Leonard Cheshire Disability

John Masefield - Care Home with Nursing Physical Disabilities

Inspection report

Burcot Brook
Lodge Burcot
Abingdon
Oxfordshire
OX14 3DP

Tel: 01865340324
Website: www.leonardcheshire.org

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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

This inspection took place on 19, 20 and 22 September 2017. It was an unannounced inspection.

John Masefield House is registered to provide accommodation for up to 22 people who require nursing care. At the time of the inspection there were 22 people with physical disabilities living at the service.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We last carried out an unannounced inspection of John Masefield House in March 2016. Following our inspection in March 2016 we published a report in which we rated the service as good service. However during this inspection we found evidence that the safety and oversight of the service had declined in that, risks associated with peoples care and wellbeing were not always managed safely.

People were not protected against the risk of choking, aspiration and pressure damage. People who were unable to access their call bells were not always supported effectively and in line with their care plans.

Staff gave a varied response when speaking about the registered manager . Relatives we spoke with told us there had been a noticeable deterioration in the positive atmosphere of the service. Peoples views and thoughts were not considered before changes were implemented within the service.

The provider did not have an effective system in place to monitor the quality of service. The registered manager had not always notified CQC of reportable events. Staff did not feel supported by the provider.

Medicines were not always stored securely. There was not an effective system in place to ensure that medicines were stored at in line with the manufacturer's guidance. Equipment relating to peoples care and the day to day running of the service was not always maintained in line with manufacturer's guidance.

Staff did not always follow recommendations and guidance made by healthcare professionals. People were not always supported effectively and in line with their support plans. Records relating to peoples care were not always up to date or accurate.

People's nutritional needs were met and they were given choices. However People at a risk of malnutrition were not always supported appropriately.

The service did not always support people in line with the principles of the Mental Capacity Act (2005). The service did not always follow the correct procedures when depriving people of their liberty.

There were sufficient staff to meet people's needs. Staff were not rushed in their duties and had time to chat with people.

Throughout the inspection there was a calm atmosphere and staff responded promptly to people who needed support. People had access to activities which included range of activities of their choosing. Staff clearly understood the likes and dislikes of the people they were caring for.

The overall rating for this service is 'Inadequate' and the service is in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel their 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 overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking further action in relation to this provider and full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations have been concluded. In the interim we have asked for and received a plan from the provider telling us how they are going to address these concerns to inform our ongoing monitoring of this service.

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 were not managed safely.

People were not protected against the risk associated with choking and aspiration and pressure damage.

People who were unable to access their call bells were not always supported effectively and in line with their care plans.

Medicines were not always stored securely.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported in line with the principles of the Mental Capacity Act 2005 (MCA).

People at a risk of malnutrition were not always supported appropriately.

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities.

Is the service caring?

Good

The service was caring.

Staff were kind and respectful and treated people with dignity and respect.

People benefited from caring relationships.

The staff were friendly, polite and compassionate when providing support to people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff did not always follow recommendations and guidance

made by healthcare professionals.

Records relating to peoples care were not always up to date or accurate.

There was a range of activities for people to engage with.

Is the service well-led?

Inadequate

The service was not well led

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

The registered manager had not always notified CQC of reportable events.

Staff did not feel supported by the provider.

John Masefield - Care Home with Nursing Physical Disabilities

Detailed findings

Background to this inspection

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

This inspection took place 19, 20 and 22 September 2017 and was an unannounced inspection. This inspection was conducted by two inspectors, a specialist advisor, whose specialism was nursing and an expert by experience (ExE). An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed notifications that the registered manager had submitted to us. A notification is information about important events which the provider is required to tell us about in law. Prior to the inspection we spoke with commissioners of the home to get their views on how the service is run.

We spoke with six people, seven relatives, five care staff, three nurses, one team leader, the chef, ,the administrator and the registered manager. We reviewed 12 people's files, five staff records and records relating to the management of the home.

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.

Inadequate

Is the service safe?

Our findings

People told us they felt safe. Relatives told us that they felt people were safe. However our observations and other evidence we gathered did not corroborate this.

Six people had swallowing difficulties that placed them at risk of choking and aspiration pneumonia. Aspiration pneumonia occurs when a foreign body, such as a small piece of food or drink goes 'down the wrong way' causing a chest infection to develop. The six people had been assessed by a speech and language therapist (SALT) as requiring a modified diet such as their fluids thickened and/or a modified texture diet. However these people were not always assisted in line with SALT professional recommendations. One person was assessed by the SALT as requiring a pureed diet and double cream consistency fluid. The person's care plan stated '(Person) 'is at high risk of choking' and 'food should be pureed and drinks (should be) a double cream consistency'. During our breakfast observations this person informed us "I had toast for breakfast". The staff member supporting the person confirmed this. We asked this staff member which people required thickened fluids and modified diets. The staff member confirmed that this person required a "pureed, assisted diet". We asked the staff member why this person had been given toast for breakfast. They replied "(Person) can eat toast". This was not recorded in the persons care record. The person's swallowing risk assessment stated the person required a pureed diet and double cream consistency drinks. The practice of giving toast to a person who requires a pureed diet, is not in line with guidance from the National Patient Safety Agency dysphagia diet descriptors which states that toast would contain lumps, crumbs and hard pieces. The impact of this practice put people at risk of choking.

During our lunch time observation we observed a volunteer preparing a drink for a person using a prescribed thickening agent. We noted that the volunteer had not prepared the drink to the correct consistency outlined in the person's SALT assessment. This placed the person at risk of harm through choking and or aspiration of fluid into the lungs. We asked the volunteer if this was the correct consistency for the person's drink and what the consistency should be. However the volunteer was unable to provide a satisfactory answer. Therefore we asked a staff member who was supporting this person with their meal. The staff member told us "No that's not (The right consistency), it should be double cream". We also noted that the thickening agent that the volunteer had used was prescribed for another person. Therefore people did not always receive their medicine as prescribed. We asked the staff members on duty to prepare another drink for the person. We observed a staff member preparing another drink for this person to the correct consistency.

We raised these concerns immediately with the registered manager. The registered manager stated that the volunteer should have received appropriate training to ensure they were competent in preparing thickened fluids for people. We asked the registered manager to confirm if the volunteer had received the appropriate training. The registered manager went away to check. On their return to the dining room they informed us, "They have not had the training". The registered manager told us, "Their (the volunteer's) competency was checked by another overseas volunteer". We asked to speak with this volunteer. However we were informed that the volunteer had left the service. We asked for documentation to support that the competency check had taken place, however the registered manager was unable to provide us with this documentation. We

asked the registered manager if they felt that this practice was adequate. The registered manager told us, "No, not at all. It's not the way it should be done". The absence of the correct skill set by volunteers put people at risk of harm through choking and or aspiration.

We noted and staff confirmed that two people who required purred diets and thickened fluids had received trifle for pudding. This is not in line with guidance from the National Patient Safety Agency dysphagia diet descriptors. The guidance highlights that jelly is not suitable for people who require a pureed diet and thickened fluids. This is because the Jelly could change to liquid in the mouth. We asked a member of the kitchen staff if they were aware that jelly was not suitable for people who required their fluids thickened. They told us, "No I was not aware of that, I didn't know". The impact of this was that people were put at risk of harm through choking and or aspiration.

People were not always protected from the risk of choking or aspiration through the use of appropriate equipment. For example, during our lunch time observation we noted one person being assisted to drink thickened fluid in a spouted beaker. People with Dysphagia should not use straws or cups with spouts unless the speech and language therapist has specifically advised the person to do so following assessment, because straws and spouts can increase the risk of aspiration. This person's SALT recommendations highlighted that the person should use a 'standard cup'. Staff supporting this person during the evening meal, were however aware of this guidance and were supporting the person effectively with a standard cup.

Prescribed thickening agents were not always stored safely which put people at risk of choking. Two people were prescribed thickener for their drinks. On the first day of our inspection we noted that thickener was not always stored safely. For example, we observed the thickener was kept in communal cupboards that were accessible to people living in the service. We spoke with the registered manager about this and they informed us that the thickeners should not have been stored in the communal area and that they would address this with staff. However on the second day of our inspection noted that the thickeners were in the same communal cupboard. We raised this again with the registered manager and a team leader. The registered manager told us "It should be locked away. The team leader said, "They could get it thinking it is sugar and end up choking". The team leader was aware of the national patient safety alert surrounding the safe storage of thickeners. Patient safety alerts are a crucial part of the NHS to rapidly alert the healthcare system to risks and provide guidance on preventing potential incidents that may lead to harm or death.

People were not always protected from the risk of pressure area damage. Two people had been assessed as at risk of pressure sores, care plans and risk assessments were in place. However, risk assessments for these people had been incorrectly completed. The two people had been scored as not having any wounds or broken areas to their skin. One person had pictures in their care record showed a blistered limb with some broken blisters and weeping areas. The person also had and a wound care assessment chart which showed the person had a blood blister on their left foot. Their daily record also documented 'had a red bottom so cream applied'.

We also noted that these people had pressure relieving mattresses in place for the prevention of pressure sores. The settings the pressure relieving mattresses for these two people and another person were set at an inappropriately high level for the people's weight. For example one person's pressure relieving mattress was set to accommodate a person of 115kg in weight. However the person's care record documented they only weighed 55.2kg. Another person had their weight recorded as being 85.4kg. However their pressure relieving mattress was also set to accommodate a person of 115kg in weight. Another person weighed 110kg. However their pressure relieving mattress was set to accommodate a person of 125kg in weight. This placed

these people at increased risk of developing a pressure sores and discomfort.

People who were unable to access their call bells were not always supported effectively and in line with their care plans. For example, one person's care records documented that the person must be supervised at all times when using a specialist chair. However we noted that this person was left unattended for 35 minutes in their room whilst being in their specialist chair. We raised this with the registered manager who told us "(person) should not be left unsupervised. I think things just got a bit busy". The registered manager made arrangements to ensure that this person was supervised appropriately.

This person's care record also documented that '(person) is unable to use a call bell to ask for assistance, so (person) will need to be at checked hourly intervals when in (their) bed. To check that person is okay'. This was recorded further in the 'Communication book. Care team' alongside a list of a further five people who had been identified as requiring hourly checks to be carried out whilst they were in bed. The entry in the 'Communication book. Care team' stated; 'When residents that can't use their bell are in bed i.e. (room numbers of six people). Please check on them every hour to check they are okay. This will need to be recorded in their red folders. Thank you'. However there was no record of these checks taking place. The impact of this is that the person would not have been able to alert staff in the event of them becoming unwell and or an emergency.

The provider did not always ensured their own medicines policy was followed to ensure people received the medicines safely. One person was supported to be independent in partially taking their own medicine. The provider's medicines policy stated that where people wished to self-medicate they would also have a risk assessment in place to risk assess their ability and to identify if it was safe for them and others living at the service. The person had a medicines care plan in place which stated they would self-medicate some of their medicines. However, the person's care records did not contain a risk assessment. We asked a nurse and the registered manager if this person had a risk assessment for self-medicating. However both the nurse and registered manager could neither confirm this or demonstrate that a risk assessment had been carried out.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Due to the level of concern that we identified during our inspection. We wrote to the provider asking them what immediate action they were taking to address these concerns to ensure people who used the service were safe. The provider sent us an action plan telling us how they would address these concerns.

We observed staff administered medicines to most people in line with their prescription. There was accurate recording of the administration of medicines. Medicine administration records (MAR) were completed to show when medication had been given. Medicines administered 'as and when required' included protocols providing guidance for staff about when the medication should be used. Staff had an understanding of the protocols and how to use them.

We spoke with people who gave a varied response about staffing levels. We asked people if staff were reliable and available when they needed them. One person told us, "For the most part yeah, not always no". Another person told us, "Yeah I think they are". Staff also gave a varied response. For example one staff member told us, "I think we have enough staff". Another staff member told us, "No I don't think we have enough staff, we are short, we have to use a lot of agency". However, we observed, and staffing rotas confirmed, there were sufficient staff to meet people's needs. The registered manager assessed people's needs when carrying out initial assessments on people's care needs. This enabled the manager to calculate the right ratio of staff against people's needs. We saw that this was reviewed regular by the management

team. Staffing rotas evidenced that the assessed staffing levels had been achieved on most occasions. On occasions where staffing levels had not been achieved the registered manager had taken appropriate action to access additional staffing. During the day we observed staff having time to chat with people. Where people could use call bells we noted that call bells were responded to appropriately.

People were protected from the risk of abuse. Staff were aware of types and signs of possible abuse. Staff had completed safeguarding training and understood their responsibilities to identify and report all concerns in relation to safeguarding people from abuse. Staff told us that if they had any concerns then they would report them to the registered manager. One member of staff told us, "I would go straight to my manager". Another staff member said, "I would report it to the nurse immediately". Staff were also aware they could report externally if needed. One staff member told us, "I would go to the police, social services or you lot (Care Quality Commission). A nurse we spoke with told us, "I would make a referral to Oxfordshire safeguarding team".

Staff holding professional qualifications had their registration checked regularly to ensure they remained appropriately registered and legally entitled to practice. For example, registered nurses were checked against the register held by the Nursing and Midwifery Council (NMC).

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and Disclosure and Barring Service checks (DBS). These checks identify if prospective staff were of good character and were suitable for their role. One new member of staff told us "A DBS was done".

Requires Improvement

Is the service effective?

Our findings

Equipment was not always maintained in line with manufacturer's guidance. People who had diabetes required regular monitoring of their blood sugar. We observed a nurse using a Gluco Nexus glucometer to measure two people's blood sugar. We asked the nurse if they had carried out a control/calibration check of the glucometer prior to use. This check is important to ensure the equipment is working correctly. The nurse told us they had not done this. According to the manufacturer's instructions a calibration control solution test should be completed at least once a week to routinely check the equipment is working properly. We raised this with the registered manager. The registered manager could not demonstrate that regular control/calibration checks had taken place. The impact of this was that people were at risk of having their blood sugar level monitored by ineffective equipment.

People were not always supported effectively and in line with their support plans. For example one person was being pushed in a wheelchair by a volunteer. The person was being pushed quickly in an outside area of the service. We noted the footplates of the wheelchair were not being used. This person's care records provided guidance for staff that included '[Person] requires help when out but would need the footplates on when their chair is being pushed'. This put the person at risk of receiving an injury because their legs could get caught in the wheelchair whilst it was moving.

Staff were not always supported through appropriate training and observation to deliver safe care. New staff were required to complete an induction programme before working on their own. The registered manager told us this included training for their role and shadowing an experienced member of staff. However, this did not always take place. For example, during our inspection we were informed that a new member of staff had been operating moving and handling equipment without having had their competencies checked. We spoke with this staff member who told us, "I've done no training yet". I've been using the (moving and handling equipment). It's wrong, for all they know I could have no idea about using (The equipment)". We spoke with the registered manager about this and they told us, "They should not be doing this". Following the inspection the registered manager provided evidence that this had been addressed with staff and that the person had received training and had their competencies checked following the inspection.

People who were assessed as being at risk of malnutrition had 'Malnutrition Universal Screening Tools' (MUST) in place. MUST is a five-step screening tool used to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan. Monthly weight charts were kept for people who were a risk of malnutrition or who needed to reduce their weight. People's monthly weights were recorded on a central document, with the aim of transferring the information into people's individual care records. However this did not always take place. For example, one person had not had their weight recorded in their care record since May 2017. Another person had a percutaneous endoscopic gastrostomy (PEG) inserted. A PEG is a tube which is inserted in a person's stomach in which liquid food and medicines are given. The person had been seen by a dietitian July 2017. The dietitian had written in the person care records that they should have their weight taken two weekly to monitor the change in care needs. There was no evidence that this person had had their weight recorded in their care records since May 2017. The impact of this was that people who were at a risk

of malnutrition were not always supported appropriately or in line with professional guidance.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 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 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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. In the majority of cases people or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided. However one person care records stated 'unable to make decisions due to (Medical condition), decisions made through Best Interest, MCA to be completed'. We also noted that the person required the use of bed rails to keep them safe whilst they were in bed. The person also required the use of a seat belt whilst they were in their wheel chair. There was no record of a mental capacity assessment for either of these decisions in relation to their care, or a best interest's decision. Neither had the service Neither had a best followed the correct procedures by submitting a DoLS application to the local authority. We raised this with the registered manager and they told us "There should be a DoLS for that". A nurse we spoke with told us, "[person] should have a DoLS". The impact of this was that the service had not always taken action to ensure the appropriate consent was in place for people receiving care.

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

Staff had completed training in MCA and DoLS. Staff comments demonstrated they had an understanding of their responsibilities to support people in line with the principles of the Act. One member of staff told us, "Everyone is deemed to have capacity to make choices and decisions until deemed otherwise". Another staff member said, "It's about whether or not a service user has the capacity to decide to do something safely or not". A nurse we spoke with told us, "It's about choice and being able to make decisions and do things like taking their own medicines if they have the capacity to understand".

Staff told us and records confirmed they had effective support. Staff received regular supervision (one to one meetings with their manager). One staff member told us, "I get regular supervision. Another staff member said, "I have supervision. They ask me about the training I have had, the residents, how I am getting on. We discuss everything". Staff told us they felt supported by the team leader. One staff member told us, "I feel supported by my team leader". Records showed staff also had access to development opportunities. For example, national qualifications in care. One staff member we spoke with told us, "I am doing my NVQ level 3".

Staff induction was linked to the Care Certificate. The Care Certificate is a set of standards that social care workers are required to work to. It ensures care workers have the same skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

People told us they enjoyed the food provided by the home. One person told us "It's ok yeah it's good". Another person told us, "It was lovely today and we had trifle for pudding". People were offered a choice of meals. Staff advised us that if people did not like the choices available an alternative would be provided. One person we spoke with told us, "If you don't want the main then you can have something else". During our observation of the lunch time meal we noted that people were offered a choice of drinks throughout. People had access to and were offered drinks throughout the day.

People who needed assistance with eating and drinking were supported to have meals in a dignified way by attentive staff. We observed staff sitting with people and talking to them whilst supporting them to have their meals at a relaxed pace that matched the needs of the people they were supporting. We observed a staff member supporting a person with their lunch time meal. Throughout the interaction the staff member maintained conversation with the person and encouraged them appropriately when needing to.

People had regular access to healthcare professionals such as, G.P's, occupational therapists, dieticians, physiotherapists and other professionals from the care home support team. Where healthcare professionals provided advice about people's care this was incorporated into people's care plans and risk assessments.

Good

Is the service caring?

Our findings

Relatives were complimentary about the staff and told us staff were caring. Relatives comments included; "The carers I cannot fault", "As far as the staff and care go, it's great", "The carers are excellent", "The care is absolutely brilliant", "The care is exemplary, I can't fault it" and "I couldn't ask for a better home when it comes to care".

Staff were respectful and friendly with people. They chatted to people as they went about their work. For example, one member of staff went into a person's room to vacuum. The person was watching the television and the staff member said, "You've got your favourite programme on. I'll come back when you have finished watching it".
People received personalised care. For example one person had difficulties communicating. The person did not use conventional methods such as sign language and Makaton. However the person used a keyboard to spell out words to support them in their communication. During our inspection we observed this person communicating effectively with staff who gave the person the time they needed to explain what they were asking or discussing.
This persons care records gave guidance for staff to recognise and respond to the person's needs.

People told us they were treated with dignity and respect. One person we spoke with told us, "Yeah they treat me well". Another person we spoke with told us, "The care on the whole I receive here is second to none, and care wise I can't fault it". Relatives we spoke with told us; "They treat him with dignity", "They are very good, if [person] is in (their) room and they need to check (them) then they ask us to leave and close the curtain", "All staff engage well with [person]. Everyone talks to her even the cleaners. They always treat [person] with dignity" and "As soon as [person] is in their room, they do things right, like ask us to leave and draw the curtains". We saw staff call out to people if their room doors were open before they walked in, or knocked on doors that were closed.

Staff told us they respected people's privacy and dignity. One member of staff told us, "We make sure people are covered (when delivering personal care)". Another staff member said, "We cover people up with towels. It's important to keep dignity intact. You have to think how would you feel if someone left you exposed". A nurse we spoke with told us, "I treat people as I would like myself treated. If they are happy then I am happy".

We saw how staff spoke to people with respect using the person's preferred name. When staff spoke about people to us or amongst themselves they were respectful. People's friends and relatives could visit whenever they wanted to. People were able to meet their relatives in the communal areas or in the privacy of their rooms. One relative we spoke with told us "We can come and go as we wish".

Relatives told us they felt involved in peoples care. Comments included; "[Person] is clean tidy and involved in everything", "We are totally involved", "I talk to them every day and I feel they listen" and "The girls are always involving me".

People were encouraged to personalise their rooms. Rooms we observed had been personalised and made to look homely. One person we spoke with proudly showed us their room which had been decorated to their choice and preference. They said, "I chose it, I love it".

Care records highlighted what people could do for themselves in order to remain independent. This included aspects of personal care, mobility and getting dressed. Were the need to promote independence had been highlighted, there was guidance for staff on how to prompt and support people effectively. We observed staff following this guidance. For example people were able to make their own drinks and were provided with adapted cutlery or a lower table so they could eat independently at mealtimes.

Staff understood and respected confidentiality. Records were kept in locked cabinets and only accessible to staff.

Requires Improvement

Is the service responsive?

Our findings

People's care records contained a 'hospital passport'. These documents contained important information about people that could be passed to professionals in the event of an emergency or healthcare appointment. They reflected how each person wished to receive their care and support. However, these documents had not always been updated when people's needs changed. For example, one person's swallowing risk assessment dated July 16 highlighted the person required a pureed diet and double cream consistency drinks. However, the person's hospital passport stated, 'All food must be soft and moist all fluids thickened to a cream consistency'. The impact of this was that the person could receive the incorrect consistency of diet and fluids if they were admitted to hospital and would be at risk of choking or aspirating.

Another person required the use of a hoist and sling to assist them during transfers. Their hospital passport stated they required a 'full body sling with orange loops at the top and black loops at the bottom.' However the person's movement and mobility care plan had been updated in August 2017 to reflect that the person's needs had changed and that they now required a sling to be on the yellow loops. The hospital passport had not been updated. This put the person at risk of not receiving a safe or comfortable transfer if guidance in the hospital passport was followed.

We were informed that one person could not use their call bell. However, this person's care records highlighted that '(person) has (their) buzzer/ mobile phone to hand (to call for help). We spoke with a member of staff about this and they told us, "(Person) can't use a buzzer and (person) would not be able to hold a phone". During the course of our inspection we noted that the person was unable to use a buzzer or mobile phone. This meant staff accessing the person care records did not always have accesses to up to date information on the persons care needs.

Outdated care protocols were not always removed from care records. For example, one person had two epilepsy rescue protocols in different sections of their care record. One was dated as October 2016 and one dated July 2017. The oldest protocol did not document the timescale for when rescue medication should be administered. This meant staff accessing the protocol may not use the most up to date guidance for supporting the person appropriately.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

People's needs were assessed prior to admission to the service to ensure the service could meet their needs. People had contributed to assessments. Peoples care records held personal information about people including their care needs, likes, dislikes and preferences. Staff we spoke with knew the people they cared for. For example, we spoke with one staff member about a person they supported they were able to tell us the person's likes, dislikes and preferences that matched those outlined in the person's care records. Staff we spoke with were able to tell us people's preferences in relation to their care.

The service had an activity coordinator. People had access to activities which included board games,

quizzes, day trips, church service and arts and crafts. Activities were designed to meet the specialist needs of people using the service. For example, on the first day of our inspection we saw people participating in games designed for people with restricted mobility. People were clearly enjoying the activity. One relative we spoke with told us, "The activities lady is great, she is always trying to get people involved"

People knew how to make a complaint and information on how to complain was available in the home. One person told us, "Yes I know how to complain, in fact I have done so once". A relative we spoke with told us, "When I have raised concerns they have been jumped on it and listened to me". We saw evidence that complaints had been dealt with in line with the provider's complaint procedure.

Inadequate

Is the service well-led?

Our findings

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager had not always notified CQC of reportable events. For example, we found three notifiable events which should have been raised as notifications with the CQC. One incident involved an allegation surrounding unexplained bruising to a person. Another incident included unexplained bruising caused by the absence of appropriate equipment. We addressed one of the incidents with the registered manager, who told us, "That was the responsibility of (Nurse). But I should have double checked to see if it was done".

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

The provider and registered manager did not have effective systems in place to monitor the quality of service. For example, the provider's quality monitoring system had not identified the concerns relating to SALT recommendations not being followed, pressure care, failure to notify CQC of notifiable events, hourly checks for people who were unable to use a call bell and incomplete and inaccurate care records.

At our last inspection on 31 March 2016. We found concerns regarding thickening agents. In that the thickener was not always stored safely. We highlighted this further in our report which was published 28 April 2016. However on the first day of this inspection we found that thickener was not always stored safely. It was not until the second day our inspection when we raised this concern again that action was taken to ensure the safe storage of thickeners. This demonstrated that the registered manager had not addressed previous concerns raised by CQC.

The system in place to monitor the temperature of the medicines room was not always effective. The fridge and room temperatures were not consistently monitored to ensure medicines were stored in line with directions from drug manufacturers. For example, there were 10 occasions in August and four occasions in September where the medicines storage room temperature had not been recorded. The fridge temperature recording sheet documented the fridge temperature should be recorded twice each day. However, there were 14 occasions in September where the fridge temperature had not been recorded. The impact of this was that there was not an effective system in place to ensure that medicines were stored at in line with the manufacturer's guidance. Following the inspection we analysed that information we had on both recorded and unrecorded room temperatures. We were satisfied that medicines were stored within the recommended guidance. This concern related to the effective use of the provider's monitoring systems.

Records relating to peoples care were not always accessible to the registered manager r staff. For example, people's monthly weights were recorded on a central document. However, the weight charts for August and September could not be found by the registered manager. A hot water heater which was in place to support people in making hot drinks was faulty. However, there was no evidence that this had been reported by the registered manager as a fault. We asked the registered manager if they could provide evidence that this had taken place but they were unable to. The registered manager then told us, "We will get (provider) out to sort

it out". These concerns had not been identified through the services quality monitoring systems.

One person's specialist chair was not designed to be used outside. The service had recognised this and the person's care records stated, 'The armchair isn't designed for outside. Therefore the integrity of the wheels and the frame need to be checked'. We observed the armchair being used outside. We asked the registered manager to provide evidence that the appropriate maintenance checks were taking place. However we were shown a document titled 'cleaning log for wheelchairs'. This document did not demonstrate that the appropriate maintenance checks had been carried out. We were satisfied that the integrity of the wheels were not putting this person at risk. However the impact of this was that the registered manager did not have an accurate record to ensure this person equipment was effective.

The provider had a system in place to report incidents and accidents. On the second day of our inspection we asked the registered manager and a senior member of staff to show us on the system some of the incidents and accidents that had occurred within the service. However, they were unable to do this. We requested that this information was made available to us on our third day of inspection. However this request was not carried out. The registered manager and senior member of staff informed us that they were unable to do this. We spoke with the registered manager who told us, "The system is so complicated that I don't think anyone uses it, it's difficult to use, I have not come across a way in which I can run a report so I can analyse (incidents). I can't figure out how to use it. There has been no training. There is no way of analysing the information further". The impact of this was that the registered manager could not analyse accidents and incidents taking place in order to reduce the risk of future occurrence. The registered manager did not always follow the provider's accident and incident reporting procedure. For example the incidents that involved unexplained bruising to a person was not recorded on the provider's accident and incident monitoring system.

We raised with the registered manager our concerns relating to the quality monitoring systems in place. The registered manager told us, "I have raised this with [person] my manager. We asked the registered manager to provide evidence of this and they did. However, there was no evidence that further action had been taken by the provider to address the registered manager's concerns.

The registered manager had recently introduced a change within the service in that they had decided to relocate the activities to a room in an outside building. The registered manager told us, "It works better in terms of space". We asked the registered manager if a consultation had taking place with people. The registered manager told us that this had been "discussed in service user meetings". We requested further evidence to support this. However the registered manager was unable to provide this evidence during the course of the inspection. Therefore we requested that this evidence was sent to us following the inspection. The registered manager actioned this request and sent us a copy of two service user meeting notes. However one of these pieces of evidence was a hand written note that sated 'Downstairs to new activities – having to go outside. New space bigger. Could have a walkway'. Another piece of evidence stated 'Everything appears to be going well in activities with no concerns raised'. Therefore the registered manager did not provide evidence that there had not been a consultation with people about the changes to the service.

People and their relatives told us that a consultation about the move in the activities room had not taken place. Comments included; "There was no consultation. [Person] won't go over there which doesn't help", "We got told it was happening when they started doing it. It happened so quickly", "He didn't start talking to us about the changes", "There has been no consultation, there was supposed to be but it all happened very quickly", "It seems that external requirements are ripping the heart out of the place. Everyone was perfectly happy. But now the residents don't seem to be a factor in it" and "I don't have a problem with it. I think it's a

good idea, my only concern is what happens when it gets cold. There was no consultation, we just got told it was happening. If we would have had a meeting then any animosity would have been ironed out". The impact of this is that people's views and thoughts were not considered before changes were implemented within the service.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

We raised some of these concerns with the provider following the inspection and asked them what immediate action they were taking to address some of these concerns to ensure that the systems in place to monitor the safety of the service were effective. The provider sent us an action plan telling us how they are going to address these concerns.

Relatives and people we spoke with told us the registered manager was not visible and involved in the day to day running of the service. Comments included; "He says he has an open door policy, but he shouldn't be sat in an office all day he should be out and about", "The old manager used to go to (persons) room and sit with (person) to check everything was alright. (They) did it at least once a month. The new manager has been here for most of the year and my (relative) does not even know who the manager is", "The (registered manager) doesn't seem able to deal with people", "The leadership at meetings is very good, but there is a lack of leadership around things like asking simple things like how are you today", "I don't see [registered manager] often, he is always in his room" and "I'm used to the manager sitting and having a chat with us, but that doesn't happen anymore".

Relatives we spoke with told us there had been a noticeable deterioration in the positive atmosphere of the service. Comments included; "The service has lost its atmosphere, "The whole atmosphere of the place has changed dramatically" and "It's gone the atmosphere has gone".

Staff gave a varied response when speaking about the registered manager comments included; "(We) don't see the manager, (we) could do with a bit more support and checking", "I have every faith in [registered manager]. We know things need addressing and we are addressing them", "I don't feel supported by [registered manager]" and "[Registered manager] is decent".

Team meetings were regularly held where staff could raise concerns and discuss issues. The meetings were recorded and made available to all staff. One member of staff told us, "We have one every Friday, we say our views and I feel listened to".

Staff understood the whistleblowing policy and procedures. Staff told us they felt confident speaking with management about poor practice. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not always notified the Care Quality Commission (CQC) of reportable events.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not always supported in line with the principles of the Mental Capacity Act 2005 (MCA).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not an effective system in place to monitor the quality of service.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected against the risk associated with choking and aspiration and pressure damage.

The enforcement action we took:

We issued a warning notice