Vivo Care Choices Limited

Curzon House

Inspection report

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21 August 2017
24 August 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Curzon House on the 14th and 21st of August 2017 with a further announced visit on the 24th August 2017.

This visit took place in response to concerns that we had received following a serious incident that had occurred in the service. These concerned had focussed on the safety of people who used the service and the management of falls.

Our last inspection took place in May 2017 and the service was rated as good.

Curzon House is a residential care home which can accommodate up to 35 older adults who need residential care and who may also be living with dementia. Curzon House is predominately a short stay service however some people live there permanently. The home is owned by VIVO Care Choices Limited. All bedrooms have en-suite facilities.

On the days of our inspection twenty people were using the service at Curzon House. This included seven people who received permanent care with others receiving respite care.

The service had a manager who was registered with us in August 2017. 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.

During this visit, we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 in relation to person centred care, safe care and treatment, consent, and good governance.

The risks faced by people in respect of nutrition and susceptibility of developing pressure ulcers were not taken into account. No risk assessments had been devised by the registered provider in respect of these risks. This had subsequently been addressed by the registered provider.

Risk assessments in relation to falls were lacking in detail and did not contain the information needed by staff to manage falls and prevent future re-occurrence. The registered provider informed us subsequent to the inspection that a new admission protocol had been introduced making specific reference to the high risk of falls that people faced.

People who did not have the capacity to use call alarms to summon help were reliant on staff physically checking them at night. The capacity to use these alarms had not been determined by the registered provider. Records indicated that gaps had occurred in the frequency of these checks.

Assistive technology designed to assist staff to monitor people at night in order to ensure their safety had not been introduced at the time of our visit but we were informed subsequent to the inspection that this was now in place.

Changes to the body structure of people in respect of minor marks such as scratches had only been partially investigated which meant that people were at risk.

The consent of people who lacked capacity to make decisions was not gained.

The principles of the Mental Capacity Act 2005 had not been fully implemented by the registered provider. An overview of a person's capacity to make decisions was included at the assessment stage prior to admission but this only translated into whether a deprivation of liberty order was needed. Care plans did not include any details on how the principles of the Act could be used to gain consent from people or to make decisions in their best interest.
The registered provider informed us that improvements in Mental Capacity Act training and the gaining of consent had been subsequently introduced.

People who used the service and their families told us that they considered the staff team and manager to be caring. Staff gave us practical examples of how they promoted the privacy and dignity of people. This was confirmed through our observations. The deficiencies identified in this report meant that the service was not consistently caring.

Care plans were not person centred. There was no evidence that people had been involved in their care plan. There was no evidence that staff had been provided with the information they needed to best assist people in making decisions in their daily lives when their capacity was limited.
The registered provider informed us subsequent to our visit that a review of the care planning approach had been made.

People who used the service were at risk of social isolation. There was no structured activities programme in place and therefore people did not receive appropriate levels of stimulation. The registered manager had identified the need to make arrangement for activities but had not yet implemented this.

The service was not well led. The registered provider had failed to identify significant risks to people's safety. Audits had not picked up issues in respect of incomplete or missing risk assessments. The complete application of the Mental Capacity Act had not been applied to those who were unable to make decisions of themselves. The lack of person centred care plans had not been identified and no analysis of accidents had been made to prevent future reoccurrence or to establish patterns/trends at the time of our visit. The registered provider subsequently informed us of a new system to identify any patterns. The registered provider also informed us subsequent to the inspection that an improvement plan was being implemented.
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An issue in respect of medication and health support for those receiving respite care had been addressed. Arrangements in medication had meant that one person had not received prescribed medication. This had been identified and was now addressed. Medication systems were safely managed.

The premises were clean and hygienic. All equipment within the service was regularly serviced and checks made on the environment to ensure that it met the needs of people.

Staff received training and supervision appropriate for their role. Supervision included observation of care practice such as medication administration and response to specific individuals' needs.

Staff adopted a caring and patient approach in their support of people. Interactions were friendly and person centred.

A complaints procedure was in place. This provided people with the information they needed to make a complaint and complaints were investigated appropriately.

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.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were at risk of harm from unsafe care practice, lack of equipment and lack of robust risk assessments.

Systems to report safeguarding issues had improved and staff had an awareness of the types of abuse that could occur.

Medication systems had been improved for those receiving respite care.

The premises were clean and hygienic.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered provider did not fully apply the requirements of the Mental Capacity Act 2005 to assist people to make decisions for themselves.

The risks associated with poor nutrition were not always identified.

Staff received training and supervision appropriate to their role.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us they felt cared for, however care practice and limited risk assessments meant that people were at risk and were not consistently cared for.

Staff outlined the ways in which they would ensure privacy and dignity was promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not person centred and did not include details of how people could best be enabled to make decisions for themselves.

There was no activities programme which meant that people did not receive the opportunity to be involved or to receive appropriate stimulation.
A robust complaints procedure was in place.

Is the service well-led?

Inadequate

The service was not well led.

This visit identified a number of deficiencies and breaches in regulation that had not been identified by the management team.

Audits were not robust.

The registered provider always informed us of incidents that adversely affected the wellbeing of people who used the service.

Curzon House

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 14th, 21st and 24th of August 2017. The first two dates of the inspection were unannounced and on the third date, the service was made aware of our intention to visit.

The inspection team consisted of one Adult Social Care Inspector.

We reviewed all the information we held about the service. This included looking at any safeguarding referrals received, whether any complaints had been made and any other information from members of the public. We looked at notifications we had received. A notification is information about important events which the registered provider is required to tell us about by law.

We contacted the local authority safeguarding and contracts teams for their views on the service. A safeguarding incident had been reported to the local authority and this was under investigation. We conducted this visited in response to the details of the incident.

On the days of our inspection we spoke with six people who used the service, three relatives, the registered manager, deputy manager, senior staff and three staff members.

Observations were carried out throughout the three days of the inspection. We also undertook a Short Observational Framework for Inspection (SOFI). A SOFI is used to gather information and understand the quality of the experiences of people who use services who are unable to provide verbal feedback due to cognitive or communication difficulties.

We looked at a selection of records. This included three people's care and support records, staff duty rotas, medication administration and storage, quality assurance audits, complaints and compliments information, policies and procedures and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People told us "Yes I definitely feel safe" and "I feel safe with the staff team". Relatives told us that they felt that their relatives were in "safe hands" and they felt confident that all their relation's needs would be met. People told us that they always received medication when they needed it and that it was never missed.

During our visit we found that people who lived at Curzon House did not receive safe care and treatment.

All bedrooms had a call alarm available enabling those who were able to use them to summon help. All call alarm cords were accessible to people during our visit. In addition to this, alarms were located on each bedroom door. Staff would be alerted if a door was opened in the night indicating to them that someone may need assistance.

However, there was no indication through records that the capacity of people to use call alarms had been assessed. As a result physical checks by staff would be the only way it could be determined if the people who were unable to use their call alarms needed assistance and were safe in their bedrooms. No assistive technology such as pressure mats or sensors were available that could make staff aware that these individuals required assistance. The registered provider informed us subsequent to the inspection that assistive technology items had been introduced with the capacity of people taken into consideration.

Care plans indicated when people needed to be checked during the night. Daily reports indicated the time that people had been checked and whether they had needed any assistance. One person required hourly checks. Daily records indicated that for one night prior to our visit, these checks had not been carried to the stated frequency. In four cases, regular checks had been made yet there were gaps in records between the hours of 06.30 am and 09:30 am when people had risen. This meant that people were at risk of harm if they were not checked in accordance with their care plan or when there were gaps in checks during the early morning. Care plans included how a person's safety could be maintained. One care plan had no reference to how staff were to keep that person safe. As a result, this person was at risk of harm given that there was no clear actions for staff to take to protect this person.

Risk assessments outlining the risks faced by people who used the service in their daily lives were not robust. The likelihood that people would experience falls was recorded in a risk assessment at levels such as "low", "medium" or "high". These did not provide staff with an indication of how the risks could be managed or prevented. The registered provider informed us subsequent to the inspection that a new admissions protocol had been introduced making reference to the risk people faced of falls.
Any falls experienced by people were recorded and sent to the registered provider for statistical reasons. There was no indication of patterns or trends of falls being identified to prevent future re-occurrence. In relation to this, care plans made reference to people needing "regular night checks". This outlined a frequency of checks which was not specific and open to interpretation from staff as to how often physical checks should be made. Records of any falls were maintained yet these were limited to the type of fall and immediate action taken with no reference made to how these could be prevented in the future. Records indicated that there had a high number of accidents sustained by individuals while using the service over

recent months. Some of these falls had been unwitnessed and some of these falls had occurred in people's bedrooms. Some accidents had resulted in people being admitted into accident and emergency. The registered provider informed us subsequent to the inspection that a new system for identifying trends and patterns was to be introduced.

The risks faced by people in respect of nutrition were not in place. The likes and dislikes of people were recorded as well as any assistance they needed to eat their meals yet no reference was made to the risks people faced from malnutrition. No recordings of people's weights were in place and as a result staff were not provided with the information they needed to monitor whether nutritional needs were being met. The registered provider informed us subsequent to the inspection that these had been reintroduced.

In addition to this, there was no information in place in respect of people's skin viability. Foam mattresses were in place on all beds but there were no risk assessments indicating the susceptibility people had to developing pressure ulcers. This meant that the health of people was not fully promoted or protected by the registered provider. The registered provider informed us subsequent to the inspection that assessments had been introduced.

Personal evacuation plans were in place. These provided information to staff on how to safely support people in the event of the building needing to be evacuated. As people's respite stay ended, their evacuation plan was removed from the fire roll call file. One person who was a permanent resident within Curzon House had changes to their mobility needs which meant that they were reliant on a wheelchair. This had not been included in the evacuation plan which meant that this person could be risk if they needed to be evacuated from the building.

Body maps were included within care plans. These documents were designed to record any changes to a person's body that had been acquired while the person was receiving support. We looked at three completed body maps. One had recorded marks and these had been investigated and a satisfactory explanation made as to their cause. Two further records indicated marks had appeared yet there was no evidence that these had been investigated to establish their cause. The registered provider agreed with this and informed us subsequent to the visit that the need for documented action had been reinforced to the staff team.

This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not protected from risks to their personal safety.

Our records outlined that a safeguarding concern had been raised since our last visit in respect of medication. This related to people who received respite care. One person had not received medication prescribed to them. An investigation found that arrangements for registering people temporarily with a doctor and ordering medication had not been robust. On this visit, the registered manager was able to confirm that this had been addressed and records were available to confirm this action. People who received respite care from the service were now all registered with a local doctor and received medication as prescribed. This action was confirmed by the Local Authority.

All medication was locked in secure cupboards within each person's bedroom. These were locked when not in use. Controlled medicines had been prescribed to some individuals. These were separately stored in a lockable cupboard. Controlled medicines are prescription medicines which are controlled under the Misuse of Drugs Act 1971. A controlled drug register was used to ensure that stocks of these could be accounted for. These had been countersigned by two people when medicines had been administered within the controlled medicines register. Checks made during our visit found that the stocks of controlled medicines tallied with

the stocks entered into the register. Medication administration records were appropriately signed. These included details of how much medication had been received, who had checked the medication and details of any allergies that people had. An accompanying photograph was placed on each medication record to assist in identifying the correct person who was to receive the medication.

Staff who handled medication told us that they had received training in medication and that their competency to do this was checked. This was confirmed through training records. In addition to this, medication administration had been observed by members of the management team to ensure that this was done correctly and safely. This formed part of the clinical supervision of staff.

The same safeguarding concern had highlighted that the service had not returned documentation to the local authority outlining any low level safeguarding concerns. Low level concerns are any safeguarding concern which put a person at risk of harm but does not meet the threshold of significant harm set down by external agencies. The registered manager had now put this reporting process in place.

Staff had an understanding of the types of abuse that could occur. They stated that they had received training in this and this was confirmed through training records. They outlined the process for reporting this to the management team and were certain that any concerns would be reported appropriately. Senior staff were clear about the types of abuse that could occur and how any allegations would be reported to other agencies. Staff were aware of the whistleblowing process. They were aware that there were external agencies to which they could report any poor care practice. No whistleblowing concerns had been received by us since our last visit in May 2017.

People who used the service and their families told us that staff were always available to assist them when needed. A staff rota was in place. This outlined management, care and ancillary staff on duty at any one time.

The premises were found to be clean and hygienic during our visit. The registered provider employed domestic staff and these attended to their task throughout the building to ensure that standards of hygiene were met. Domestic staff had access to personal protective equipment (known as PPE) and these were used by staff. There were sufficient stocks of PPE for staff to use. In addition to this, there were sufficient stocks of paper towels and hand soap for staff to maintain hygiene as well access to hand sanitizer.

Records provided evidence that there was regular servicing to equipment used within the building. Fire fighting and detection equipment was regularly serviced and checked to ensure that they would be effective during an emergency. Portable appliances had also been tested to ensure their safety. Portable hoists had been subject to regular servicing. Tests had been done within six month intervals as legally required.

Requires Improvement

Is the service effective?

Our findings

People told us that they were happy with the way they were supported. This view was echoed by relatives. People told us "Staff know what they are doing" and "I have confidence in them [the staff]. People were happy with the food provided they told us that the food was of good quality, sufficient in portions and that a choice was available to them in line with their preferences.

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 are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered provider was not following the provisions of the mental capacity act 2005.

Prior to people receiving a service from Curzon House, an assessment document was completed. This made reference to whether someone had capacity to make decisions for themselves or whether a deprivation of liberty order was needed. While the capacity of individuals was considered at this stage, there was no evidence in care plans that this process continued. There was no evidence how people with limited capacity could best be assisted to make decisions for themselves. For example, all people who used the service had been provided with a call alarm in their rooms as a means of alerting staff that they required assistance. There was no information available within care plans to state whether the capacity of people to use these had been assessed.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because where a person lacks mental capacity to make an informed decision or to give consent, staff must act in accordance with the MCA.

Training records outlined that staff had had training in the Mental Capacity Act. Staff were able to give an overall account of the principles of the Mental Capacity Act and how these could be used in enabling people to make choices about their daily lives. There was little information within care plans as to how people who did not have capacity could be assisted to make decisions in their best interest. Applications had been made to the local authority for deprivation of liberty order for some individuals. These applications had been made to support the use of coded locks on the main doors of the building as people were deemed to be vulnerable if they were alone in the wider community. Delays in the process had meant that no orders had yet been granted.

The registered provider informed us subsequent to the inspection that the capacity of people to use call alarms would be included in a newly introduced assessment process. We were also informed by the registered provider that consent would be further reinforced through the new care planning process and that further training had been identified for staff.

The registered provider employed a cook and kitchen assistant. The kitchen contained all the equipment needed to provide meals to people who used the service. Information was available within the kitchen outlining the food preferences of people, any dietary preferences they had to fit in with their lifestyle and whether any softer diets were required. The cook was knowledgeable about the nutritional needs of people who were currently living or receiving respite at Curzon House.

Lunchtime was a relaxed and unhurried time. People were offered a choice of cold drinks before their meal and were able to choose where they wished to sit. People who required assistance with their mobility were escorted to their seat and were given the time to settle. Two people required some assistance with eating. On both cases, staff were available to assist them with eating. One member of staff sat with the person and provided assistance. In the case of the other person, the member of staff did not sit with the person but remained standing during the time they needed assistance. This gave an impression that assisting this person was a task rather than a meaningful experience for this person. This was fed back to the registered manager who stated that they this would be highlighted and addressed.

Staff received training in line with their role. A training matrix was available outlining training that was scheduled and when refresher training was needed. Training included mandatory health and safety topics as well as protecting vulnerable adults from abuse and mental capacity act awareness training. Staff told us that training was "very good with the company" and included a mix of online (e-learning) and external training. Our visit concluded that while MCA training was provided, this did not appear to be applied effectively.

Staff received supervision. This was confirmed through supervision records and through discussions with staff. Supervision included one to one meetings as well as team meetings specific to staff roles. In addition to this, observation of care practice was made and recorded. This included observations of medication administration and instances where staff had supported people who used the service in everyday tasks such as assisting them to eat.

Requires Improvement

Is the service caring?

Our findings

People told us that they were supported in a caring manner. They said "I cannot fault them [the staff]" and "They [staff] treat me with absolute respect". Other comments included "They [staff] have gone above and beyond to help me and my relation".

The service did not provide a consistently caring approach to the people it supported. There were gaps in the frequency of checking people in their rooms at night. This was demonstrated in care records which identified that while some people received checks to the required frequency others did not. In those instances, there were occasions when people were at risk given that there was no means that people could get help given their lack of capacity to use call alarms. This combined with gaps in staff checking people meant that people were at risk of harm. The registered provider subsequently informed us that the protocol for checking people at night had been reviewed and a personalised frequency of checking introduced for those at risk.

In addition to this, where body maps identified that people had sustained changes to their person; there was little or no information to suggest that these had been consistently investigated, actioned or reported. The registered provider informed us subsequent to the inspection that the need for thorough recording and investigation had been reinforced to the staff team.

There had been a delay in the registered provider contacting the family of a person who had sustained a serious injury within Curzon House. The registered manager had now done this.

This meant that people who used the service did not receive support that was consistently caring.

Staff gave an account of how they would promote the privacy of people. They gave practical examples of ensuring that doors were closed when supporting people with personal care tasks and knocking on bedroom doors before being invited to enter. They told us that they ensured that people were addressed in their preferred manner whether this was by first name or more formal terms.

Staff interactions with people were respectful, friendly and caring. However, one person was being assisted to eat but staff did not sit next to them at eye level while assisting them. This gave the impression that assisting this person was a task rather than a positive experience for this person. We told the registered manager about this and they had fed this back to the staff team. Staff provided information to people verbally and other written information such as the statement of purpose, complaints procedures and menus were on display for people to refer to. An emphasis was made on maintaining the independence of people. Some people were able to mobilise around the building independently while others relied on walking aids. Those who used walking aids were given the time to mobilise at their own pace and staff adopted a patient and unhurried approach with these individuals.

Those people who were permanently residing at Curzon House were able to personalise their bedrooms. This included them bringing in photographs, ornaments and other personal items in order to make their

personal accommodation as personal and home-like as possible. Other people receiving respite care still had the opportunity to bring in personal items if they so wished.

An inventory of people's personal items was maintained when people were admitted and this was added to as people bought new personal items or clothing. This enabled the service to demonstrate that the correct clothing, for example, would return to their owner after being laundered. One relative stated they had experienced some issues with the wrong clothes being returned to their relation but this had been addressed.

Compliments were received by the service. These took the form of letters and cards thanking staff for the care and support they had provided. These were available for staff to refer to.

Requires Improvement

Is the service responsive?

Our findings

People told us "I have not had to make a complaint" and "I have made a complaint in the past and things were eventually done to my satisfaction". People also told us that while they had never had to make a complaint they knew how to do so. They also felt confident that any concerns they had would be listened to. People who used the service and their families were aware of their care plans but did not want to be routinely involved in them. Other people were actively involved in their care plan and this extended to family involvement as well. People told us that there were not many activities on offer for them.

This visit found that people were not receiving a person centred approach to their care.

Care plans were in place for people who used the service. This included care plans for those who permanently resided at the service and those who were receiving respite care. Care plans had been devised following an assessment of need process undertaken by the service. This included gaining all other relevant information from other agencies such as the local authority or hospitals.

One senior member of staff had responsibility for the assessment of individuals' needs. This member of staff outlined the assessment process and how the needs of people were gained with a view to them receiving a service. The assessment process covered issues such as the support required with mobility, personal care and other general health issues. The registered manager considered that the process was robust and that those people whose needs could not be met by the service were not offered support. The senior member of staff responsible for admissions confirmed this by stating that people whose needs could not be met by the service were not offered support.

Care plans were available for all people who were using the service at the time of our visits. All care plans were located within each person's bedroom but it was not clear whether people looked at them or understood the way they were to be supported.

Care plans were not person centred. Person-centred care can be considered as an approach which sees the people receiving support as equal partners in planning, developing and monitoring care to make sure it meets their needs. The service supported some people who were living with dementia. Care plans referred to people having "primary dementia", "mixed dementia" and "vascular dementia". There was no indication on how these forms of dementia would impact on people's daily lives and how staff could best support them. In addition to this, care plans made reference to supporting people by "using verbal prompts", promoting independence" and "providing support in all aspects of personal care". This meant that support could be delivered in an inconsistent and unclear way. There was no evidence in care plans that individuals who were able to had been involved in devising their plan of care. The same applied to people who had been assessed as lacking capacity. Support included within their care plans did not demonstrate how to assist them to make decisions or meet their best interests.

The registered provider informed us subsequent to the inspection that staff were to receive training in the different types of dementia and how this impacted on people who lived with dementia.

Each care plan included a section on how to maintain people's safety. One care plan had no direction for staff on how to keep this individual safe. This meant that this person was at risk of harm.

Care plans were evaluated monthly although there was no indication whether people had been involved in monitoring the progress of their own care. Care plans were accompanied by daily records indicating the progress for each person on a day to day basis.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as the registered provider had failed to ensure that personalised records were held in respect of each person.

An activities co-ordinator had been employed by the registered provider but was not available due to long term sickness. As a result there was no regular activities programme in place at Curzon House and there were no planned future activities on display. The registered manager acknowledged this and was looking towards introducing temporary arrangements until the situation could be rectified. The lack of an activities programme meant that the people who used the service did not receive appropriate stimulation and were at risk of social isolation.
The registered provider informed us that the activities programme had been reinstated subsequent to our inspection.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as the registered provider had not provided care that reflected individual needs and preferences.

A complaints procedure was available and this was on display and available for people who used the service and their families. The complaints procedure outlined where complaints could be made if they arose and the timescale for investigation. Where complaints had been made, a complaints log had been devised outlining the nature of the complaint, the action taken to address it and feedback given to the person raising the concern. One relative had had to make a complaint in the past and told us that there had been a delay in addressing the issues but that this had been addressed.

Inadequate

Is the service well-led?

Our findings

People told us that the registered manager was supportive and approachable. One relative said "I am very grateful for the support and patience shown by the manager and the staff team".

The service had a registered manager. They had become registered with CQC since our last visit in May 2017. 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.

This visit found deficiencies in the governance of the service.

We found that people were at risk of harm. Risk assessments in relation to falls were brief and contained no information on how any risk of falls could be managed. The registered provider told us that a new protocol for admissions had been introduced making reference to the risk people faced of falls. There was a lack of assistive technology to ensure that people were adequately supervised at night. The registered provider informed us subsequent to our inspection that assistive technology had been introduced. Records indicated that there were gaps in the checks staff made on people during the night which meant that at times people who were in need of immediate assistance could not summon help. While call alarms were available no assessment had been made to ensure that people had the capacity to use them. Other risk assessments in relation to the prevention of pressure ulcers and malnutrition were not in place further placing people at significant risk. This had been subsequently addressed by the registered provider.

Personal evacuation plans were in place yet no action had been taken to amend these if the needs of people had changed. One person had experienced a change in their mobility which meant that arrangements for enabling a safe evacuation from the building had changed significantly. This had not been reviewed and meant that the person was at risk during an emergency.

Accident and incident records were recorded. These outlined details of accidents that had occurred and the action taken to provide any medical assistance that was required. The number of falls was then submitted to the registered provider for statistical purposes. Records showed that there had been a significant number of accidents and incidents within Curzon House. There was no evidence outlining what action had been taken in respect of each incident and how it could be prevented in future at the time of our visit. The registered provider informed us subsequent to the inspection that a new system for identifying trends and patterns was to be introduced.

There was a lack of information to identify how changes to the body structure of people (such as marks or scratches) had been acted upon and reported in all instances.

A number of audits were in place for monitoring the quality of support within the service. These included manager reports and visits from a representative of the registered provider. These audits had not been

effective and had not identified the issues that we identified during this visit. The lack of a structured activities programme had been identified but not acted upon and the incomplete application of the principles of the Mental Capacity Act 2005 had not been picked up. Care plan audits had been completed but did not identify that they needed to be person centred in their content. The registered provider informed us subsequently to the inspection that an audit of all aspects of the service had been devised and was to be implemented.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as good governance had not been applied to the running of the service.

The registered manager had started to set up an action plan identifying all those issues that needed to be improved within the service. This plan was on-going. The registered manager had started to inform the local authority safeguarding team of any low level safeguarding incidents on a monthly basis. This had been identified as not being done at a safeguarding meeting held prior to our visit.

Staff told us that the management team were approachable and supportive. This view was echoed by people who used the service and relatives. The registered manager maintained a presence within the building enabling them to be aware of the quality of support provided and any issues with the running of the service.

At our last visit in May 2017, we rated the service as good. The ratings from this visit were put on display within the service as well as the registered provider's website.

The registered provider continued to have a legal responsibility to inform us of any incidents that adversely affect the wellbeing of people. Our records outlined that the registered provider always let us know when such incidents occurred.