Four Seasons Health Care (England) Limited

Preston Glades Care Home

Inspection report

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18 May 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 14, 16, and 18 May 2018.

Preston Glades is a purpose built home, registered to provide accommodation for up to 65 people who require nursing or personal care. The home is arranged in three units. The two first floor units provide services for people who are living with dementia. All accommodation is provided on a single room basis, with the majority of rooms having en-suite facilities. At the time of the inspection visit 53 people were receiving care and support at the home.

Preston Glades 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.

At the time of the inspection visit 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.

At the last inspection, carried out in January 2017 Preston Glades was rated as requires improvement. This was because we identified concerns related to the safe management of medicines, processes for ensuring consent was lawfully achieved and the way in which the service was managed. Following the inspection visit we asked the registered provider to submit an action plan to demonstrate how they intended to make the required improvements to meet the fundamental standards. The registered manager told us improvements would be in place by May 2017.

At this inspection visit carried out in May 2018, we found not all required improvements had been made. Breaches were identified to Regulations, 9, 12, 13, 17, 18, and 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014 and Regulation 18 of the Care Quality Commission Registration Regulation 2009.

We found improvements had not been made to ensure people received their medicines safely. Good practice guidance had not been considered and implemented to ensure the safe management of medicines.

Auditing systems established and operated by the registered provider continued to be ineffective as they had failed to identify the concerns we found during the inspection process. For example, monthly audits had failed to identify safeguarding and medicines concerns we identified during the inspection visits.

Risk was not always suitably managed at the home. Risk assessments were not always completed in a timely manner to ensure all risk was suitably addressed. When people displayed behaviours which challenged the service we found risk management plans were not in place to direct staff to protect the person and other people who lived at the home. In addition, staff sometimes failed to ensure risk assessments were followed

to protect people from harm.

People were not always protected from the risk of abuse. Staff responsible for providing care and support had knowledge of safeguarding procedures and were aware of their responsibilities for reporting any concerns. However, processes were not always followed to ensure safeguarding concerns were consistently reported to the local authority safeguarding team for review. Processes to ensure people were safe from abuse were not consistently followed by the registered provider.

Recruitment processes for ensuring staff were suitably qualified to work with people who may be vulnerable were not suitably implemented as suitable checks had not been consistently applied in a timely manner.

Processes to ensure people's nutritional needs were met were inconsistent. People did not always receive appropriate support to ensure their dietary needs as identified within their care plan were met.

We found deployment of staffing was not always effective to ensure the safe care of people. Staff were not always suitably allocated within roles to ensure people remained safe.

Care plans did not always have all the appropriate person centred information in them to promote individualised care being provided. Religious and cultural needs were not consistently addressed and met.

We noted documentation was not always accurate, accessible and fully complete. Of the eleven care records viewed, we identified concerns within the paperwork for five people. Individuals care plans were sometimes reviewed to accommodate peoples changing needs. Additionally, information relating to investigations into staff conduct were sometimes inaccessible.

The registered provider had failed to ensure notifications were submitted to the Care Quality Commission in a timely manner. During the inspection visit we identified three serious injuries and three safeguarding concerns which the registered provider had a responsibility of reporting to CQC but had not done so.

There were processes in place for managing infection prevention and control within the home. However these were not consistently followed. During the inspection visit we noted the kitchen was not suitably maintained to promote hygiene and we had to request this was deep cleaned. The registered provider took immediate action to ensure the kitchen was clean and suitable for purpose. In addition, there was no care plan in place for one person who had support needs which impacted upon the cleanliness and hygiene standards within the home. We have made a recommendation about this.

Staff we spoke with were aware of the principles should someone require being deprived of their liberty. Whilst good practice guidelines were sometimes considered these were not consistently implemented to ensure all principles of the Mental Capacity Act (MCA) 2005, were lawfully respected. We have made a recommendation about this.

People were supported to have maximum choice and control of their lives in relation to the Mental Capacity Act and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff told us they were happy with the training provided and said the registered manager encouraged staff to develop their skills. Whilst the registered provider had maintained high levels of training at the home, we identified clinical training deficits for qualified nursing staff. This sometime impacted upon the quality of care provided. The registered manager had already identified this training need and had commenced action

to ensure training was provided. Following the inspection visit, we received confirmation this had been addressed.

During our inspection visit we observed some activities taking place. People told us activities took place on a regular basis.

People who lived at the home and their relatives told us they had no complaints about the way in which the home was managed. When people had complained they told us they were happy with the way in which the complaint was managed.

People who lived at the home told us they had good relationships with the staff. During the inspection visits we observed staff being patient and kind with people. However, during the first day of the inspection visit we saw that call bells to assist people to summon help had been removed in a high number of rooms across all units. The registered manager investigated why this had occurred but could not identify who had done this. Following the investigation the registered manager took swift action to prevent this from occurring again.

People's healthcare needs were monitored and managed appropriately by the service. People told us guidance was sought from health professionals when appropriate. We saw evidence of partnership working with multi-disciplinary professionals to improve health outcomes for people.

End of life care had been discussed when appropriate with people and their relatives. Provisions were in place to promote a dignified and pain free death.

There was ongoing commitment by the registered manager to make the home pleasing for people. We noted refurbishments within the building were ongoing.

Feedback was routinely sought from people who lived at the home. People told us residents meetings took place. Additionally we saw people had been consulted with regarding food quality and choice.

Staff praised the improvements made by the registered manager who was registered with the Care Quality Commission in May 2017. They told us morale and staff turnover had improved at the home since the new registered manager had been recruited.

The overall rating for this service is 'Inadequate' and the service is in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel 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.

Procedures were not consistently established and followed to ensure safeguarding concerns were suitably managed.

Processes for ensuring staff were suitable for working with people who may be vulnerable were not consistently implemented.

Staff were not consistently deployed to meet the needs of people who lived at the home.

Risk was not consistently addressed and managed within the home.

Suitable arrangements were not in place for safe management all medicines.

Infection prevention and control processes were inconsistent and dis not always meet the needs of people who lived at the home.

Is the service effective?

Requires Improvement

The service was sometimes effective.

People's dietary needs were not consistently met by the registered provider.

Whilst good practice guidelines were sometimes considered these were not consistently implemented to ensure all principles of the Mental Capacity Act (MCA) 2005, were lawfully respected.

Staff were provided with training but this did not always reflect the skills required.

People's health needs were monitored and advice was sought from other health professionals, where appropriate.

Consideration had been taken to ensure the environment in which people were living met their needs.

Is the service caring?

Requires Improvement

The service was sometimes caring.

People and relatives told us on the whole staff were kind and caring. However we identified concerns to suggest staff were not always kind and caring.

People had access to advocacy services, if required.

The registered provider sometimes promoted equality and diversity.

Visitors were welcomed and encouraged at the home.

Is the service responsive?

Requires Improvement

The service was sometimes responsive.

Care plans did not always have appropriate person centred information in them. Person centred care was not consistently delivered.

People told us they were happy with the service provided and felt assured concerns and complaints would be appropriately managed.

Activities were offered to people who lived at the home.

End of life care was discussed with people and relatives. Processes were in place to promote a dignified and pain free death.

Is the service well-led?

Inadequate

The service was not well led.

Required improvements set out within the last three inspections had not been appropriately acted upon to ensure the service was meeting the required regulations.

Systems for reporting statutory notifications were inconsistent and notifications were not provided to the Commission in a timely manner. Procedures for ensuring the service was suitably managed were not always followed.

Documentation did not always reflect people's assessed needs and risks. Records reviewed were sometimes inaccurate and incomplete. Quality audits of the service were inconsistent and ineffective.

Preston Glades 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.

The inspection was prompted in part following information of concern being shared with us from another stakeholder. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the risk of unsafe medicines management and staff recruitment. This inspection examined those risks.

This comprehensive inspection took place on 14, 16 and 18 May 2018. The first two days of the inspection were unannounced.

Prior to the inspection taking place, information from a variety of sources was gathered and analysed. We reviewed minutes from a multi-agency meeting. In addition, we reviewed information held upon our database in regards to the service. This included notifications submitted by the registered provider relating to incidents, accidents, health and safety and safeguarding concerns which affect the health and wellbeing of people. We also reviewed other feedback upon our database which had been provided to us. This information was considered as part of the planning process.

We looked at 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 used this information to help us plan our inspection visit.

On the first day of the inspection, three adult social care inspectors, a pharmacy inspector, an inspection manager and an expert by experience visited the home to carry out the inspection process. The expert by experience was a person with experience of caring for older people. On the second day, the inspection team consisted of two adult social care inspectors. On the third day, one adult social care inspector, an inspection

manager and a pharmacist inspector visited the home to complete the inspection process and to give feedback to the registered provider.

Throughout the inspection visits we gathered information from a number of sources. We spoke with eleven people who lived at the home and five relatives to seek their views on how the service was managed. Because not everyone who lived at the home could speak with us we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. In addition we sought views on how the service was managed from a visiting health professional.

As part of the inspection process we spoke with the managing director of care, the care service director, the regional resident experience manager, the registered manager, the deputy manager, the area manager, the resident experience support manager, three registered nurses, seven members of staff responsible for providing direct care, the activities coordinator, the housekeeper, the cook and the maintenance person.

To gather information, we looked at a variety of records. This included care plan files related to eleven people who lived at the home and medicines administration records for 15 people. We also looked at other information related to the management of the service. This included health and safety certification, auditing schedules, training records, team meeting minutes, policies and procedures, accidents and incidents records and maintenance schedules. We also viewed recruitment files relating to fourteen staff members employed to work at the home.

In addition, we walked around the building to carry out a visual check. We did this to ensure required improvements had been made; and to ensure it was clean, hygienic and a safe place for people to live.

Following the inspection visit we shared our initial findings with the local authority and the clinical commissioning group so support could be offered to the registered provider to make the required improvements. We also made a safeguarding referral to the local authority to ensure safeguarding concerns could be reviewed. Additionally, we met with members of the senior management team to share our immediate concerns so action could be taken to reduce the risk and improve the service provision within the home.

Inadequate

Is the service safe?

Our findings

At the inspection visit carried out in January 2017, we found systems for ensuring the safe management of medicines were inconsistent. Processes for ensuring people received their medicines safely did not reflect good practice guidance. This was a breach of Regulation 12 of the Health and Social Care Act 2008, (Regulated Activities) 2014. We asked the registered provider to complete an action plan to tell us how they intended to make the required improvements. The registered provider sent us an action plan to state they would be compliant with the regulation by May 2017.

We used this inspection carried out in May 2018, to check improvements had been made to ensure medicines were being suitably managed. We found not all improvements had been made. We looked at how PRN (as and when required) medicines were managed. We found the medicines administration records (MAR) were not always suitably completed so we could be assured people had received the medicines as prescribed. For example, one chart had been signed to indicate it had been given when a dose of the medicine had not been due. We discussed this with the member of staff who told us the medicine was on the MAR record twice as a regular dose and as a PRN dose. They had signed both entries even though only one regular dose was given. We looked at the storage and administration of insulin pens and noted that administration and destruction processes were unclear and inconsistent. The inconsistencies meant we could not be assured the insulin had been administered in accordance with good practice guidance.

We looked at stock checks of medicines in use and randomly spot checked fifteen people's medicines. We found three discrepancies so we could not be sure these medicines had been given in the right way.

We found MAR charts were not always suitably completed. When a medication was refused this was recorded with a code on the MAR chart but the reverse of the chart had not been completed to advise why the medicines had been refused. In addition, we found MAR charts for the administration of creams and ointments were not routinely completed by staff. For example, one person's MAR chart showed a twice daily cream had only been applied four times in the last 44 days. This demonstrated systems to ensure people received the appropriate medicines, as directed, were ineffective.

We looked at how medicines were stored. We found that guidance for storage of temperature specific medicines was not always considered. For example, we found eye drops which were to be stored within a fridge stored upon a medicines trolley which is not temperature controlled.

We looked at how controlled drugs were monitored and managed by the registered provider. Controlled drugs (CD's) are subject to tighter controls as they are more likely to be mis-used. Two controlled drugs had recently been destroyed, but the CD register had not been updated to show these had been destroyed and was therefore inaccurate. In addition, there was no recorded evidence within the CD register to show managers at the home had checked the CD register to ensure safe practice was taking place.

These above matters demonstrate there was a breach of Regulation 12 of the Health and Social Care Act 2008, (Regulated Activities) 2014 as suitable processes for the safe management of medicines were not in

place.

At this inspection visit we looked at how safeguarding procedures were managed by the registered provider. We did this to ensure people were protected from harm. Staff told us they had received safeguarding training and were confident they could identify and report abuse. When asked, staff could describe different forms of abuse and said they would report any concerns internally to management.

Although staff told us they were confident in identifying and reporting abuse we found processes had not been followed when concerns had been identified. During the inspection visit we looked at recorded incidents that had occurred at the home. From the completed accident and incident records we viewed we identified four incidents where people had been found with unexplained bruising with no given explanation as to how these bruises had arisen. In addition, whilst reviewing care records of two people we saw there had been multiple episodes when the two people had sustained multiple unexplained bruises and injuries. We discussed these concerns with the registered manager. They confirmed no processes had been implemented for investigating multiple unexplained injuries at the home.

Additionally, whilst reviewing records we noted one incident whereby a person had sustained an injury whilst being supported by staff to use equipment within the home. On another occasion a person had sustained injuries which required medical attention after a piece of equipment at the home fell on them. The registered manager confirmed these had not been raised as a safeguarding alert to the local authority safeguarding team for review.

We reviewed the organisation's policy in relation to management of allegations of abuse and saw the process stated that all allegations of abuse were to be reported immediately to the local authority safeguarding team and to the relevant regulatory body. This process had not been completed for any of the above incidents which we identified during the inspection visit.

In addition, the registered provider's policy stated as good practice, registered managers should attend any local authority safeguarding training. We asked the registered manager if they had attended any training offered by the local authority. They told us they had attended two safeguarding champions meetings organised by the local authority but had been unable to attend any further training. We spoke with the registered manager about local safeguarding processes. They told us they were not aware of these and processes to follow. This demonstrated processes for following safeguarding protocols were inconsistent and ineffective.

This was a breach of Regulation 13 of the Health and Social Care Act 2008, (Regulated Activities) 2014 (Safeguarding service users from abuse and improper treatment) as systems were not implemented and followed to ensure people were protected from abuse and harm.

Following the inspection visit we made a safeguarding referral in relation to people identified at risk of harm.

As part of the inspection process we looked to see how the registered provider managed and addressed individual risk. To do this we reviewed eleven care records related to people who lived at the home. We found systems for managing risk were ineffective and inconsistent. On the first day of the inspection visit we reviewed care records related to one person who lived at the home who had placed themselves at risk of significant harm. We looked at the risk assessment for this person and noted it was incorrectly completed and did not contain all the required information. This meant the risk had not been calculated so an outcome and direction as to how to support the person could be determined. In addition, the risk assessment had not

been reviewed since it was completed in January 2018. Upon reviewing the person's care record it was noted there had been a further two repeated incidents which had had the potential to cause further risk of harm. These had not been taken into consideration and the risk assessment had not been reviewed. We raised concerns with the registered manager about this at the end of the first day and they agreed to take immediate action.

We spoke with the director of care about this on the second day. They were unaware of these incidents, confirming they had not been escalated to senior management. On the third day, we were informed a new risk assessment had been drafted. Advice and guidance had been taken from the registered provider's health and safety team in order to promote the safety of the person. We looked in the person's care record to check this was the case. We noted the risk assessment was in place but the individual checks which had to be considered had not been completed. We fed this back to the managing director and area manager. Following the inspection visit we were provided with written confirmation this had been completed.

In addition, in order to keep the person safe, the person was subject to hourly checks by staff. We looked at documents maintained by the provider to demonstrate hourly checks took place. We saw there was no documented evidence to show the person had been checked upon for three hours. The registered manager said the person had been supervised by staff but they had not completed the required documentation. This demonstrated processes to manage risk were ineffective.

We looked at how people who were at risk of choking were supported to remain safe. We saw advice and guidance had been sought when people were showing any signs of being at risk of choking. Although guidance had been sought from professionals we found risk assessments were not always routinely followed. One person's care records indicated the person was to have food cut up in small pieces. We saw this did not happen.

In addition, information related to peoples care and support to manage the risk of choking was not always clear. For example, one person had been reviewed by the dietitian and the speech and language team (SALT) within the same week. Whilst one professional advised the person could resume a normal diet, the other professional had advised the person required a specialised diet to reduce the risk of choking. This anomaly had not been picked up by the staff working on the unit.

We looked at how the registered provider supported people who displayed some behaviour which challenged the service. During the course of the inspection, one person who lived at the home disclosed information of concern to us. We discussed this with the person's relative and the registered manager. They told us the person sometimes became confused and made unfounded allegations. We spoke with the registered manager about this. They confirmed there was no written documentation within the person's care record to demonstrate there was a risk of the person making allegations and how to safely manage these.

During the inspection visit we noted one person who lived at the home demonstrated some behaviours which at times could make other people who lived at the feel vulnerable. No processes were implemented so staff could monitor the person's whereabouts. Also there was no written behaviour management plan guiding staff as to what triggered these behaviours or instructing staff how they should manage the behaviours.

Whilst carrying out a walk around the home, we were made aware that one person did not have a call bell alarm in their room. We asked the staff member why this was so and they told us there was a risk of strangulation from the cord. We asked if this was highlighted in their care record. They advised us it was not

identified as a concern. This placed the person at risk of harm as the identified risk had not been documented to make all staff aware of the risk.

The above matters show the registered provider was not meeting legal requirements in relating to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had failed to ensure risk was suitably identified, managed and addressed to ensure people received safe care and treatment. We raised a safeguarding alert with the local authority to inform them of our findings.

Prior to the inspection taking place, we were made aware that recruitment procedures at the home were not robust. On the first day of the inspection visit we looked at recruitment procedures to ensure people were supported by suitably qualified and experienced staff. To do this we reviewed 14 records related to staff currently working at the home. We found recruitment processes at the home were not robust or consistent. Of the 14 files viewed we found full employment checks had not taken place for four of the 14 staff employed. For example, full employment histories had not been gathered for all staff recruited. In addition when staff recruited had criminal convictions, suitable processes had not been consistently followed to manage risk. In addition, we noted that on one occasion a management audit identified that a member of staff working at the home had previous criminal convictions which could have baring upon the role which they were performing. The management team had undertaken a risk assessment to ensure people were safe and to mitigate any risks. We found however that recommendations made within the risk assessment were not robust and actions set within the risk assessment were not consistently followed to ensure safe practice.

We discussed our concerns with the registered manager. They informed us they were aware of the shortfalls within the employment records and advised a full audit of all records had recently been undertaken by their Human Resources (HR) department. Following the inspection process we received a copy of the HR audit and were given assurances action had been taken. Whilst the registered provider had taken action to review recruitment procedures at the home, this process had been reactive and triggered by concerns raised by an external party, not by the registered provider themselves.

This was a breach of Regulation 19 of the Health and Social Care Act (2008) Regulated Activities 2014. (Fit and Proper Persons employed,) as procedures were not established and consistent to ensure staff employed were of good character and suitable for working with people who were sometimes vulnerable.

As part of the inspection process we reviewed staffing levels at the home. We did this to ensure there were appropriate numbers of staff employed to meet the needs of people. There was recognition from people and relatives that staffing levels had improved at the home since the registered manager had been appointed. One relative said, "In the last few months it seems to have been fine". Although we were informed levels had improved, three people told us there were some times when they had to wait for assistance. Two people told us they had experienced waiting for staff assistance the day previous in excess of twenty minutes.

As part of the inspection process we checked call bell response times by pressing call bells and waiting to see how long it took for staff to attend. We identified no concerns in regards to call bell response times. However, whilst undertaking call bell checks we identified not all rooms had call bell alarms present. We carried out an audit of all the rooms in the home and identified 27 call bell points had no attached call bells. In addition, 14 call bells were attached to call points but were inaccessible to people. We raised concerns with the registered manager about these findings. They agreed to investigate this immediately and take action. On the second day of the inspection we saw call bells had been replaced and were informed

additional handsets had been ordered. On the third day of the inspection visit we were told an investigation had taken place and call bells had been located in people's drawers. The registered manager said they could offer no explanation as to why call bell's had been removed. The area manager said daily checks and audits had now been put in place to ensure this did not occur again.

Although people told us there were sufficient numbers of staff on duty, we found staff were not always suitably deployed to meet people's individual needs. Two people upon the dementia unit had been assessed as high risk of choking. Both care records indicated the people required supervision whilst eating meals. We noted on two occasions these individuals had been left with food without any staff oversight and with no means of summoning help in an emergency. On one occasion we had to intervene and ask staff to provide immediate support to keep a person safe.

We looked at documentation maintained by the registered provider to keep people safe. This included reviewing how often staff were deployed to check the welfare of people. One person was being nursed in bed. Staff had been directed to ensure the person was re-positioned every two hours. We noted from documentation maintained there were two occasions within a 48 hour period, where there was no documentary evidence to show the person had been repositioned in line with the care plan. In addition, the person was subject to hourly checks from staff. Documentation maintained demonstrated these hourly checks had not been consistently carried out.

In addition we looked at staff deployment in communal areas. We found at times, there was an absence of staff in communal areas. We identified three occasions when there were no staff deployed within the communal area of the Sherwood unit and people did not have ready access to call bells to summon help in an emergency. On one occasion we had to summon help and assistance for one person who was coughing and required some support and assistance. Similarly, on the first day of the inspection we observed three people who were living with dementia on the nursing unit unsupervised in a lounge without any means of summoning help.

The above matters demonstrate this was a breach of Regulation 18 of the Health and Social Care Act 2009 (Regulated Activities) 2014 (Staffing), as the registered provider had failed to ensure suitable numbers of staff were deployed at all times.

We looked at infection prevention and control measures within the home. People said they were happy with the standards of hygiene at the home.

Although people told us they were happy with the cleanliness of the home we found infection prevention and control measures at the home were inconsistent. The home employed a housekeeper and domestic staff who were responsible for maintaining standards of cleanliness. We saw furnishings in the lounge areas were made of fabric which allowed them to be appropriately cleaned. We saw there were some systems for managing infection prevention and control. For example processes were in place to ensure people had their own slings for the hoist. Mattress checks took place on a regular basis. The registered manager said improvements had been made as people now had hand hygiene points within their rooms. Hand hygiene points promote effective hand hygiene.

We observed personal protective equipment (PPE) being worn during the inspection process, however this was inconsistent. For example, some staff wore gloves whilst handling foods but others did not. On three occasions we observed staff handling people's foods with their bare hands. This does not reflect good practice. We reviewed the availability of PPE around the home and on two separate days we found gloves were not always readily available in all bathrooms.

As part of the inspection process we looked around the kitchen area and found suitable levels of hygiene had not been maintained. We noted grease stains were upon cupboards and staining on the window guards. We commented upon the standards of cleanliness as we were aware there had been concerns with rodents and ants at the home. The cook agreed improvements were required to make the kitchen clean. We fed back our concerns to the registered manager and the director of care. They agreed to take immediate action. The kitchen was deep cleaned the next day.

During the inspection visit, we noted some areas were in a poor state of repair. For example, two toilets on the dementia unit had peeling paint on the walls and the rubber skirting around the floor areas was peeling away. This meant surfaces could be more prone to exposure of cross infection.

On the first day of the inspection visit we looked around the home and noted there were some malodours around the building. We highlighted these to the registered manager. On the second day of the inspection visit we noted malodours had improved. However there were noted continued concerns about standards of cleanliness and hygiene within one person's bedroom. We were informed the person had specific needs which made the cleanliness of their bedroom difficult to maintain but were advised staff were appropriately managing this. We looked in the person's room and noted furniture in the room was in a poor condition. Furniture had started to perish. This meant it could not be suitably cleaned. In addition, the floor had some staining. We looked at documentation maintained by staff to demonstrate the room was cleaned regularly. There was no information available to show the room was routinely cleaned to meet the needs of the person.

We spoke with the housekeeper who was responsible for overseeing the standards of cleanliness at the home. We asked them if they had received any training in regards to infection prevention and control processes. They confirmed they had not. In addition, they were unaware of good practice guidance developed to promote effective standards of hygiene.

We recommend the registered provider consults with best practice guidance to ensure infection prevention and control processes are consistently implemented throughout the home.

As part of the inspection process we reviewed accidents and incidents that had occurred at the home. We were advised by the registered manager that accidents and incidents were inputted onto a database system which is accessible to all managers of Four Seasons Healthcare (England) UK. We looked at information held upon the system and saw details of all accidents and incidents were recorded alongside action taken. Accidents and incidents were split into categories as to whether or not minor, moderate or major injuries were sustained. In addition, as part of the accident investigation lessons learned were to be documented. We saw evidence of lessons being learned and action being taken after one incident involving a person's wheelchair.

Although systems were in place. We found not all accidents and incidents upon the spread sheet matched with information we held. Prior to the inspection taking place we had been provided with information from the provider in regards to a serious injury that had taken place at the home. There was no evidence of the serious injury being documented within the accident and incident information shared by the registered provider. We raised this at feedback but have received no clarity as to why this had occurred.

We looked at how fire safety was promoted at the home. We found suitable checks took place to maintain a safe environment. Staff had recently undertaken fire evacuation training to develop their skills to enable them to respond in an emergency. The registered manager had identified a need for further training and had enrolled the skills of a health and safety advisor who worked for the registered provider. This showed us

the registered manager was committed to ensuring safe processes were in place in the event of an emergency.

We carried out a visual inspection of the home. We saw windows had restrictors on them and radiators were covered to minimise the risk of burns. During the inspection visit we checked taps had controls upon them to ensure water temperature was restricted to prevent scalds.

We also looked at documentation relating to the health and safety of the home. All required certification was up to date, regular maintenance checks took place and records were maintained.

Requires Improvement

Is the service effective?

Our findings

At the inspection visit carried out in January 2017, we found systems ensuring the principles of the Mental Capacity Act 2005, (MCA) were not consistently followed. This was a breach of Regulation 11 of the Health and Social Care Act 2008, (Regulated Activities) 2014. We asked the registered provider to complete an action plan to tell us how they intended to make the required improvements. The registered provider sent us an action plan to state they would be complaint with the Regulation by May 2017.

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 checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.
We looked to see if consent was consistently obtained. We found the service had made the required improvements. We saw that MCA assessments had been completed to demonstrate when people lacked capacity.

Although processes had been implemented, on the first day of our inspection visit we identified one person who had recently moved into the home. We reviewed their care records and noted the person lacked capacity. We saw consent had not been consistently obtained in order to provide care and support to the person. For example, we saw consent had not been received to use bed rails for the person. We highlighted this to the registered manager. Action was taken immediately to ensure consent was achieved in a timely manner.

We recommend the registered provider reviews processes to ensure consent to care and treatment is consistently considered and achieved.

We looked to ensure applications had been made to the appropriate professional body when people were being deprived of their liberty. We found the registered provider had undertaken the appropriate steps to ensure people were not being unlawfully deprived of their liberty. For example, one person was unable to consent to living at the service therefore an application had been made ensure they were not unlawfully being deprived of their liberty.

We looked at how people's nutritional needs were met by the registered provider. We received positive feedback about the food provided. Feedback included, "I like some of it, I get enough to eat and drink". And, "It's brilliant, the chef's very good". Also, "I've always been a fussy eater, I like chips. They make good custard

and cake". And, "It's very good, I enjoy it. If I don't want it I get an alternative".

We observed lunch being served. People were able to choose where they would like to eat their meals, including dining areas and bedrooms. Contrasting plates and cups were available to support people living with dementia. This showed us good practice guidance had been considered. In addition, equipment was available to promote independence, for example one person had a plate guard to prevent food from spilling off the plate. This showed us the registered provider understood the importance of maintaining independence.

During the course of observations we saw that one person was given a meal but did not eat this. At the end of the lunch time period staff took away the person's sandwich and left them with their soup. Two hours later, when staff brought around a drink we observed the staff member taking the soup away as the person had not eaten it. We looked at the care records for the person. The care records indicated the person was at risk of malnutrition. Staff were instructed to document all foods the person had consumed. After the meal was taken away we reviewed the food chart and noted staff had reported the person had eaten the soup and sandwich. This was in effect inaccurate and did not accurately reflect the nutrients the person had consumed that day.

During the inspection visit we reviewed records related to another person who was at risk of malnutrition. The person had a medical condition and it was important they were provided with a regular intake of food. The person required full support to eat and drink. Staff at the home were directed to log all food and nutrition the person consumed on a daily basis. We looked at the record maintained to see if the person had been provided with adequate nutrition. We found there were no entries for a period of nineteen hours. We discussed this with the registered manager. They told us they believed this was a recording error but were unable to provide evidence to demonstrate this was the case.

The above matters demonstrate a breach of Regulation 14 of the Health and Social Care Act (2008) Regulated Activities 2014 as the registered provider failed to ensure systems to ensure peoples dietary needs were met were implemented and consistent.

We looked at how the registered provider met people's health needs. People told us they had access to a doctor whenever they needed to see one. Relatives told us they were kept updated if their family members' needs changed.

During the inspection visit we spoke with a visiting health professional. They were visiting the home to offer nursing support to some of the people who lived at the home. They told us they had no concerns about the service at the time of their visit.

We reviewed care records and noted health professionals were consulted in a timely manner. We saw evidence of involvement from SALT, District nursing teams, and general practitioners (GP's). On one occasion when staff had noticed a person was having difficulty chewing staff arranged for the person to see a dentist. This showed us the registered provider was working proactively to promote good health care.

At this inspection visit we looked to see if staff had the appropriate training and skills to effectively carry out their roles. People and relatives told us they considered staff to be appropriately trained. One person said, "I'm very pleased with them, they do their job very well."

Staff were positive about the training offered by the registered provider. Feedback included, "There has been an increase in training under the new manager. It's much better." And, "We get plenty of training if

needed."

We looked at the training statistics for staff that worked at the home and saw training had been provided to staff in relation to a number of topics including fire safety, first aid, food hygiene, health and safety and medicines. It was noted all identified training had been completed by at least 96% of staff.

Although training had been provided, during the inspection visit we noted qualified staff required further training around the safe management of a medical condition. This was discussed with the registered manager who had already identified this as a training need and had requested additional training and support within the home. Following the inspection visit we received confirmation this training was planned to take place.

We spoke with the staff about the implementation of good practice guidance within the delivery of care. One nurse told us they had recently revalidated their skills. They said this ensured their skills were up to date and in line with good practice.

We found the implementation of good practice guidance to meet people's healthcare needs were inconsistent within the home. We noted guidance had sometimes been referred to upon the unit where people were living with dementia. For example, we saw coloured crockery and signage in communal areas to promote independence. Additionally we saw good practice had been referred to when supporting a person with a stoma bag. However when asked the housekeeper was not aware of good practice guidance surrounding infection prevention and control processes.

We recommend the registered provider consults with good practice guidance to ensure people's health care needs are met in line with good practice guidance.

We looked to ensure staff were provided with a suitable induction when they started within their role. We spoke with a member of staff who had recently been recruited. They told us they completed a two day induction period at the start of their employment and then shadowed more experienced members of staff. They said the induction process continued for a period of twelve weeks. In this time they were also required to complete additional training. They said they were satisfied with the induction offered.

We spoke with staff about supervision. Staff confirmed supervisions took place and said they took place with a senior member of staff. We noted from a supervision board that supervisions had taken place but had not been fully completed for all staff. Staff said they could always ask for advice and guidance in between supervision sessions and described both the deputy manager and manager as "approachable." We were advised by the registered manager they were in the process of completing appraisals for all staff.

We reviewed the design and adaptation of the home. The registered manager told us they had worked hard since the last inspection visit to improve the living standards at the home. We saw there was a period of refurbishment taking place and rooms were being refurbished as part of on-going improvements. People were encouraged to personalise their own private spaces and bedrooms were individually decorated according to people's tastes. People who lived downstairs had open and ready access to a garden area. We observed people sitting outside in the garden whilst we were at the home. Other areas of the homes were accessible by keypad entry. This was to ensure people remained safe. When people had capacity, we observed them leaving the building if they so wished.

Requires Improvement

Is the service caring?

Our findings

People who lived at Preston Glades Care Home told us on the whole staff were kind and caring. Feedback included, "They are brilliant, they're kind". Also, "They all seem to be happy and smiling". And, "I love it here. I am looked after and that's the truth."

Relatives also told us staff were caring. Feedback included, "They're very good, they have a giggle with them". And, "I've no complaints about any of them". Also, "They're quite bright and give her a big hug. They're very friendly with her".

Although we received positive feedback about staff, during our inspection we found evidence to suggest staff were not consistently caring. On the first day of the inspection visit we found call bells around the home were not always present and accessible in people's bedrooms and communal areas. Following an investigation it was confirmed by the registered manager that some call bells had been unplugged and placed in people's drawers. This meant people could not always seek help in an emergency. The registered manager could offer no explanation as to why this had occurred. In addition, no staff had identified this as a concern and hadn't taken action to ensure all people's needs could be addressed in a timely manner.

We looked at how equality and diversity was achieved at the home. The registered manager said they had an equal opportunities policy. In addition, staff were expected to complete equality and diversity training. When asked, staff were able to tell us how they would ensure people's rights and beliefs would be supported and promoted. Although staff could tell us how to promote people's rights we saw that on one occasion there had been a noted delay in ensuring one person's rights and beliefs were fully discussed and recorded within the person's care record. It is important that rights and beliefs are addressed prior to a service beginning so that person centred care can be consistently delivered. Person centred care prevents discrimination from occurring. We brought this to the attention of the registered manager who agreed to take immediate action. At the end of the inspection visit we were informed a review of the person's rights and beliefs had taken place with the person's family and a health professional so that care could be provided in the best interests of the person. Following the inspection visit however, we spoke with a professional who confirmed the registered provider had documented the incorrect information and had recorded the person's incorrect religious beliefs. This evidenced that the registered provider had failed to ensure the person's human rights had been met under Article 9 of the Human Rights Act 1998; Right to Freedom of thought, belief and religion.

During the inspection visit we observed some positive interactions. For example, we observed one staff member offering reassurance to a person who was upset as they wanted to see a family member. Staff spent time with the person talking to the person in order to reduce their anxieties. On another occasion a person complained about a chair being uncomfortable. A member of staff responded immediately and brought the person another chair. The staff member then asked the person if they were okay. They did this to ensure the person was comfortable before leaving them.

We observed staff promoting and encouraging independence. For example, one person who lived at the

home enjoyed cleaning. The person had their own cleaning pack so they could carry out cleaning duties around the home. This gave the person a sense of achievement. Another person liked to go out independently. We observed the person going out for the morning to undertake tasks. This enabled the person to remain independent and carry out tasks of their choosing without having to rely on staff.

People who lived at the home told us privacy and dignity was promoted at all times. They told us staff knocked on doors before entering. One person had requested their bedroom door was closed when they were not in their room. We saw staff had placed a notice on the person's door to prompt staff to do this. People said privacy and dignity was always maintained when supporting them with personal care.

We observed visitors at the home. Relatives were able to access communal areas and family member's bedrooms. Relatives and visitors said they were welcomed at the home. We observed one relative visiting over a lunch time. Staff asked the relative if they would like to join their family member for lunch and offered them a meal. We spoke with two relatives who were visiting the home during the inspection. They told us they had visited the home on a number of occasions whilst their family member was ill and had overheard conversations between people and staff. They praised the staff at the home and said, "We have overheard some lovely conversations. You could hear the kindness. They were gentle. It was all the things you want to hear."

We looked at how people were supported to have a voice and were supported to make decisions when they required assistance to do so. Advocates were consulted with when choices had to be made and the person themselves did not have capacity to make their own decisions about their care and support. Advocates are independent people who provide support for those who may require some assistance to express their views. This showed us people could be supported to express their views, if required.

Requires Improvement

Is the service responsive?

Our findings

We received mixed feedback from people and relatives as to whether or not they were consulted with in regards to planning their care. Whilst some people could not remember being consulted with, two people confirmed discussions regarding their care had taken place. Feedback included, "It's been discussed but I've not signed it". And, "We've had a review and it was discussed with me".

We looked at care records relating to eleven people. Although pre-assessment checks took place prior to a service being provided we found these were not always referred to and actioned when planning care and support for people. For example, one person had recently moved into the home with pressure care needs. These had been fully addressed and documented within the pre-assessment document. However action had not been taken in a timely manner to ensure their pressure care needs were documented within the care record. We brought this to the attention of the registered manager so action could be taken on the first day of our visit. Action had been taken to ensure a plan of care was documented on the second day of the inspection visit.

Care plans addressed a number of topics including mental capacity, medication, managing health conditions, personal hygiene, diet and nutrition needs, continence and psychological needs. Care plans detailed people's own abilities as a means to promote independence. Professionals were involved wherever appropriate, in developing the care plan.

Although care plans were in place, we found person centred care was not always provided. During the inspection visit we reviewed care records for one person who lived at the home and noted the person was described as having a 'staunch' religious belief. This information had not been used to determine and plan the person's care provisions in line with their religion. In addition, the person was noted as having some difficulties in verbally communicating as English was not their first language. The registered provider had identified this but the care plan had not addressed how to promote effective communication with the person.

During the inspection visit person we were made aware one person who lived at the home was known to sometimes present with behaviours which challenged the service. There was no plan of action in place to show what triggered the behaviours and the care plan failed to provide direction to staff as to how to minimise the behaviours from occurring.

The above matters demonstrate a breach to Regulation 9 of the Health and Social Care Act 2008, (Regulated Activities) 2014 as person centred care was not always provided to people who lived at the home.

People and relatives told us that activities took place at the home. Feedback included, "Bingo and games (take place) it stops you getting bored." And, "[Family member] sits in the foyer and they do bingo". Also, "They had an Easter bonnet competition. [Family member] used to paint, they won the competition."

The registered provider employed an activities coordinator who was responsible for organising activities at

the home. They told us they were supplied with a budget to ensure activities took place. Activities organised included organising games and functions such as afternoon tea parties and cocktail evenings. The activities coordinator said they had established links with community groups who visited the home. These included a local scouts group, a children's nursery and the Salvation Army. This showed us the registered provider was aware of the need to address isolation and loneliness for people who lived at the home.

Whilst walking around the home we noted various pieces of artwork were on display which had been completed by people who lived at the home. Also, games, puzzles and equipment which could stimulate thinking and activity were placed around the home. In addition, on the first day of the inspection we observed some activities taking place. We observed a staff member using scented oils to generate discussion with people. Also we saw staff encouraging people to take part in games. On the second day of the inspection we observed the activities coordinator preparing for a party to celebrate the royal wedding. People told us they were not forced to take part in activities and told us they were optional.

We reviewed how end of life care for people was planned and provided at the home. Care plans sometimes included peoples and relative's final wishes as to how they wished to be supported and cared for in the latter stages of their life. The registered manager said they tried to hold conversations with people about their preferred wishes at the end stages of life. The registered manager said they would access support from other health care professionals when required. We spoke with two relatives. They praised the end of life care provided by staff to their family member. This showed us the registered provider was supportive in ensuring people had a comfortable and dignified death.

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. Staff said they were aware of the importance of using visual cues to promote and enhance people's communication when they had difficulties in communicating. We were advised one person who lived at the home used picture cards to support them with decision making and communicating their needs. The activities coordinator said there were a number of people living at the home who due to disability could no longer read. They said they were encouraged to read talking books. This showed us the registered provider sometimes addressed people's communication needs.

As part of the inspection process we looked at how complaints were managed by the registered provider. The registered provider had a policy which documented processes to follow should a complaint be raised. People and relatives were aware of their rights to raise complaints and were aware of how to complain. People told us when they had raised minor concerns with the registered provider they had been suitably addressed. The registered provider maintained a log of all complaints received and the outcome following the complaint being investigated.

Inadequate

Is the service well-led?

Our findings

At the inspection carried out in January 2017, we identified a continued breach to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the registered provider had failed to ensure auditing systems in place were effective. We asked the registered provider to complete an action plan to tell us how they intended to make the required improvements. The registered provider sent us an action plan to state they would be compliant with the Regulation by May 2017.

We used this inspection visit to check to see if the required improvements had been made. We saw there was a variety of auditing systems in place ranging from daily audits carried out by staff to monthly audits carried out by area managers. Although auditing systems were in place we found auditing systems continued to be ineffective. For example, monthly audits had failed to identify the safeguarding concerns we noted during this inspection process. Care plan audits had failed to identify that paperwork was sometimes, inaccurate, incomplete and conflicting. Medication audits had failed to identify that good practice guidance was not being followed. In addition, no audits had identified inconsistencies in reporting concerns to the Care Quality Commission.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Good governance) as the registered provider had failed to evaluate practice to ensure fundamental standards were consistently addressed.

As part of the inspection process carried out in May 2018, we looked to ensure the registered provider was meeting its legal responsibilities in providing information to the Care Quality Commission, (CQC). To do this we compared information held upon our database to accidents and incidents that had occurred at the home. During the course of the inspection process we identified six incidents where people had been injured or placed at risk of harm. The registered provider had a legal responsibility to report these incidents to the Commission but had not done so.

We discussed the incidents with the registered manager and reviewed the systems for reporting such incidents. The registered manager said they held responsibility for ensuring notifications were supplied to CQC. They confirmed these incidents had not been reported to the CQC in a timely manner as expected.

The above matters show the registered provider was not meeting legal requirements in relation to Regulation 18 of the Care Quality Commission Registration Regulations 2009. This was because processes were not consistently implemented to statutory notifications were submitted in a timely manner.

We reviewed the quality of care records maintained by the registered provider. We found records were not consistently and accurately completed in a timely manner. For example, Peoples weight assessments and risk calculators had been incorrectly documented and measured. Risk assessments sometimes failed to capture all relevant risk for people who lived at the home. Positioning charts to evidence people had been repositioned were not suitably completed to show when a person had been re-positioned. MAR records had not been consistently completed to reflect good practice guidelines. Also, review dates for reassessments of

people's needs were documented within care records but action was not always taken to reassess people's needs within the timeframe instructed.

Documentation at the home was not always clear and concise. For example, one person's care record held conflicting information from two health professionals about the person's dietary needs. Staff had not identified this whist reviewing the care record so that action could be taken to ensure continuity of care and safe practice.

Documentation at the home was not always effectively stored and easily accessible. We asked to see copies of safeguarding investigation meetings that had been reported as taking place in relation to a series of incidents. The registered manager could not locate these documents and no senior manager could confirm where these documents were placed or whether or not the investigatory meetings had taken place.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Good governance) as the registered provider had failed to ensure records maintained were accurate, complete, up to date and accessible.

Although systems were in place to communicate information to the senior management team, systems were not always effective. For example, processes to ensure high risk incidents were escalated to senior managers were not always followed. For example, senior managers informed us they had not been made aware of two high risk incidents at the home which had placed a person at risk of significant harm. In addition, advice and guidance from other departments within the service had not been routinely sought to ensure risk was suitably managed.

Policies developed to maintain people's safety were not always consistently followed by management. For example, the registered provider's policy for safeguarding vulnerable adults had not been consistently followed by the registered provider. In addition, the registered provider's policy in relation to safe recruitment of staff had not been consistently followed to ensure staff employed to work at the home were of suitable nature.

This was a breach of Regulation 17 of the Health and Social Care Act 2008, (Regulated Activities) 2014 (Good governance) as effective systems were not in place to ensure the safe care and treatment of people who lived at the home.

We found the service acted reactively rather than proactively to manage situations at the home. For example, the auditing of the recruitment files took place after the registered provider being made aware of concerns from an external body.

Leadership and management at the home continued to be inconsistent and failed to ensure compliance with the regulations. The registered provider had failed to make the required improvements requested at the last inspection visit. In addition, new breaches to regulation had been identified during this inspection visit. This meant the registered provider had not been compliant with regulations at Preston Glades Care Home since 2015.

We spoke with the registered manager about managing the home. The registered manager told us they felt they had been 'firefighting' at the home since they came into post. They said, "Since the last inspection we have been firefighting. I felt we were getting to the ashes but now it feels like we are firefighting again." Both the registered manager and deputy manager said the support provided to them from senior management team to make the required changes at the home had been inconsistent. They said however this had recently

improved since the home had been appointed a new managing director.

Although we identified significant failings at the location, staff praised the registered manager who had been in post since April 2017. Staff told us the registered manager had worked hard to make improvements at the home. They said morale had increased since the registered manager came into post. Staff reported this had contributed to a decrease in staff turnover at the home and had promoted continuity in care. Feedback included, "It is better here under [registered manager]. Things are better than they have ever been." And, "Staff are more settled. Staff aren't leaving." Also, "[Registered manager] is committed to making changes." And, "We now have stability. I hope this one (registered manager) stays." Staff told us they were regularly communicated with.

People who lived at the home were aware of who the registered manager was. They told us there was management presence from the registered manager within the home. One person said, "[Registered manager] comes and sits on my bed and talks to me." Another person said, "[Registered manager] is lovely, they make people smile. I have never seen them mad."

We looked at how the registered provider engaged with people who lived at the home. We were informed by people who lived at the home that regular residents meetings took place where people could express their views. In addition, we saw evidence of people being consulted with in regards to food provision at the home.

The registered manager said they organised regular relative meetings so relatives could be kept up to date as to what was happening at the home. They said however relatives rarely attended meetings. In addition, the registered manager and deputy manager made themselves available on a weekly basis for relatives to come in and visit them if they had any concerns. This showed us the registered provider was committed to listening to relatives in order to improve service provision.

As part of the inspection process we looked to ensure the registered provider had their performance assessment on view as set out in the 2008 Health and Social Care Act. We saw the performance assessment was on view as required.