PNP Care Home Limited

PNP Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

PNP Care Home offers a homely environment with accommodation arranged in 12 single bedrooms and 4 double rooms over three floors, serviced by a passenger lift. Each bedroom is individually decorated and contains a nurse call system and television points.

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

PNP Care Home was newly registered on 23 November 2016. Consequently, this was their first inspection.

There was a registered manager in place. 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 asked the registered manager how they monitored accidents within the home. We were told all accidents were reported using accident forms. We reviewed the records and found no oversight of the accidents and no action taken following these to lessen the risk of accidents happening again.

We looked at medicine administration records (MARs) of people who lived at PNP Care Home. We checked the records and found several omissions in the documentation. We checked against individual medicines packs and found some discrepancies in the totals. This meant that we could not confirm that all administered medicines could be accounted for.

We viewed three care records to look how risks were identified and managed. We found inconsistencies in individualised risk assessments and the plans in place to mitigate these. The documentation did not always contain information to adequately mitigate the risks to individuals.

We viewed maintenance records which had documented water temperatures of 46°C, 50°C, and 45°C. No action had been taken by the service as a result of these readings. This could have put people at risk of scalds.

From the documentation reviewed we saw that fire safety equipment audits had not been completed at the home since September 2017. Therefore we could not be assured that the fire safety equipment at the home was safe, this put people at risk.

The above paragraphs amounted in a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2008 (Safe care and treatment.)

People are not supported to have maximum choice and control of their lives and staff do not support them in the least restrictive way possible; the policies and systems in the service do not support this practice.

This failure to follow the code of practice amounted to a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Need for consent.)

We spoke with the registered manager to assess their understanding of their responsibilities regarding making appropriate Deprivation of Liberty (DoLS) applications. We noted three people had alert alarms in place. These are alarms which are used to minimise the risk of falls. We asked the registered manager if DoLS applications had been made regarding the use of the alarms and the locked door that is in place at the home. The registered manager told us they had not.

We found that staff were able to tell us about safeguarding principles and recognised signs of possible abuse. However, they did not always put this knowledge into everyday practice. For example, we found that not all safeguarding incidents had been appropriately reported to the relevant authorities, in line with current legislation and the policies and procedures of the home.

The above paragraphs amounted in a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2008 (Safeguarding service users from abuse and improper treatment.)

There was no training matrix in place at the time of the inspection so the registered manager was not aware which staff were trained. We asked for this to be completed and sent to us following the inspection. Staff completion of training was low with only three out of 21 staff having dementia training. Nine out of 21 staff had completed health and safety training. Staff we spoke with told us that they would like further training.

These shortfalls in training of staff amounted to a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed five care files and found people's current needs were not always identified. Care plan information was not always an accurate, complete and contemporaneous record. Person centred information in care files was inconsistent.

We looked at what arrangements the service had taken to identify, record and meet communication and support needs of people with a disability, impairment or sensory loss. We viewed one care file for a person who was nonverbal we could not see any care plan in place for this assessed need.

We saw, from care records, staff had not discussed people's preferences for end of life care. This meant the provider would not know what the person's preferences were and would not be able to respect these on death. At the time of our visit, no one living at the home was receiving palliative or end of life care.

The above paragraphs amounted in a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the management and registered provider to tell us how they monitored and reviewed the service to make sure people received safe, effective and appropriate care. We found the service did not have a robust quality auditing system.

The lack of consistencies we found across the service also demonstrated the lack of oversight from the registered provider. From the evidence we found during the inspection it was apparent that the leaders in

the home lack the knowledge to ensure that the home is run effectively. The Registered manager demonstrated insufficient knowledge of the regulations.

These shortfalls in leadership and quality assurance amounted to a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers of health and social care services are required to inform the Care Quality Commission, (CQC), of important events that happen in their services. The registered manager of the service had not informed CQC of significant events as required. This meant we were unaware of the events and could not check appropriate action had been taken.

This resulted in a breach of Regulation 18 (Notification of other incidents) CQC (Registration) Regulations 2009.

You can see what action we told the provider to take at the back of the full version of the report.

Following the inspection the provider has provided us with an action plan to address the concerns that we highlighted, this is considered good practice. We found the whole staff team receptive to feedback and keen to improve the service. They worked with us in a positive manner and provided all the information we requested.

We received consistent positive feedback from people who used the service.

We reviewed staff rotas and observed that there were enough staff on duty to meet people's needs. People who lived at the home told us, "There are enough staff they come when I ask." And, "The staff come straight away when you need them." Staff we spoke with confirmed that they felt that there was enough staff on duty. We have made a recommendation about assessing staffing levels.

We looked around the home and found it was clean and tidy. The management team employed designated staff for the cleaning of the premises and cleaning schedules were completed.
We found the home was pro-active in supporting people to have sufficient nutrition and hydration. People we spoke with told us they enjoyed the food served at the home. Comments about the food included, "The food is very good." And, "I like the food if you don't like the choices they will get you something else."

There were activities for the residents to engage in and people were supported and encouraged to take part. One person told us, "We have a singer who comes in and we play pass a ball."

Following the inspection the provider has provided us with an action plan to address the concerns that we highlighted, this is considered good practice.

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 always safe.

We found not all assessed risks had a completed risk assessment as per the provider's own policy and procedures.

People could not be assured the premises were safe for their intended use and used in a safe way. Environmental risks were not consistently well managed.

Best practice guidance was not always followed in relation to the safe management of medicines.

Staff did not always follow safeguarding policies and procedures.

Is the service effective?

Inadequate

The service was not always effective.

People's rights were not always protected, in accordance with the Mental Capacity Act 2005.

Deprivation of Liberty Safeguards applications were not always submitted to the supervisory body as required.

Staff training was ineffective in ensuring staff were competent and had sufficient skills to meet the needs of people they cared for.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We received consistent positive feedback from people who used the service.

There was lack of consistence with care planning.

Records containing people's personal information were not always stored securely.

People's privacy and dignity were sometimes compromised as

personal details were on display.

Is the service responsive?

Inadequate

The service was not always responsive.

Peoples' needs were not reviewed when they had experienced a change in circumstances.

People's care plans did not contain up to date person centred information.

People and their relatives said they knew how to raise a complaint.

People were not supported to discuss their future wishes.

Is the service well-led?

Inadequate

The service was not well-led.

Audit processes had not consistently identified shortfalls found on inspection.

People were put at risk because systems for monitoring quality and safety were not in place.

Policies and procedures were in place but were not always adhered to.

PNP Care Home

Detailed findings

Background to this inspection

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

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

PNP accommodation is arranged in 12 single bedrooms and 4 double rooms over three floors, serviced by a passenger lift. During the time of inspection there were 17 people living at PNP Care Home.

Before the inspection visit we contacted the commissioning department at Blackpool Council. In addition we contacted Healthwatch Lancashire. Healthwatch Lancashire is an independent consumer champion for health and social care. This helped us to gain a balanced overview of what people experienced accessing the home.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

This inspection took place on 06 December 2017 and was unannounced. A further inspection site visit took place 07 December 2017 which was announced.

The inspection team comprised of one adult social care inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care home. The expert-by-experience had background knowledge of caring for the elderly.

We spoke with a range of people about PNP Care Home. They included nine people who lived at the home,

four relatives, the registered manager and four staff members.

We closely examined the care records of three people who lived at the home. This process is called pathway tracking and enables us to judge how well the home understands and plans to meet people's care needs and manage any risks to people's health and wellbeing.

We reviewed a variety of records, including policies and procedures, safety and quality audits, four staff personnel and training files, records of accidents, complaints records, various service certificates and medicine administration records.

We observed care and support in communal areas and had a walk around the home. This enabled us to determine if people received the care and support they needed in an appropriate environment.

Inadequate

Is the service safe?

Our findings

People we spoke with told us, "I couldn't ask for anything more." Another said, "Everything is fine by me."

We viewed three care records to look how risks were identified and managed. We found inconsistencies in individualised risk assessments and the plans in place to mitigate these. The documentation did not always contain information to adequately mitigate the risks to individuals. For example, we found in the daily records that one person was becoming physically aggressive with staff during personal care and was hitting out and trying to bite staff. There was no record of this behaviour within risk assessments or the care plan. This put the person and staff at risk.

Another example was a person who was assessed as high risk for 'skin marks, bruising and skin integrity'. There was no care plan in place for staff to follow to mitigate this risk for the individual.

We asked the registered manager how they monitored accidents within the home. We were told all accidents were reported using accident forms. We reviewed the records and found no oversight of the accidents and no action taken following these to lessen the risk of accidents happening again.

We found one person had five falls over a three month period with no further action documented. Three of the falls documented the person had hit their head. The other two were unseen falls. We could not see that medical attention had been sought. No additional checks were documented to show that the condition of the individual had been monitored. We spoke to the registered manager about the recorded accidents and they were not aware that the accidents had taken place. We checked the documentation for the people concerned and found care plans and risk assessments had not been updated. This put people at risk as medical attention was not sought where necessary and there were no plans in place to prevent the incidents from occurring in the future.

A lack of sufficient risk management for individuals amounted to a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2008 (Safe care and treatment.)

We found that staff were able to tell us about safeguarding principles and recognised signs of possible abuse. However, they did not always put this knowledge into everyday practice. For example, we found that not all safeguarding incidents had been appropriately reported to the relevant authorities, in line with current legislation and the policies and procedures of the home. We found one person had been involved in three separate incidents involving physical altercations with other people in the home. We could see no action that had been taken to safeguard the person or others. There had been no investigation and no lessons learned were recorded. We asked the registered manager about these and again they were unaware that they had taken place. Only seven of the 21 staff working at the home had received training in relation to safeguarding people.

This amounted to a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safeguarding service users from abuse and improper treatment.).

We referred the above accidents and incidents to the local safeguarding team.

We looked at medicine administration records (MARs) of people who lived at PNP Care Home. We checked the records and found several omissions in the documentation. We checked against individual medicines packs and found some discrepancies in the totals. This meant that we could not confirm that all administered medicines could be accounted for.

Audits of MARs documentation were not carried out therefore we could not see explanations for the errors. The registered manager said these are checked but could not provide explanations for the omissions. There was a book for staff to document any mistakes or near misses with regards to medicines. We found two recorded incidents in the book. One was where a tablet was found in someone's bedroom and the other was for someone who missed the medicines. There was no information on what was done about this. There was no investigation to find out which medicine it was or any action to seek medical advice. This put people at risk of medication errors.

We looked at people's care plans and found gaps in information regarding people's medicine regimes. The staff were giving one person their medicines covertly and this had been agreed by the GP. However, there was no documentation in the care plan to guide staff around how the medicines should be given to the individual. I spoke to a staff member who confirmed that the information was gained from the pharmacy and this was held in the communication book. The information was not easily located which put the person at risk of medicines mismanagement.

We found that people did not have support plans to guide staff when giving medicines which are taken "as needed". Therefore staff did not have all the relevant and necessary information to give the medicines appropriately and safely. One of the people receiving medicines "as needed" was nonverbal and could not express when medicine was needed. This could have put people at risk of medication mismanagement.

We spoke to the manager about this and they confirmed to us that there were no support plans for medicines in place.

We saw that people were prescribed topical treatments for skin conditions. Topical cream administration was found not to be safe. There were no topical cream charts in place. We found that the MARs sheets had not been signed to say when creams had been applied. The person administrating these treatments should have clear direction and demonstrate accountability by signing administration records.

Controlled medicines were kept separate in a secure cupboard; records for these medicines were completed in full.

These shortfalls in medication arrangements amounted to a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We viewed maintenance records which had documented water temperatures of 46°C, 50°C, and 45°C. No action had been taken by the service as a result of these readings. The health and executive guidance states if hot water used for showering or bathing is above 44 °C there is increased risk of serious injury or fatality. Where large areas of the body are exposed to high temperatures, scalds can be very serious and have led to fatalities. We raised this issue with the registered manager on the day of the inspection and they were unaware of the high water temperatures. An engineer was contacted to attend. We requested a risk assessment and plan to be completed immediately to help safeguard people from the identified risk.

From the documentation reviewed we saw that fire safety equipment audits had not been completed at the home since September 2017. We spoke to the registered manager who confirmed that this was correct. Therefore we could not be assured that the fire safety equipment at the home was safe, this put people at risk.

The issues found with the water and fire audits amount to a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2008 (Safe care and treatment.)

Under current fire safety legislation service providers are required to provide a fire safety risk assessment that includes an emergency evacuation plan for all people likely to be on the premises in the event of a fire. In order to comply with this legislation, a Personal Emergency Evacuation Plan [PEEPs] needs to be completed for each individual living at the home. We looked at PEEPs during this inspection and found people had up to date PEEPs in their files to aid safe evacuation.

The service did not have a tool in place to calculate the number of staff required. Additionally as there was no up to date training matrix at the service we could not identify if there was the correct skill mix amongst the staff on duty. We spoke to the registered manager about this. They confirmed that they could not provide evidence that the staffing was determined based on peoples individual needs. We reviewed staff rotas and observed that there were enough staff on duty to meet people's needs. People who lived at the home told us, "There are enough staff they come when I ask." And, "The staff come straight away when you need them." Staff we spoke with confirmed that they felt that there was enough staff on duty.

We recommend that the service consider current guidance for use of a dependency tool to assess staffing levels at the home.

People were protected by suitable procedures for the recruitment of staff. The registered provider had carried out checks to ensure staff had the required knowledge and skills, and were of good character before they were employed at the home. The checks included written references from previous employers. Checks on new care workers had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

We looked around the home and found it was clean and tidy. The management team employed designated staff for the cleaning of the premises and cleaning schedules were completed. We observed staff making appropriate use of personal protective clothing such as disposable gloves and aprons.

Inadequate

Is the service effective?

Our findings

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We looked at how the home gained people's consent to care and treatment in line with the MCA. The home provided a service to people who may have an impairment of the mind or brain, such as dementia. We found people's capacity to consent to care had not always been assessed and information was at times conflicting. For example, in two people's care file their next of kin had signed for the consent to the service where the person's mental capacity had not been considered. The MCA stipulates that if a person lacks capacity to consent to a decision then a best interest process needs to be undertaken. Therefore the correct processes had not been followed.

Records confirmed staff had not undertaken training in MCA and DoLS. Staff told us they were unsure of how this applied to their practice. We asked staff about their understanding of the MCA. Staff told us, "I haven't had training in MCA." And, "I don't have knowledge of MCA and DoLS I think I am due to do that training."

This failure to follow the code of practice amounted to a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Need for consent.)

We spoke with the registered manager to assess their understanding of their responsibilities regarding making appropriate Deprivation of Liberty (DoLS) applications. We were told there was one authorised DoLS in place and no further applications in place at the time of our inspection. The registered manager told us they were aware of the processes to follow and would ensure these were followed if the need arose. During the inspection we noted three people had alert alarms in place. These are alarms which are used to minimise the risk of falls. We asked the registered manager if DoLS applications had been made regarding the use of the alarms and the locked door that is in place at the home. The registered manager told us they had not. We asked the registered manager if they understood that the restrictions would amount to a deprivation of someone's liberty and the confirmed they were not aware of this.

This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2008 (Safeguarding service users from abuse and improper treatment.)

We asked staff if they received training to help them understand their role and responsibilities. Staff told us, "I have only done two training courses." And, "I have been given some online courses to do but they aren't

completed."

There was no training matrix in place at the time of the inspection so the registered manager was not aware which staff were trained. We asked for this to be completed and sent to us following the inspection. The training matrix we received showed that training was not considered for key areas such as behaviours that challenge. Staff completion of training was low with only three out of 21 staff having dementia training. Nine out of 21 staff had completed health and safety training.

There are no documented staff competency checks to ensure that the staff are competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs. Staff we spoke with expressed concerns around the training and stated that they felt that they would benefit from additional training.

These shortfalls in training of staff amounted to a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed staff supervision and appraisals at this inspection and found these were taking place and documented. Staff told us they were able to access informal support from other staff members and management in between supervisions.

We reviewed documentation which evidenced people were supported to see other health professionals as their assessed needs required. This demonstrated information was communicated to ensure people received care and support which met their needs. For example, we saw people were referred to doctors and district nurses if there was a need to do so. However, we noted care records were not always updated to reflect the health professional's advice. Information could be located in the staff communication book but was not accessible in individual's files.

We found the home was pro-active in supporting people to have sufficient nutrition and hydration. We observed people were encouraged to take fluids. People had been assessed on an individual basis and care plans showed associated risk, action plans and people's preferences. We saw evidence the plans had been followed by staff.

We observed lunch being served, we saw some people who had difficulty cutting their food being offered support to eat their meal. We observed people eating in a relaxed manner and they enjoyed their meals. People were offered a variety of meal options, such as two choices at lunch. In addition, a staff member told us if someone did not want what was available they would provide another alternative. People we spoke with told us they enjoyed their meals. Comments about the food included, "The food is very good." And, "I like the food if you don't like the choices they will get you something else."

Records we looked at confirmed all staff who prepared food completed food safety and hygiene training. The kitchen was clean and tidy with modern equipment. Staff completed associated safety and cleaning records, such as appliance temperature checks, to maintain food safety.

We walked around the home to check it was a suitable environment for people to live. We found it was suitable for the care and support provided. There was a lift which serviced the building and all rooms could be easily accessed. Each person's door had a photograph on the outside to help them identify their own room.

Requires Improvement

Is the service caring?

Our findings

We received positive feedback about the staff from people who lived at PNP Care Home. One person told us, "The care is very good." Another said, "The staff here are nice and polite."

We found that records were not always stored securely at PNP Care Home. We noted a book was left out on the medicines trolley unattended. We asked to see this and on viewing it, we found this contained personal details of people who lived at the home.

This amounted to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance).

People's privacy and dignity were not always respected and promoted. Staff told us about how they protected people's dignity, such as when helping them with personal care. They demonstrated they had a good understanding of the importance of maintaining people's dignity and treating people with respect. However, we found a notice board in a communal area displayed personal details of people including listing their individual care needs. Prior to the inspection concluding, we saw this had been addressed.

We did not see evidence that the home offers information to people and their families about other agencies such as safeguarding or advocacy. Therefore people are not always fully informed about the services available to them. We discussed the provision of advocacy services with the registered manager. We were informed there were no people accessing advocacy services at the time of the inspection.
We did not see that people were fully involved in their care planning. People's beliefs, likes and wishes were not always recorded within care records. Care files did not always contain a comprehensive history of each person to support staff in developing positive and meaningful relationships with people. However we did observe staff as they went about their duties and provided care and support. We saw staff speaking with people who lived at the home in a respectful and dignified manner. For example, we observed staff members speaking to people at their level so they had good eye contact.

People had their own bedrooms and had been encouraged to bring in their own items to personalise them. We saw people had bought in their own ornaments and rooms were personalised with pictures and paintings.

Staff had a good understanding of protecting and respecting people's human rights. Some staff had received training which included guidance in equality and diversity. We discussed this with staff; they described the importance of promoting each individual's uniqueness. There was a sensitive and caring approach, underpinned by awareness of the Equality Act 2010. The Equality Act 2010 legally protects people from discrimination in the work place and in wider society.

Inadequate

Is the service responsive?

Our findings

We asked people who used the service if staff were responsive to their needs. One person we spoke with told us, "The staff meet all my needs, I couldn't ask for anything more."

We reviewed five care files and found people's current needs were not always identified. Care plan information was not always an accurate, complete and contemporaneous record. Person centred information in care files was inconsistent. For example, we viewed the file for one person which said two staff were to assist with personal care. However, the daily notes documented that when two care staff were in attendance the person would become agitated. The care plan did not contain any information on how best to approach the person to ensure their individual care needs could be met.

We looked at what arrangements the service had taken to identify record and meet communication and support needs of people with a disability, impairment or sensory loss. We viewed one care file for a person who was nonverbal we could not see any care plan in place for this assessed need. Staff told us the staff had a way of communicating with the person through gestures. This was not reflected in the person's care plan

There was no documentation in place to be shared with other professional's about people's needs. For example, when a person visited the hospital. This meant other health professionals may not always have information about individuals care needs before the right care or treatment was provided for them.

We saw, from care records, staff had not discussed people's preferences for end of life care. This meant the provider would not know what the person's preferences were and would not be able to respect these on death. At the time of our visit, no one living at the home was receiving palliative or end of life care.

The above concerns amounted to a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there was a complaints procedure which described the response people could expect if they made a complaint. Staff told us if people were unhappy with any aspect of the home they would pass this on to the registered manager. This demonstrated there was a procedure in place, which staff were aware of to enable complaints to be addressed. People and relatives we spoke with told us they were aware of the complaints procedure and were confident their complaints would be addressed. At the time of our inspection visit the home had received no complaints.

There were activities for the residents to engage in and people were supported and encouraged to take part. One person told us, "There are things to do here but I don't get involved." Another said, "We have a singer who comes in and we play pass a ball." During the inspection we observed people being supported to play a pre- arranged activity. This demonstrated people were encouraged to engage in social events to minimise the risk of social isolation. During the activity we saw people laughed and joked. People were smiling and singing. We saw the activity was enjoyed by those who attended.

Inadequate

Is the service well-led?

Our findings

People told us, "The manager is very nice." And, "The manager always seems busy, but they are nice."

We looked at how staff worked as a team and how effective communication between staff members was maintained. Staff reported that the culture in the home could be improved. Staff said that they thought that communication could be better within the home. Staff told us they were involved in the day to day running of the home and that they felt their input was not always valued by the registered manager.

We asked the management and registered provider to tell us how they monitored and reviewed the service to make sure people received safe, effective and appropriate care. We found the service did not have a robust quality auditing system. There were no audits for care files, daily notes and medication administration records. The maintenance and safety audits had not been completed since September 2017. We found issues which could have been identified by audits such as missed signatures on MARs charts, errors in care documentation and water temperatures that exceeded 50 degrees centigrade.

The lack of consistencies we found across the service also demonstrated the lack of oversight from the registered provider. This highlighted the need for robust oversight and monitoring to ensure the response was appropriate and without delay.

We reviewed the provider's policies and procedures. We found these were not being followed by management or staff. We asked the registered manager about the procedure for medicines and they responded that the policy was lengthy and they had not read it. The staff told us that the home did have 'policy of the month' where staff were to read a policy and sign to say they had read this. However the content of the policies and procedures was not put into practice.

We found that records were not always stored securely. We noted the MARs book was left unattended on the medicines trolley in the corridor. We asked to see this and on viewing it, we found this contained personal details of people who lived at the home.
The registered manager was not aware of accidents and incidents that had happened and families had not been made aware. Failure to maintain robust recording systems around accidents and incidents meant that the service was not effectively monitoring and auditing its daily practices to allow lessons to be learnt and to keep people safe.

Staff had access to online training however this was not embedded into their practice. The registered manager had not ensured that the staff working at the home had completed the training and has the correct knowledge and skills to care for people effectively. No additional resources had been accessed to help develop the staff team and drive improvement in the home.

From the evidence we found during the inspection it was apparent that the leaders in the home lack the knowledge to ensure that the home is run effectively. The registered manager demonstrated insufficient knowledge of the regulations.

These shortfalls in leadership and quality assurance amounted to a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers of health and social care services are required to inform the Care Quality Commission, (CQC), of important events that happen in their services. The registered manager of the service had not informed CQC of significant events as required. This meant we were unaware of the events and could not check appropriate action had been taken.

This resulted in a breach of Regulation 18 (Notification of other incidents) CQC (Registration) Regulations 2009.

The home had a registered manager in place. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the home is run.

We looked at how the service gained the views of others. No documentation was seen to evidence the views of stakeholders or staff had been sought and acted on. Surveys had been sent to people who use the service in January 2017 however there was no oversight or evaluation of the responses for the purposes of continually evaluating and improving the service.

The registered manager told us people were encouraged to feedback their views on the service provided. We viewed documentation which evidenced 'residents meetings' took place and surveys were provided to enable people to express their views. However we did not see evidence that any action was taken when feedback was received.

We found the registered manager was familiar with people who lived at the home. We observed people smiling when they saw them and approaching them without hesitation. It was clear from our observations that people knew the staff team.

Following the inspection the provider has provided us with an action plan to address the concerns that we highlighted, this is considered good practice. We found the whole staff team receptive to feedback and keen to improve the service. They worked with us in a positive manner and provided all the information we requested.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider of the service had not informed CQC of significant events as required. Regulation 18 (1) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that people who use the service receive person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences, whatever they might be. Regulation 9 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not have suitable arrangements to ensure the treatment of service users was provided with the consent of the relevant person in accordance with the Mental Capacity Act 2005. Regulation 11(1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 12 HSCA RA Regulations 2014 Safe

personal care	care and treatment The provider did not have suitable risk management arrangements to make sure that care and treatment was provided in a safe way for all service users. Regulation 12 (1) (2) (a) (b) The provider must ensure that staff follow plans and pathways to ensure that safe care and treatment of individuals. Regulation 12 (1) (2) (b) The provider did not have suitable arrangements to ensure medicines were managed in a safe way. Regulation 12 (1) (2) (g) The registered provider had not ensured the premises were safe for their intended use and used in a safe way. Regulation 12 (1), (2), (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People who lived at the home were not always lawfully deprived of their liberty. Regulation 13 (1) (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured the processes they had to monitor quality and identify areas for improvement were always effectively implemented. Regulation 17 (1) (2) (a) (b) (c) (f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not have suitable arrangements in place in order to ensure that persons employed were trained to deliver care to people safely and to an appropriate standard. Regulation 18 (1) (2) (a) (b)