Curzon Professional Services Limited

Curzon Park Residential Home

Inspection report

13 Curzon Park South
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Date of inspection visit:
06 December 2016

Date of publication:
08 January 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on the 12 & 14 January 2016. Since that inspection we received concerns regarding the safety of the premises. As a result we undertook a comprehensive inspection to look into those concerns on the 6 December 2016. We also followed up on concerns raised at the last inspection.

Curzon Park is situated in a residential part of Chester. It is registered to provide personal care for up to 25 older people and people living with dementia. At the time of the visit there were 20 people living at the service.

There was no registered manager in post, and the service was without a manager. There had been four managers employed by the registered provider over the last 12 months, and following the visit a new manager started. 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.

In January 2016 the service was rated as 'requires improvement' and we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were no systems in place to monitor the quality of the service. At this inspection we found that the required improvements had not been made. We also identified a number of new breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Prior to our inspection, the fire service had identified a number of concerns relating to the premises. As a result an enforcement notice has been issued with a compliance date of 9 February 2017.

Parts of the environment were not safe and placed people at risk of harm. In two examples we required the registered provider to take immediate action to keep people safe. There were no audits of the environment to ensure that it was safe, and therefore the registered provider had failed to identify issues that needed rectifying.
Action was not taken to ensure people's physical health was maintained. There was no system in place to ensure that pressure relieving mattresses were on the correct settings, and in one example we found the setting was far too high. This increased the risk of people developing pressure sores. Risk assessments were not always accurate and action had not been taken to keep people safe. For example, the malnutrition risk assessment for one person had failed to identify that they were at high risk of malnutrition.

There had been a high proportion of accidents and incidents within the service since September 2016 in relation to the number of people using the service. On multiple occasions during the visit we saw that staff had left people unobserved in communal areas, which increased the risk of incidents occurring.

People were not protected from the risk of infection. An up-to-date legionella check had not been

completed to ensure that bacteria levels in the water were safe and water temperatures were not being monitored. Laundry processes were not sufficient to prevent cross contamination and parts of the environment were dirty.

Recruitment processes were not robust. Staff had not been required to provide references from previous employers. This meant that the registered provider had not had access to important information needed to make judgements about their suitability to work with vulnerable people. A check by the disclosure and barring service (DBS) had been completed.

Staff had not received training in key areas such as safeguarding, infection control and moving and handling. This meant that the registered provider had failed fulfil their duty to ensure that staff knowledge and skills were up-to-date.

People were not always treated with dignity and respect and their confidentiality was not protected. For example staff spoke sharply to people at times and one person's care record described them as "demanding" and was not strengths based. Letters labelled as 'private and confidential' were not kept securely and were left in a tray near the entrance to the building.

There were limited activities available for people. People's relatives told us that staff did nail care and baking activities, however during the visit there was no entertainment for people. One relative told us that there had previously been an activities co-ordinator, however this post had been cut to save money.

Leadership within the service was poor. Staff did not have a management structure to refer to and we saw examples where they did not receive the support they needed from the registered provider. There were no audit systems in place to monitor the quality of the service, and the registered provider had not completed quality monitoring checks. This meant that the registered provider had failed to identify and act upon serious issues that we identified.

Following the visit CQC took urgent action and placed a condition on the registration of the provider to ensure that the service had sufficient staff working in the home to maintain people's safety in the event of a fire.

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.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The environment posed a risk to people's safety. People were at risk from cross infection due to parts of the environment being unclean.

Risk assessments were not always accurate, and action was not taken to ensure people's safety was maintained. People did not receive some medications as prescribed.

Recruitment processes were not robust and did not ensure that people were protected from the risk of harm.

There had been a high number of accidents and incidents within the service which showed people's wellbeing was not being maintained.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received the training and support they needed to carry out their role effectively.

Mental capacity assessments had not been completed in line with the Mental Capacity Act 2005. Staff were not aware of their roles and responsibilities in relation to the Act.

People were not always referred to healthcare professionals as required.

Is the service caring?

Inadequate

The service was not caring.

People were not always treated with dignity and respect. Information contained within care records was not always positively worded.

People's confidentiality was not maintained. Records and letters containing personal information were not stored securely.

Information around advocacy services was not available to people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records did not always contain accurate or up-to-date information.

There were not enough activities available for people.

There was a complaints process in place, however this did not contain or address all concerns that had been raised with the service.

Is the service well-led?

Inadequate

The service was not well-led.

There was no manager within the service, and there had been a high management turnover over the past 12 months.

Staff morale was low and there was not enough support available to them from the registered provider.

Quality monitoring systems were not in place to ensure the quality of the service was maintained.

Curzon Park Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on the 6 December 2016 and was unannounced. The inspection was completed by an adult social care inspector and inspection manager.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Due to technical problems a PIR was not available and we took this into account when we inspected the service and made the judgements in this report.

Prior to the inspection we were contacted by the fire service who raised concerns about the safety of people using the service. We also spoke with the local authority contracts and commissioning team who raised a number of concerns relating to the environment, a lack of activities and fire safety concerns. We contacted the local authority safeguarding teams who did not report any concerns at the time.

During the inspection we spoke with four people who used the service and four people's relatives. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We spoke with four members of staff and the registered provider. We looked at five people's care records and the recruitment records for two members of staff. We also looked at other records relating to the day-to-day management of the service. We made observations around the interior and exterior of the premises.

Inadequate

Is the service safe?

Our findings

People's family members told us that they felt people were safe. However they commented that there had been deterioration in the environment. One relative commented that parts of the service "Smelled unclean", whilst another commented that at times they did not think there were enough staff.

At the last inspection in January 2016 we identified concerns relating to the use of 'child gates' on the stairs and these were subsequently removed. However there was now a gate in another of the corridors but there was no risk assessment in place. This showed that the registered provider had failed to consider the risk of people attempting to climb over this and cause themselves injury. Following the inspection the registered provider informed us that a risk assessment had been completed and a new gate had been put in place.

At the last inspection we found that auditing of accidents and incidents was not being done in a timely manner and we found no improvement on this visit. We observed on multiple occasions throughout the day that staff were congregated in the dining room whilst people were sat on their own in the lounge areas. This meant that there were insufficient levels of observation in place which increased the risk of accidents and incidents. Accidents and incidents records showed that In September 2016 there had been 13 falls. In October 2016 there had been six falls and five altercations between people. Between the 1 November 2016 and 2 December 2016 there had been 11 falls and five altercations between people. This showed a high number of incidents in relation to the number of people who used the service. We requested records prior to this period but we told that they had been lost and were therefore not available. Incident reports showed that action had been taken to refer people to health professionals where this had resulted in injury. However an audit of these incidents had not been completed which meant that trends could not be highlighted and appropriate action taken to minimise the risk of these occurring again in the future.

We looked at the care records of five people and found that risk assessments regarding their needs were not up-to-date. The risk assessments in one person's care records had not been reviewed since July 2016. In another example the moving and handling risk assessment had been reviewed in August 2016, however changes had not been made to the mobility care plan.

Prior to this visit we were contacted by the Fire Authority as they found concerns relating to the safety of the service users in the building in particular if there was an outbreak of fire. The registered provider had failed to take action in response to a fire safety risk assessment carried out in 2015, which had raised a number of concerns. These issues had been raised again in a fire risk assessment in October 2016. These concerns included the fact there were insufficient staff working during the night shift to ensure that people living in the home could be evacuated in a safe manner. The registered provider had agreed that he would increase the levels of staffing at night time from two to three in order to promote the safety of the people who use the services. Following our inspection we took urgent action and placed a condition on the registered provider's registration such that they must ensure there are sufficient numbers of staff in place to facilitate a safe evacuation. We also stipulated that the registered provider must ensure that people requiring the assistance of two staff when mobilising, must be accommodated on the ground floor for evacuation purposes.

Fire drills had not been completed during the night to ensure that people could be evacuated safely and quickly from the premises with the minimum number of staff available. Some fire doors, including the dining room door did not close properly and needed replacing. This compromised the people's safety in the event of a fire as this enabled the fire to spread more quickly. We looked in the basement and found that there was a crack in the ceiling along the joist which meant that a fire would be able to spread more rapidly to the upper levels.

There was a generic personal emergency evacuation plan (PEEP) in place, however this did not identify any specific support individual people may require in the event of an emergency. For example, there was no information around how many staff people would require to support them. This meant that plans were not robust enough to support people in the event of an emergency.

At the last inspection we identified that improvements were required to the environment. On this inspection, we found that environmental checks were not in place to ensure the environment was safe and suitable for the people that used the service. Parts of the environment were unsafe and required immediate attention. In one example, the lock on a door leading up to the attic via steep stairs was broken. This placed people at risk of injuring themselves should they attempt to climb the stairs. We raised this with the registered provider who told us that they had identified this issue "a couple of days ago" but failed to take action to rectify this. Action was taken during the visit to remedy this. There were a number of wardrobes in people's bedrooms which were not fixed to the wall and one of these was unstable which could have potentially caused injury to people. Immediate action was taken during the visit to secure this wardrobe to the wall. The registered provider also told us that other wardrobes deemed to be a risk, would be dealt with as a matter of priority. Following the inspection the new manager confirmed that this had been done.

We identified two radiators in people's bedrooms that were hot to the touch and not covered. We asked the registered provider to take action to ensure these were covered as there was a risk of injury though burning. The registered provider told us that immediate action would be taken to address this. Some people had portable radiators in their bedrooms. There were no risk assessments in place regarding their use to ensure people's safety.

The lock to some people's doors had been partly removed, leaving a sharp outer case which was at risk of causing damage to people's skin. There was also a 'child gate' in use on one of the corridors for which there was no risk assessment in place and beyond this there were three steps. These were difficult to see because of poor lighting, and there were no markers in place to distinguish the edge of each step. This placed people at risk of falls.

At the last inspection, we highlighted some improvements that could be made to the management of people's medication. On this inspection, we identified a number of new concerns. People's medicines were not always stored securely. We found people's skin creams that had not been put securely away. This was unsafe for people living with dementia. Medication administration records (MARs) were not always signed by staff to show that people's medicines had been administered as prescribed. People's MARs had not been signed to show that creams had been applied as required. In one of these examples records showed that skin cream had not been applied for seven days, and before that an additional ten days. This person's records stated that these needed to be applied daily. This placed this person at risk of deteriorating physical health.

Following the visit we received confirmation that staff had not recently completed medicines training, and that their competencies to do so had not been assessed. The new manager confirmed that staff had been booked onto training and that agency staff with the required training were being used in the interim to help

administer people's medication.

These are all breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because action had not been taken by the registered provider to ensure that people were safe.

Legionella is a water-borne bacteria that can be harmful to people's health. Consistent action had not been taken to comply with the action plan outlined in the legionella risk assessment carried out in 2015. For example monthly monitoring of water temperatures had not been completed since September 2016, quarterly disinfection of shower head had not been completed since April 2016. There was no evidence that an annual check of water systems had been completed as required. We asked that the registered provider do this as soon as possible as this placed people at risk of harm.

The environment was not always clean and people were not safe from the risk of infection. At the front of the premises, on the roof of the bay window we found cleansing wipes with faeces on them. Two bedrooms smelled strongly of urine, and the floor in one bedroom was sticky to walk on. In the laundry room, dirty clothes were placed on the floor before being washed and there was a large crack in the laundry room floor. This increased the risk of cross infection.

The food standards agency (FSA) had inspected in May 2016 and awarded the service a rating of '3' ('generally satisfactory'). The FSA had identified some parts of the kitchen that needed cleaning more thoroughly. They had given two months for this to be carried out. This had not been done, as we identified that under the fridge and freezers were dirty, and the shelves needing cleaning.

These are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because action had not been taken to protect people from the risk and spread of infection.

Recruitment processes were not robust enough to protect people from harm. We looked at recruitment records for two members of staff and found that references had not been sought from previous employers. In one file there were no references, and in the other two personal references had been obtained, one of whom was an employee at Curzon Park. Checks had been completed by the disclosure and barring service (DBS). The DBS alerts employers to any criminal records prospective staff may have, and helps them make an informed decision about their suitability for the role.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider did not have safe recruitment processes in place.

People's relatives told us that there were enough staff to meet people's needs, however they commented that there was a lot of staff sickness which meant that other staff had to cover.

Following the visit we were provided with an up-to-date list of outstanding training, which showed that staff had not received training in safeguarding vulnerable people. However staff demonstrated that they were aware of how to report and concerns that they may have. The registered provider had a safeguarding policy in place which outlined what action staff should take if they identified any issues.

Inadequate

Is the service effective?

Our findings

Relatives told us that staff were skilled and good at their job. Their comments included "Staff seem good at what they do" and "They take care of my relative". Some relatives also told us that they felt the environment was suitable to meet the needs of their relatives.

Where people were at risk of developing pressure ulcers they had been provided with pressure relieving mattresses. However, staff were unaware of what settings needed to be applied to these. It is essential that the setting is adjusted to a person's weight, as failing to do so can increase the risk of damage to their skin integrity. One person did not have their weight recorded in their care records and we found that their mattress was set to 120Kg. This person was observed to be very frail and this weight not correct, meaning this setting was far too high. In another example their mattress was set between '9' and '10'. There was no information available around what weight this setting corresponded to. Staff were not aware as to how to correctly set or adjust this equipment. We ensured that immediate action was taken to address these issues. We asked that the registered provider share these concerns with the local authority to determine whether they reached the threshold to be investigated as a safeguarding concern as there was a risk of possible harm.

Weight monitoring charts had been completed in October and November 2016, however no analysis had been completed to highlight any weight loss or gain, a change in body mass index (BMI: BMI is used to identify where people are at risk of being under or overweight) or any risk of further weight loss. People's care records contained malnutrition risk assessments, however in two cases we saw that the BMI had not been recorded since March 2016. In another example we looked at the weight monitoring charts between January and August 2016 and found that the malnutrition risk assessment had been completed wrongly, failing to identify that one person was at high risk of weight-loss. In this example the person had been recorded as being at no risk. A referral to the dietician had not been made for this person in line with guidance. We asked that this was done immediately and that all malnutrition risk assessments be reviewed.

The design and adaptation of the premises was not suitable to meet the needs of people living with dementia. There were no distinctive markers in corridors to help people to orientate themselves, and the doors to people's rooms were uniform and without distinction. In one corridor there were three steps, however these were difficult to see due to low lighting and no markers to show the edge of each step. This placed people living with dementia and/or a visual impairment at risk of falls. Other parts of the environment were unsafe and placed posed a risk to people's safety. We have reported further on this under the 'safe' domain.

Wall paper was hanging off the walls in the office and at the entrance to the building and there was a crack in the glass to one of the external doors off the downstairs corridor. The window sills in two bedrooms were rotting and that chunks of wood had broken away. There was a one inch gap in the glass in the attic window letting cold air in, and the window frame was rotting. Windows in some of the rooms were being held open using blocks of wood, and in one example a cup was being used. This showed that due care and attention was not being given to the maintenance of the premises to keep them safe and fit for purpose.

There were not sufficient shower and bathing facilities for people using the service. There was only one shower and one bath available for 20 people. There were two bathrooms, however one of these was being used as staff toilet and the bath in this room was being used to store a piece of machinery. We found a bathing rota, which showed that people were only supported to have a bath or shower once a week.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because premises were not always suitable for the service being provided.

At the time of the visit there were no up-to-date records in place to show when staff had last completed training or when this was due to be completed. Staff told us that they had recently received training in fire safety; however they did could not recall having completed other essential training such as safeguarding vulnerable people or the Mental Capacity Act 2005 (MCA) or DoLS. Following the visit an up-to-date record of outstanding training was sent to us. This confirmed that staff had not completed training in key areas such as infection control, the MCA, dementia, moving and handling, first aid or food hygiene.

Staff files contained certificates to show that there was an induction process in place for new staff. Records showed that this had been completed in a day. This would not have allowed sufficient time for a thorough induction to have been carried out. New staff had not been supported to undertake the care certificate. The care certificate is a national set of standards that new health and social care staff are required to meet. There is a requirement on the registered provider to ensure that new staff are supported to undertake this.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider had not ensured that staff had the skills and knowledge to carry out their role.

People were not always supported to access support from health care professionals as required to ensure their health and wellbeing was maintained. For example we identified that one person was at high risk of malnutrition, however they had not been supported to access support from the dietician. We asked that this be done immediately. There was evidence to show that other people had been supported to access to support they needed from their GP or from the district nurse.

The 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). Records relating to DoLS could not be found at the time of the visit. We checked with the local authority who confirmed that applications had been made and were waiting assessment. They also confirmed that one person subject to a DoLS. The registered provider was not aware that this person had a DoLS in place. We checked whether the service was working within the principles of the MCA and found that they were.

Staff did not have a good understanding of the principles of the MCA or DoLS and who this may impact on how they provide support. However they did offer people basic choice. For example during meal times people were offered a choice of hot and cold drinks. We also observed people being able to walk freely about the service. However, mental capacity assessments had not been completed in line with MCA guidance. For example there were no assessments in place around the use of bed rails. The use of bed rails

can be restrictive, therefore steps need to be taken to ensure that their use is in the person's best interests. In another example however we found that the details for one person's relative who held lasting power of attorney were being kept, which is good practice.

During meal times people received the support they needed from staff with eating and drinking. One person had a specially adapted plate to prevent food from going onto the table which made it easier for them to use their cutlery. Where people were struggling, staff sat with them and gave them assistance. Alternatives were offered to people where they did not appear to like the options available. There was a menu on display in the dining room, however this was not available in any alternative formats for people who may not be able to read.

Inadequate

Is the service caring?

Our findings

People looked smart and well dressed. Some people had nicely manicured and painted nails which people's relatives told us was done by staff on occasion. People's relatives described staff as "kind", "caring" and "magnificent". Staff spoke passionately about the people they supported and one person's relatives told us how staff had come in on their days off to help paint in an effort to improve the environment. However relatives also commented that they felt in recent times there was a lack of support from the registered provider and previous management which had impacted negatively upon staff morale and wellbeing.

People presented as comfortable and at ease around staff. However, on occasion we observed at staff to be ill at ease and they appeared to be under pressure. They did not always speak with dignity to people who used the service, which was at odds with the very positive comments made by people's relatives. For example we heard a member of staff speaking sharply to one person throughout the day, on one occasion telling them to "Just sit down". Staff did not act to use distraction techniques to help settle people, or prioritise those people who were more restless during meal times, which may have helped to prevent behaviours that challenged.

Care records were not always worded in ways that were respectful or dignified. For example, one person's care record described them as "demanding", and stated that they "Continue to tell lies about the staff and change their story!!". The registered provider is required to ensure that people are treated with dignity and respect at all times.

People's privacy and confidentiality was not always protected. Just inside the entrance to the building there was a tray containing letters for people which could be accessed by anyone. Some of these were marked 'private and confidential' and had been opened before being placed back. In the dining room documents containing personal information had been left on the window sill and were therefore not secure. We asked staff to move these to somewhere more secure. In the downstairs bathroom there was one window which did not have a blind in place. Whilst the glass was frosted, it would still have been possible to see people's outlines through the window.

Staff told us that they did not always feel that they had the time to spend talking with people and positive relationships were not always natural and apparent between them. For example we observed people sat in the lounge area, whilst staff sat talking amongst themselves in the dining room. In another example one person was sat in the lounge crying. A member of staff responded to this by speaking kindly to the person but failed to, stay and comfort this person until they were less distressed. On other occasions we did observe people and staff laughing or joking together.

These are breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not always treated with dignity and respect.

There was no information about advocacy available to people and staff did not show an understanding of when a referral to the local advocacy service would be required. Advocates act as an independent source of

support to people where decisions about their care needs are being made. They ensure that their wishes and feelings are taken into consideration.

Requires Improvement

Is the service responsive?

Our findings

People told us that staff were helpful. Relative's also commented that they felt their family members received the care and support that was appropriate to meet their needs. They also told us that staff had a good understanding of their relative's needs. Despite this we found areas of the service that needed to be improved.

Care records containing details around people's needs were not consistently reviewed or kept up-to-date. For example one person's care records had not been reviewed since July 2016. In another example a moving and handling risk assessment had been updated in August 2016 but the updated information had not been added into their care plan. One person's care record made reference to a physical health need, however there was no information around how staff should act to manage or support them with this. In another example information around the risk of one person becoming malnourished was not accurate, and no action had been taken to seek support from the dietician. This placed this person at risk of deteriorating physical health. This meant that staff did not always have access to relevant and important information around what they needed to do to meet people's needs.

Records did not always evidence that people or their family members had been involved in the development of their care needs. Reviews were not consistently completed which meant that people did not have the opportunity to make comments on how their care was being delivered, or any changes that would be required. Where decisions had been made on people's behalf this decision making process was not recorded in people's care records in line with guidance around the MCA. There were no alternative formats in place to aid communication with people living with dementia around their care and support needs.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because records relating to people's care and treatment did not contain sufficient information and were not accurate or up-to-date.

There was a complaints record in place which showed that two complaints had been received over the last 12 months. One of these records did not include information regarding the action had been taken in response to the concern, or the outcome of complaint. In addition to these people's relatives told us of concerns that they had raised, to which they had not received a response. These concerns were not recorded in the complaints record. This showed that the registered provider had failed to deal with complaints effectively.

There were not enough activities available for people and throughout the visit we did not see any activities taking place. People's family members commented that staff did activities such as baking, or nail painting. However, they also commented that there had not been much available in recent times, which they attributed to management issues. There was no activities co-ordinator in place and one person told us that a previous manager had stated to them this was due to money saving.

Daily records around people's needs were maintained by staff. These demonstrated that night time checks

were being completed to ensure people's safety through the night. They also included information around what level of support people had been given by staff, such as having a wash or getting dressed, and information around people's presentation and general wellbeing.

The local church visited the service on a weekly basis so that people could have communion if they wished. This ensured that people's religious and spiritual needs were being met.

Inadequate

Is the service well-led?

Our findings

People's family members commented that there had been a deterioration in the standard of the service since the last registered manager had left. One family member told us, "At one time this place was magnificent. At the moment I would not advise anyone to live there", whilst another commented that there had recently been "management and staff sickness issues".

There was no manager in post within the service, and there had been no registered manager in place since May 2016. Over the past 12 months there had been five managers employed by the registered provider. At the time of the visit there was no one available to show us round and the task of overseeing the day-to-day running of the service had been given to a senior member of staff.

At the last visit we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because there were no audit processes in place. In addition the registered provider had not completed any quality monitoring checks to ensure the quality of the service was being maintained. At this visit we found that no action had been taken to rectify this.

There were no audit systems in place around care records, accidents and incidents, medication, people's weights or the environment. The registered provider did not carry out any checks on the quality of the service. This meant that issues we had identified had not been picked up by the registered provider and improvements could not therefore be made.

External contractors had been used by the registered provider to carry out risk assessments relating to fire safety and legionella bacteria in the water systems. In both examples an action plan of remedial actions had been provided by the contractor, but the registered provider had not taken consistent action to ensure that these improvements were made to ensure the safety of the premises.

Accidents and incidents reports prior to November were not available. We were told by staff that they had been lost. This meant that the registered provider could not be sure that people were receiving the care and support that they needed.

Leadership within the service was observed to be poor. Morale amongst staff was low and they failed to receive the support they needed from the registered provider. There was no management structure in place for staff to refer to, and in one situation a member of staff felt that had no option but to contact the previous registered manager for advice and support.

Where we identified issues within the service that required immediate attention, the registered provider placed the responsibility back on the care staff to remedy issues as they could not make themselves available. This demonstrated a lack of accountability from the registered provider. It also meant that staff were taken away from their day to day duties whilst they completed these tasks.

There was a lack of investment from the registered provider into the fabric and environment to ensure that it

was safe and well maintained. There was no handyperson in place to help ensure the maintenance of the building and we found parts of the environment to be in need of urgent remedial attention. The registered provider had delegated tasks such as monitoring water temperatures and fire alarm systems to care staff but had not provided them with the knowledge and skills to ensure that this was done correctly. As a result that this was not always done adequately.

Satisfaction surveys had not been completed by the registered provider and so people had not been able to formally express their views. There had also not been any meetings with people using the service or their relatives. This meant that the registered provider could not act to make improvements in line with comments from people using the service, their relatives or staff.

The registered provider had a service user guide in place which outlined their commitment to promoting people's independence, dignity and respect. During the visit we found examples that demonstrated people's dignity and respect was not being upheld. The issues identified showed that the registered provider did not have regard for people's wellbeing.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because systems were not in place to monitor or ensure the quality of the service.

The registered provider is required by law to notify us of specific events that occur within the service. This is so that we can ensure that appropriate action has been taken in response to these. Accidents and incidents records prior to September 2016 were not available; however we identified an incident in November where a person had required hospital attention following an incident. Our records showed that we had not been notified of this event. We had also not been informed of four deaths that had occurred within the service between April 2016 and November 2016. This meant that the registered provider was not complying with the law.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 because the registered provider had failed to notify us of events as required by law.

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 18 Registration Regulations 2009 Notifications of other incidents The registered provider must ensure notifications are sent to the CQC as required by law.

The enforcement action we took:

We issued a notice of proposal to cancel the registered provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider must ensure that people are treated with dignity and respect at all times.

The enforcement action we took:

We issued a notice of proposal to cancel the registered provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider must ensure that systems are in place to keep people safe from harm and the risk of infection

The enforcement action we took:

We issued a notice of proposal to cancel the registered provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered provider must ensure that the premises are safe and suitable for the purpose of their intended use.

The enforcement action we took:

We issued a notice of proposal to cancel the registered provider's registration.

Regulated activity	Regulation

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider must ensure that records are accurate and kept up-to-date. The registered provider must ensure that systems are in place to monitor and maintain the quality of the service being provided.

The enforcement action we took:

We issued a notice of proposal to cancel the registered provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider must ensure that recruitment processes are robust enough to protect people from the risk of harm. The registered provider must ensure that staff have the necessary skills and knowledge to carry out their roles.

The enforcement action we took:

We issued a notice of proposal to cancel the registered provider's registration.