looks dishevelled, this has not been changed for six years." We discussed this with the registered manager who told us they are always raising the carpets and other aspects of the home, but so far, the provider has been reluctant to replace them. We found other aspects of this audit failed to identify the shortfalls we found, such as the compromised garden area located close to the dining room and appliances that were not in good working order still being stored in communal areas.

We found the provider did not have a good oversight of the medicine systems at the service. We were provided with an electronic medicines audit, which did not pick up on the issues we found. The registered manager or senior staff completed an electronic medicine audit, which recorded the medicines and balance

for each person, but this audit did not record if any anomalies were found. The registered manager acknowledged these audits needed improving and would start to do undertake paper audits of the medicines at the service. We found the medicine electronic systems should have been resolved much sooner, as staff had indicated throughout the inspection that the system was poor. One senior staff member told us. "The electronic medicines system is so poor. We don't know if any of the balances are correct, because what the pharmacy inputs electronically doesn't match out systems. It has been like this for months."

We found the provider did not undertake any compliance audits of the service. This meant the provider did not have adequate oversight of the service, and relied on trust that the managers in post had been performing effectively. The provider had failed to ensure timely action was taken to ensure the environment at Prema Court was maintained to a satisfactory standard. Furthermore, we found the provider had no oversight of issues relating to the medicines systems, care planning and the poor-quality audits completed by the management team.

During the inspection the registered manager told us the service still received an annual visit from a 'Care Management Consultancy'. Their last inspection was in February 2018. During this inspection, we viewed the care consultants feedback. This indicated improvements were needed, but failed to identify areas for improvement connected to the shortfalls we found, such as management overview of staff training, medicines systems, care planning, the mental capacity act, and health and safety within the service.

During the inspection the registered manager provided us with an audit completed by a member of the provider's quality assurance team. This audit was completed in September 2018 and looked at the following areas; staff supervisions, meeting minutes, cleanliness of the service, interior/exterior of the service, activities, and staff morale. We found this audit was not robust at picking up the shortfalls we identified during this inspection. For example, this audit stated the interior/exterior appearance of the service was in good order. As stated in the report we found the service's condition had deteriorated since our last inspection. Furthermore, this audit identified staff moral 'is not great' due to the process of how staff needed to request annual leave, however, no decisive action had been taken to resolve the low staff morale.

We saw a number of surveys and questionnaires were completed by people with an interest in the service. This included resident's surveys and surveys for professionals. We found the surveys were not monitored and action plans were not developed from them. Surveys are a tool for improvement and should be used as such. If actions are not identified from the feedback provided then the feedback has not served its purpose.

Over the past three inspections since 2016 of this service we have found several breaches of the regulations. We found the same or similar breaches in regulations where the provider had failed to act on these to improve the care and support people received. Whilst we rated the service good overall at our last inspection, we have not seen sustained improvements to the service due to the lack of reliable and effective governance systems in place.

The provider did not have robust processes in place to ensure the safety and quality of the service was adequately monitored and improved, and to ensure known risks were acted upon. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers are required to notify CQC of certain significant events that occur within their services, including deaths, serious injuries, safeguarding incidents and DoLS authorisations. A review of CQC records of notifications and records held by the service showed that the service had failed to notify CQC of five granted DoLS authorisations. This meant we were unable to see if appropriate action had been taken by the service

to ensure they were following the Mental Capacity Act 2005.

We found this was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notifications of other incidents. The provider had failed to make the required notifications to the Commission.

We saw the last Care Quality Commission report that included the rating of the service was displayed in the main reception area of the home, where people could see it. The rating was also displayed on the provider's website.