Ramond Limited

Elsinor Residential Home

Inspection report

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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Elsinor Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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.

The service accommodates up to 35 people in one adapted building and primarily caters for older people, some of whom may be living with dementia. The service does not provide nursing care.

The inspection took place on the 16 November, 4 and 22 December 2017. The first day of inspection was unannounced; the second and third days were announced. At the time of our inspection, 28 older people were using the service and a registered manager was in post. A registered manager is a person who has registered with the 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.

At the last comprehensive inspection in January 2016, we rated the service 'Good', but asked the provider to take action to make improvements as the environment was not suitable for people living with dementia. We completed a focussed inspection in January 2017 and found this action had been completed.

At this inspection, the overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

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

Following the first day of our inspection, we communicated our concerns urgently with the provider who began taking action to make sure people who used the service would be safe.

After the second day of inspection, the registered manager left the service. A manager from another service owned by the provider took over this responsibility and informed us they planned to register with the CQC to manage Elsinor Residential Home. Therefore they were responsible for the service at our visit on 22 December 2017. We have referred to them as 'manager' throughout the report.

Insufficient numbers of staff were deployed throughout the service and staffing levels impacted on the quality of the experience people received within the service. The provider had not regularly reviewed staffing levels to make sure they were sufficient to respond to people's needs. This was discussed with the manager who immediately began to recruit three more care staff positions and a waking night staff position to the service. Staff deployment throughout the service was also being reconsidered by the manager.

Robust systems and process were not in place to ensure the safety of people who used the service in the event of a fire. Fire drills had not been completed to simulate the night time staffing levels and ensure the procedure would work during the night time. This was immediately rectified with all staff attending drills and evacuation practises.

The provider had not assessed or properly managed environmental risks. Environmental risk assessments had not been completed and deficits within the service had not been identified and rectified by the provider. For example we found fire doors had not been fitted where required and window opening restrictors were not consistently in place to minimise the risk of falls from height. This put people at risk of avoidable harm.

Medicine management was not safe. We identified numerous examples where staff had failed to administer people's prescribed medicines. This placed people who used the service at increased risk of harm. People's medicine administration records (MARs) were inaccurate and not updated by staff when medication had not been given. Staff responsible for administering medicines and the provider's audit process had not identified and addressed these concerns. The registered manager delegated the role of medication audits to senior care staff, however, these audits were not robust enough to help them identify and address errors. Staff had not received regular training on how to administer medicines and the provider had not ensured competency checks were completed to monitor staff's practice.

People were not supported to have maximum choice and control of their lives and the policies and systems in the service did not support this practice. People, and their representatives, were not involved or consulted when planning their care. Care planning documentation did not evidence consent had been considered. The registered manager and the provider failed to adhere to the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff were knowledgeable about the people who lived at the service, however, the provider had not ensured staff training was up-to-date. Staff had not received regular support through supervision and appraisal to enable them to fulfil their role.

The registered manager had sought people's views on the service, including the quality of care provided. However, no evaluation of the findings had occurred or action plan produced to evidence improvements made. The provider did not have effective systems to ensure safety and quality at the service. This meant they had failed to identify and address the significant issues and risks to people's safety we found during our inspection.

The registered manager had systems in place to ensure safe recruitment processes were followed.

Safeguarding procedures and policies were in place within the service, but staff did not follow these procedures as they had not identified, or reported, the safeguarding concerns we found regarding missed doses of medicines.

Staff respected and protected people's dignity and privacy; staff knocked on doors before entry. People said staff knew them well and treated them with kindness and compassion.

Staff supported people to access healthcare services when they required them. Staff had good working relationships with local doctor's surgeries and the local hospice. Staff followed health professionals' guidance regarding people's specific needs. People's preferences around food and drink were respected and support was in place for people with specialist dietary requirements.

At this inspection, we found the provider was in breach of five Regulations: safe care and treatment, staffing, person-centred care, need for consent and good governance. You can see what action we told the provider to take at the back of the full version of the report.

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.

Risks to people's safety were not adequately assessed and managed.

Staff were not deployed appropriately across the service to ensure people's needs were met in a compassionate and person-centred manner.

Medicines were not safely managed. People did not consistently receive their prescribed medicines.

Staff were recruited safely and relevant pre-employment checks were completed prior to appointment.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not receive regular and up-to-date training or supervision to enable them to perform their duties effectively.

The service was not consistently working within the principles of the Mental Capacity Act (2005). Consent to care was not always sought when devising care plans, and relevant persons involved in people's lives were not involved in the planning or review of people's needs.

People were supported at mealtimes by staff who demonstrated compassion and empathy.

Staff worked with healthcare professionals to monitor people's health needs.

Is the service caring?

Good

The service was caring.

People consistently told us the service was caring. We witnessed positive and meaningful care interactions. Staff demonstrated kindness and compassion to people who used the service.

Visitors to the service were encouraged and were made to feel welcome.

Staff were kind and considerate and maintained people's privacy and dignity.

Staff knew people extremely well and demonstrated a positive, empathetic and caring attitude.

Is the service responsive?

Requires Improvement

The service required improvement to be responsive.

Care plans were not sufficiently person-centred and were task orientated in nature. Preferences were not recorded in people's care plans.

Recommendations made by visiting professionals were not always followed.

People, and their representatives, were not involved in planning or reviews of their care.

The provider had an activities programme, but records did not evidence people were supported to engage in activities or to go out of the home.

Is the service well-led?

Inadequate

The service was not well-led.

The provider and registered manager were not proactive in identifying and managing risks.

Quality assurance processes were not effective in monitoring the service provided. This placed people who used the service at risk of harm.

The provider had failed to respond effectively to feedback received via surveys to improve the service.

Meetings for staff and people who used the service were held on a regular basis. People and staff had regular opportunities to discuss the service with the registered manager.

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

This inspection took place on 16 November, 4 and 22 December 2017. The first day of inspection was unannounced, on subsequent days we announced our intention to visit the provider.

On the first day of inspection, the inspection team consisted of two inspectors and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service. The expert by experience who supported this inspection was a specialist in dementia and care for older people. They supported the inspection by speaking with people who used the service and visitors to gather their feedback about the service provided. On the second day of inspection, the team consisted of two inspectors, and on the third day, the team consisted of one inspector.

Prior to the inspection, we viewed all the information we held about the service. We examined notifications received by the Care Quality Commission. Notifications contain information about changes, events or incidents that the provider is legally required to send us. We requested feedback from the local authority commissioning and safeguarding teams. We requested feedback from external professionals who were involved in supporting people who used the service. We also contacted the local Healthwatch. Healthwatch are a consumer group who champion the rights of people using healthcare services. We used all of this information to plan our inspection.

During our inspection, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed four people's care files, three staff files and medication administration records. We looked at a range of records relating to the management of the service. We spoke with 14 people who used the service and five of their relatives. We spoke with three members of staff including care workers and senior care workers, the registered manager, manager and the nominated individual. The nominated individual for this

service was the managing director of the company registered as provider.

Inadequate

Is the service safe?

Our findings

Environmental risks were not appropriately identified, assessed and managed. Window opening restrictors were not in place on the majority of windows above ground floor level to manage the risk of people falling. The building was housed over four floors and primarily supported people who had dementia, which may compromise their ability to assess risks to themselves. The registered manager told us they had not considered the risk that this posed and stated this would be remedied immediately. Four weeks later we spoke with the provider and the registered manager to check this work had been completed and were informed that it had not. When we visited on 22 December 2017 window restrictors had been fitted.

We found a number of trip hazards had not been identified by the registered manager or provider. Bathroom lino was not sealed to the floor on the entry to one toilet. Carpet strips were not always in place between different carpeted areas of the home and the non-slip edgings which were in place on the stairs of the basement were disintegrating.

There were inadequate systems in place to ensure people received their prescribed medicines. Staff had not maintained a record of medicines in stock and were not monitoring the temperature at which medicines were stored to ensure these were within safe limits.

We looked at medicine administration for ten people and found multiple examples where people had not received their prescribed medicines. This included examples where staff had signed to record they had administered someone's medicines, but they had not been given.

Staff responsible for administering medicines had not identified or sought medical advice where people had missed doses. They did not have up-to-date training on how to safely administer medicines and the registered manager did not complete competency checks to ensure staff understood their responsibilities. We observed a member of staff administering medicines and noted they did not always follow best practice guidance. The medication system had been audited, but these checks had not identified the significant shortfalls and concerns we found. This demonstrated there had been a systemic failure to follow best practice guidance regarding the safe management of medicines.

The registered manager acknowledged the significant failings we found and submitted 11 safeguarding alerts in relation to medicines arrangements to the local authority to investigate the failings.

We reviewed the documentation the provider held in relation to fire safety. Fire drills were completed annually, but did not include the night staff and no fire drills were completed at night time. One member of staff, who had worked at the service for two years, told us they had not had fire training and had not attended a fire drill. We completed a tour of the building and found self-closing mechanisms on fire doors were not consistently working and a fire door was wedged open with an ornament. We discussed this with the registered manager who agreed that plans would be implemented to ensure night time drills were practised and actions would be taken to resolve the identified issues.

A fire safety audit had been completed on 20 July 2017 by North Yorkshire Fire and Rescue Service. They identified the provider needed to install additional fire screenings to reduce the risk of a fire spreading. At the time of our inspection, this work had not been planned or completed. When we visited the service on 22 December 2017, we were told a quote had been received for this work to be completed. The failure to take adequate steps to manage and minimise the risks associated with a fire put people who used the service at significant risk of harm. We shared our findings with the North Yorkshire Fire and Rescue Service.

The failure to ensure the safety of their premises and the equipment within it, the failure to assess and mitigate individual risks and to review identified risks are all breaches of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels were not sufficient to meet people's needs. We sat in the ground floor lounge area over a half hour period and noted there were no staff present to interact with, or observe the safety and wellbeing of the people on this floor. The doorbell was ringing and went unanswered for ten minutes, leaving an older person who had arrived for a respite stay, on the doorstep in the cold. A relative we spoke with said, "I had to wait outside for over 20 minutes before someone came to let me in the other day, it was freezing." We discussed our findings with the registered manager who informed us that a member of staff should be present on this floor at all times.

Staff told us they would like the opportunity to spend more one to one time with people who used the service. Comments included, "I wish we had more staff to enable us to do things on a more individual basis, like going out with people" and "If I could improve one thing it would be the staffing. If people need more support because of their needs then it does sometimes detract from the attention given to others."

Staffing rotas over a four week period showed that minimum staffing levels, as stated to us by the registered manager, were not in place on a number of shifts. The registered manager agreed there were periods where the service was inadequately staffed and agreed this impacted upon the quality of the service provided to people.

The provider was not adequately assessing night time staffing levels to establish the number of staff required to safely support evacuate people in the event of a fire. They had not provided supervision to the night staff, had not worked a night shift to monitor staffing levels and did not provide fire drills which involved night staff. At the time of our inspection there were 28 people using the service and only two waking night staff on duty. The registered manager did not complete a dependency level assessment of the people who used the service. This tool determines how many staff should be on duty at different points over a 24-hour period. We found the provider had not considered this.

Failure to develop a systematic approach to determine the number of staff needed and the failure to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed to meet people's care needs is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that as a result of our feedback, they were going to recruit three more care staff. They also informed us that a third waking night staff would be implemented to ensure adequate staffing was in place on a night.

We provided feedback to the provider at the end of day one of this inspection which highlighted the concerns we had found in relation to the safe running of the service. By day two and three, we could see the provider had begun to take action to address some of the concerns we found. Fire doors were closing

effectively and the trip hazards identified had been rectified.

We looked at the recruitment records for three members of staff. We found safe recruitment practices were being followed. A Disclosure and Barring Service (DBS) check, and two references had been sought before staff started their employment at the service. These checks help employers make safer recruitment decisions.

Measures were in place to reduce the risk of spreading infections. The service was clean and personal protective equipment (PPE) in the form of gloves, aprons and hand sanitizing gel was available and used throughout the service.

A safeguarding policy was in place to inform staff of the procedure to follow if they were concerned people may be experiencing abuse or neglect. The staff were knowledgeable about their responsibilities in this area and people who used the service told us they felt safe. One person said, "Yes I feel safe, what more could I ask."

Completed safeguarding alerts were stored in a box file in the office. Accidents and incidents were recorded and also stored within the office. The registered manager had no documented overview of safeguarding and accidents and incidents so they were unable to monitor patterns and trends, which would help support the reduction of incidents.

Requires Improvement

Is the service effective?

Our findings

Staff had not received appropriate and regular training to enable them to perform their roles safely and effectively. The registered manager showed us a copy of their 'training matrix', which contained details of training staff had completed. The provider had deemed specific topics should be periodically updated. For example, medicines training needed to be updated every two years. However, the senior staff who were delegated the role of medication administration had not had medication training for three to four years and their competencies had gone unchecked in this time. We identified significant concerns about the support provided for people to take their medicines safely and were concerned that the failure to provide adequate training resulted in people receiving poor and unsafe care.

Staff had not received appropriate levels of support from the provider to carry out their duties. Staff we spoke with told us they did not receive regular supervision or appraisals. One staff file we looked at showed the staff member had not received one to one supervision since 2013. We saw another member of staff had not received supervision since 2015. The registered manager acknowledged that formal supervisions had not been regularly completed and documented. The failure to provide adequate training and regular supervision and appraisals placed people who used the service at risk of receiving poor care.

Failure to provide appropriate support and training to enable staff to carry out their duties is a breach of Regulation 18 (Staffing) of the Health and Social Care Act (Regulated Activities) Regulation 2014.

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and found consent and decision making was not considered in line with legislation or best practice. Where people were unable to consent to their care, appropriate assessments of their capacity and best interest decisions had not been carried out. This was confirmed by a relative of a person who used the service who raised concerns with us regarding the lack of involvement in planning their relative's care following their admission.

We did see staff offering explanations to people before providing direct care. However, as a result of dementia and severe cognitive impairment, a significant number of people being supported lacked the capacity to agree to the care they were in receipt of. We looked at staff training in this area and found staff had not received updated training in MCA for three years. However, the provider's schedule for refresher training on the MCA was two years.

Failure to consider and apply the principles of the Mental Capacity Act 2005 is a breach of Regulation 11

(Need for consent) of the Health and Social Care Act (Regulated Activities) Regulation 2014.

The registered manager had not consistently considered whether an application to deprive a person of their liberty was required for new people to the service or where they were staying there for a period of respite. The provider had a 'locked door policy' with a key code to exit the building. People who could not consent to this were subject to a restriction of their liberty and an application to assess for DoLS was required. Where DoLS had been authorised for people living at the service, copies of the DoLS authorisation were not held within the person's care file and the authorisation were not referred to in their support plan. This is important to ensure that the person is supported in the least restrictive way and enables the provider to monitor any conditions on the DoLS authorisation.

The lunchtime experience was positive, relaxed and unhurried. The meal was well presented and looked appetising. People were offered a choice of what they would like to eat and alternatives were available. Where people required support with their meal, staff were on-hand and we observed people's specific dietary requirements were catered for. For example, where people who used the service had been assessed as having swallowing difficulties, pureed food was prepared. We spoke with the chef who told us, "I have a list of the people who have a specific dietary need and I prepare their food separately. Where people have a pureed diet, I puree things separately and portion the plate up as you would any other meal. That gives people the taste sensation of having the meal and its ingredients." People we spoke with said, "I look forward to my meals", "The food is lovely here" and "My [relative] has settled in here and has put weight on so the meals must be good."

The registered manager and staff worked in a positive and collaborative manner with health professionals. For example, the community mental health team were contacted by the registered manager to assess a person. Advice was given to implement and utilise diversion and distraction techniques and this was actioned through the use of picture cards to enhance communication as the person experienced a hearing impairment. During the inspection, paramedics visited the home to assess a person who used the service. We observed the registered manager and staff provided all the relevant information to the medical staff to ensure the person's smooth admission to hospital. We found health issues were recorded and monitored effectively.

The home was not purpose built to provide residential care, it was housed over several floors which were reached via a small lift and had narrow corridors with no natural light. The provider had adapted the environment as best they could to support the needs of people living with a cognitive impairment. Signage was in place throughout the service. This was clear and included pictures, as well as words. This supported people to orientate themselves, for example, to the location of the toilet facilities. People were orientated to the location of their rooms with their picture on the door and décor throughout the service had been chosen specifically to ensure a 'dementia-friendly' environment.

Good

Is the service caring?

Our findings

People who used the service and their relatives consistently told us the service was caring. Comments included, "The staff are very nice" and "One staff member who works here is very kind. They sit and talk to me and keep me company."

Although staff were very busy, we observed they showed kindness and respect towards the people who used the service. Where people were disorientated or distressed, we observed staff gave people the time and explanations required to reduce their anxiety. For example, we observed a staff member sat with a person and gave them a hug as they were visibly upset. When the person's anxiety reduced, the staff member distracted their attention by escorting them to the window and pointed out the trees, cars and people that were passing. The person then settled and drank a cup of tea with no signs of distress. We saw the staff member was very caring and understanding in their approach to this person, which reduced their anxiety and distress.

Staff respected people's privacy and dignity, we observed them knocking on doors and announcing their presence before entering people's bedrooms. Staff made sure sensitive conversations were not overheard by others who used the service. They were genuinely caring, and treated people with respect. A relative of a person who used the service said, "I could not ask for a friendlier home for my relative, they are respected and cared for." We witnessed staff providing people with good explanations before starting care tasks. For example, where people were supported to take medicines, staff offered explanations to the person about their medicines and the benefits of taking it.

Staff talked with people in language which was tailored to their communication abilities and helped people understand. Staff used communication tools such as picture cards and objects of reference to communicate with people and aide their understanding. For example, when offering a cup of tea to one person, the staff member showed them the cup to orientate them and help them decide.

It was evident staff knew the people they supported extremely well. A number of staff had been employed at the service for many years and there was a very low staff turnover. We observed interactions and noted staff were aware of people's needs and preferences. Where people were unable to communicate their needs, we saw staff anticipated the support required. A staff member we spoke with told us, "The Elsinor is very family orientated and it really feels like a home from home. It's very friendly and staff know the residents really well." A relative said, "My relative feels like part of the family at Elsinor and for that I am very happy."

Visitors were encouraged and welcomed by the staff and people could visit their relatives in the privacy of their room or in the communal areas of the home. A relative of a person who used the service said, "Staff are always pleasant and caring and we feel very welcome each time we call."

The provider had policies in place which provided staff with information on key pieces of legislation such as the Human Rights Act 1998 and the Equality Act 2010. These policies referred to equal and impartial treatment irrespective of race, gender, age, religion, colour, ethnic origin and sexual orientation, as well as

other areas, and provided further information on how to respect diversity and plan areas of support to meet people's individual need. For example, how to support people to observe religious festivals and holy days through support with fasting. Staff we spoke with demonstrated that they understood how to support equality and diversity and gave examples such as supporting same sex couples to maintain their relationship and supporting vegetarians with their dietary choice.

Requires Improvement

Is the service responsive?

Our findings

Staff knew people who used the service well and met people's basic day to day needs, such as communication and completing aspects of personal care. However, the care files we viewed did not contain sufficient personalised detail to enable staff to provide person-centred care to meet people's individual complex needs based upon that person's preferences. We found generic, task orientated terms were used in care planning documentation. These terms included, 'needs prompts with keeping up personal hygiene' and 'requires full assistance with all personal care needs'.

We looked at the care files of three people who used the service. Care plans were not in place for every area of people's needs for example; where people displayed behaviour which may challenge the service or specific nutritional needs. One person received support from the local community mental health team (CMHT) as they presented with behaviours which may challenge the service. Their care plan stated they were 'under the mental health team', but contained no further guidance for staff about how to support the person to avoid engaging in behaviours that may challenge the service. For example by recognising triggers to that behaviour, how the person presented when anxious or upset, or what the risks were to that person, or others, in relation to their presentation. This meant that the person was not receiving person-centred support which was tailored to their specific needs and therefore put them at risk of not receiving the care they needed.

People's care needs were reviewed on a regular basis. However, people, and their representative's, were not consistently involved in the review of their care. The service primarily supports older people with dementia, a number of who do not have the capacity to understand their support needs due to limited cognition. When planning these reviews we found the registered manager had not considered the principles of person-centred care and the Mental Capacity Act 2005. The Act states that consultation must be held with close relatives and friends about actions completed in the persons best interests. We found the involvement of relevant people in the assessment and review of their care was not consistently applied. As a result people's support needs were not assessed or reviewed in a person-centred manner as the person had no independent advocate representing them or their previously expressed wishes.

Staff did not consistently update people's care plans when their needs changed. For example, one care file stated the person slept well. We explored the daily notes in relation to this person which indicated the individual was 'unsettled and wandering, and awake most of the night'. The meant that the person was at risk of not receiving the care they needed. We discussed this with the registered manager who confirmed that documentation had not always been updated following review and this was an area which needed to be addressed.

Failure to ensure people receive appropriate person-centred care that is based on an assessment of their needs and preferences is a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had an activities programme in place and this listed events such as, hairdresser, board games,

dancing and singing, armchair exercise and mini-bus outings. A copy of this was on display on the notice board. The document was not presented in an accessible 'dementia friendly' format. There were no pictures and the writing was in small inaccessible print. It was unclear which of the activity programmes was being offered that week.

We looked at feedback received from a 'service user questionnaire', which had been completed in September 2017. Comments returned from this survey included, "I would like to go out more, at least once per week" and "I would like more trips out, like going for an ice-cream." Staff did have use of a mini-bus and staff and residents told us that trips were organised, but we saw no evidence of this within activity plans. We spoke with the registered manager about our findings and were told staffing would be reconfigured to ensure staff were deployed more effectively to support people's needs on a more individual basis.

Care files we viewed made some reference to the person's interests and hobbies, but we found no detail within daily notes, which informed us what activity the person had engaged in. We discussed this with the registered manager who said they would implement a system to record activities people had participated in.

The provider had a comprehensive complaints policy in place, this detailed the complaints process, who to contact if people were unsatisfied with the service or the outcome of the complaint, and timescales for the complaint to be heard. We found the complaints procedure was not displayed in public areas of the home, was not made available to new and existing people who used the service or their relatives and was not available in an accessible dementia friendly format. The provider had received one complaint in the two years since our last inspection and we found this had been dealt with in line with their policy.

We spoke with the registered manager and recommended they make this documentation freely available to people and advised that they post easy read copies of the policy throughout the service. The registered manager agreed to implement this recommendation.

We saw staff had received a number of compliments over the past year. Comments included, "Thank you for the care you gave to my relative, we cannot tell you how much we appreciate everything you have done", "Your patience and understanding enabled [my relative] to spend their last years with as much dignity as possible" and "You all did an amazing job caring for [my relative], we truly thank you all."

End of life care needs were met within the home and this was supported by collaboration with community health professionals. Staff had close links with the local hospice team and they worked with the service to devise and implement end of life care plans, which were supportive of the person, their family and friends. Where end of life care preferences had been discussed with people, or with people representing them, this was documented within their care file. For example, where people had a do not attempt to resuscitate agreement, this was signed by relevant parties and contained within their care plan.

Inadequate

Is the service well-led?

Our findings

The service was not well-led. There were insufficient numbers of staff deployed to provide care and stimulation, both during the day and also at night. The registered manager and provider did not use a dependency level assessment of the people who used the service. Staff we spoke with described some of the difficulties encountered in such a large building, which supported the complex needs of people living with dementia.

The quality assurance system, which ensured the service was meeting expected standards, consisted of audits. These were completed in areas such as medication, spot competency checks of staff and their practice and questionnaires. The quality assurance explored the experiences of the people who used the service by asking them and their representatives for their opinions.

Records showed some aspects of the service had been audited on a regular basis such as maintenance and medication. However, audits and checks needed to be developed further as they were not robust enough to identify the issues we found on inspection. Audits in areas such as the environmental checks made within the service, to ensure premise safety, needed to be completed and screened to monitor patterns and trends and mitigate risk.

Medication audits completed by senior members of staff had identified no issues. However, during the inspection we found administration errors had been made, these included numerous missed doses of prescribed medication. These mistakes had not been identified through the provider's internal auditing and quality assurance process, which showed us their auditing process in this area were ineffective in identifying issues.

Although during our inspection, the provider and registered manager began taking action to ensure risks to people's safety were reduced; this was evidence of reactive not proactive risk management.

The registered manager had not completed staff competency checks. Competency checks are a way of observing and exploring staff practice and help identify any poor practice and the potential need for further training in the staff team. This was discussed with the registered manager who agreed that they had not implemented clear oversight of the service and assured us they would develop and implement clearer oversight of staff practice and competency.

'Quality Assurance Questionnaires' had been given to people who used the service in September 2017 and we explored the responses. Of the questionnaires sent, 12 had been returned. Topics such as 'Do you enjoy the entertainers' and 'Do we have enough outings' were covered. Although the feedback was generally positive, 11 out of 12 people had stated there were not enough outings at the home. The registered manager said there was no evaluation of the results completed therefore areas for improvement had not been explored and no plan of action had been developed. The registered manager informed us they would explore this matter and respond to the comments made within the surveys.

The provider's nominated individual regularly visited the service and audited the care and support provided. We were concerned that despite these visits, they had not identified and addressed the significant concerns we found regarding the care and support provided at Elsinor Residential Home. This showed us there were inadequate systems of governance to ensure the quality and safety of the care and support provided. This placed people who used the service at risk of avoidable harm.

Although the registered manager and provider were a visible presence, and available to people and staff within the service, the service lacked robust governance and failure to notice and act upon areas of concern. After the second day of inspection, the registered manager left the service and a manager from another service owned by the provider took over this responsibility. We were informed they planned to register with the CQC to manage Elsinor Residential Home.

Failure to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act (Regulated Activities) Regulation 2014.

The registered manager held regular staff meetings with the team at the service. Topics discussed included infection control, key working, ensuring people were supported to drink enough and staff training. The registered manager shared safeguarding concerns with the staff team to enhance learning, improve staff practice and improve the experience of the people who used the service. The meeting records demonstrated that the majority of staff attended the meetings and staff signed to say that they had read the transcribed minutes. Staff we spoke with said the meetings were a good support to them.

'Resident Meetings' for people who used the service were held on a regular basis and minutes we viewed informed us 16 people who used the service had attended the last meeting which was at the end of September 2017. Topics of discussion included: food, outings and people's opinions of the service. Where people had made suggestions about the menu we saw the menus had been changed to accommodate people's suggestions.

The registered manager was aware of the responsibility to report accidents, incidents and other events that occurred within the service. Notifications such as safeguarding and expected deaths had been submitted as required to ensure people were protected through sharing relevant information with the regulator.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People using the service had not received appropriate person-centred care and treatment that was based on an assessment of their needs and preferences. Regulation 9 (1), (a), (b), (c). People using the service or those lawfully acting on their behalf had not been involved in the planning, management and review of their care and treatment. Regulation 9 (3) (a), (b), (c), (d), (e), (f), (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People using the service, and those lawfully acting on their behalf, had not given consent before care or treatment was provided. Regulation 11 (1), (2), (3), (4), (5).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There had been a failure to assess and mitigate the risk to people who used the service. Environmental risks had not been assessed. Regulation 12(1), (2)(a), (2)(b), (2)(d).

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to assess, monitor and improve the quality and safety of the service had not been established and operated effectively. The systems in place to monitor and improve the service were not effective. Regulation 17 (1), (2)(a), (2)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was no systematic approach to determine the number of staff required to meet the needs of the people who used the service. Insufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed to meet people's care needs safely. Regulation 18, (1), (2) (a), (b), (c).