Flightcare Limited

Courtfield Lodge

Inspection report

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Date of inspection visit:
20 May 2019
21 May 2019
13 June 2019

Date of publication:
06 August 2019

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

About the service:
Courtfield Lodge Residential Care Home is a residential home registered to provide accommodation and personal care for 70 people aged 65 and over. At the time of the inspection, 53 people lived at the home. Some people were living with dementia.

People's experience of using this service and what we found:
People told us they felt safe and staff were kind and caring. However, practices in the home did not always demonstrate that staff understood how to safeguard people from neglect and abuse. Information we received before the inspection demonstrated people's safety had been compromised due to lack of consistency in seeking medical attention and poor risk assessment and monitoring practices.

Systems for supporting people after incidents had not been adequately implemented to monitor people's well-being. People were not always monitored following a fall or incident. The provider had not adequately analysed accident and incident to identify themes and trends and prevent re-occurrences. There were no lessons learnt processes to show how staff had learnt from events. This led to a repeat of incidents that exposed people to risk.

There had been a rapid decline in the quality of the care at the home. There had been instances when people had suffered significant injuries and deterioration of their conditions however staff had not always recognised a deterioration in people's conditions and sought medical attention in a timely manner. The provider needed to improve systems for monitoring people's healthcare needs to ensure people had access to healthcare services, as necessary without delay. The changes that the provider had planned to introduce to improve people's safety were not robustly implemented or monitored for effectiveness.

The registered manager and staff had not always followed safeguarding protocols to ensure all reportable concerns were reported to the local authority.

Staff had not carried out effective risk assessments to enable people to retain their independence and receive care with minimum risk to themselves or others. Risk assessments completed were not always accurate and environmental risks had not been adequately managed to prevent harm or injuries.

The provider had an effective recruitment procedure, which ensured only suitable staff were employed in the home. However, the disciplinary procedures were not always robust to give confidence to people that staff who acted unprofessionally would be held accountable. The provider informed us they had reviewed this and brought a new independent process in place.

People did not always receive their medicines as prescribed because medicines management practices were not always safe. This included the management of medicines such as topical creams, thickening powders and 'as required medicines'. Some of the staff who administered medicines were not competent to

do so.

The standard of cleanliness and infection control practices needed to be improved. We have made a recommendation about the management of infection prevention measures.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. However, the systems and documentation in the service did not always support this practice. Authorisations to restrict people were not always renewed when they expired. During the inspection, the registered provider showed us an action plan which assured us action would be taken to address these issues.

The provider had not ensured their staff completed relevant training and supervision in line with their policy.

The governance systems at the home were weak. The system did not proactively monitor areas where the care delivered was not safe or meeting standards. Furthermore, arrangements in place did not ensure accountability and transparency. The registered provider was not always aware of shortfalls and serious concerns in the home due to a lack of robust oversight on the care provided. This had led to repeated cases of people being exposed to risk. There had been instability in the leadership arrangements at the home which had been attributed to a high management turnover.

While people were supported to eat a nutritionally balanced diet, there had been concerns about lack of robust action to support people at risk of unintentional weight loss. During the inspection we saw improvement had been made in this area.

Our observations during the inspection, were of positive and warm interactions between staff and people who lived in the home. Staff treated people with kindness, dignity and respect and spent time getting to know them and their specific needs and wishes. However, before the inspection we had received concerns that reflected that people were not consistently treated with kindness and dignity. The provider gave us assurances that they would introduce robust systems for reporting any concerns.

Daily activities were provided, events were celebrated in the home and professional singers and entertainers were booked on a regular basis. People were aware of how they could raise a complaint or concern if they needed to and had access to a complaints procedure.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection:
At the last inspection the service was rated Good. (published 01 September 2018). The overall rating has dropped.

Why we inspected:
The inspection was prompted in part by notification of specific incidents. One of these incidents was subject to an investigation by the coroner's office and three other incidents are subject to investigations by CQC. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incidents indicated concerns about the management of falls, people going missing, seeking medical attention in a timely manner. This inspection examined those risks.

We have found evidence that the provider needs to make improvements. Please see the safe and effective sections of this full report.

Enforcement:
We have identified breaches in relation to the arrangements for keeping people from harm to self or others, the management of medicines and infection prevention. We also found breaches in relation to person-centred care, seeking consent, staff training and supervision and good governance.

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

Follow up:
We will meet with the provider to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Courtfield Lodge

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, 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 by notification of incidents following which two people using the service had sustained serious injuries and died. In addition, concerns of neglect had been raised regarding two other people following hospital admissions. These incidents were subject to investigation by the Coroner and the local safeguarding authority. As a result this inspection did not examine the circumstances of these incidents.

However, the information shared with CQC about the incidents indicated potential concerns about the management of risk of falls, falls from a bed, seeking medical care in a timely manner, poor medicines management and risks of people leaving the home without staff's knowledge. This inspection examined those risks of falls, leaving the building unattended, risk of physical assault and medicines management.

Inspection team:
This inspection was carried out by four inspectors on the first day and an expert by experience, one inspector on day two and two inspectors on day three. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
Courtfield Lodge Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service accommodates up to 70 people.

The manager was registered with Care Quality Commission. This meant they and the provider were legally responsible for how the service was run and for the quality and safety of the care provided.

Notice of inspection:
This inspection was unannounced.

What we did before inspection:
Before the inspection, we reviewed all the information we held about the service such as notifications. These are events that happen in the service the provider is required to tell us about. We also sought information from the local authority's contract monitoring team and safeguarding team. We used our planning tool to collate and analyse the information before we inspected.

We did not ask the provider to complete a Provider Information Return (PIR) in advance of this inspection. This was because the inspection was unannounced and in response to information of concern. The PIR 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.

During the inspection:
During the inspection, we spoke with five people who lived in the home, three relatives, six members of staff, the chef and the registered manager who is also the regional care quality manager. We also discussed our findings with the director who is the owner and a manager who had been recently recruited. We looked at the care records of 11 people who used the service, looked around the premises and observed staff interaction with people. We also examined a sample of records in relation to the management of the service such as staff files, quality assurance checks, staff training records and accidents and incidents.

After the inspection:
Following our inspection visit in May 2019, the Care Quality Commission received concerns regarding unsafe care and poor practice practices for keeping people safe and secure. A further unannounced visit was undertaken on the 13 June 2019 where we found ongoing concerns about people's safety.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse

- People were not protected from risks of harm because there were poor arrangements for assessing and monitoring risks. We found three incidents where people had been exposed to harm due to physical assault from others, however there was no documented evidence of risk assessments or protection plans that staff could follow to reduce the risk or consideration whether the home continued to be suitable to manage the risks.
- Staff had not always followed the care plans and the protocols for monitoring injuries and for promptly seeking medical attention. Before the inspection we received concerns regarding the management of risks associated with falls, head injuries, the lack of medical attention and monitoring following injuries and the security of the building. One person had experienced a fall and a fractured leg in December 2018. Despite the person complaining of pain and a deterioration in their walking, the fracture was not detected until February 2019.
- People were not adequately supported against incidents of physical assault from others or challenging behaviours because there were no protection plans in place to prevent re-occurrences. One person had attacked another and also attacked care staff however there was no risk management plan to reduce harm to other and staff. Incident record stated 'care plan reviewed' however there was no written care plan to review as one had not been written.
- The provider did not always undertake risk assessments to reduce incidents of harm or exposure to harm. We saw records of a person who had a pressure sore, there was no care plan to manage the wound however, staff had documented that there was a care plan which had been reviewed. Which meant the risk was not adequately monitored for improvements or deterioration.
- Staff had not carried out robust environmental risk assessments to ensure the safety of people's living space. Records of incidents showed that before the inspection two people had been injured as a result of tripping on hoists that had not been safely stored. On the day of the inspection we observed the hoists causing obstruction in the corridors. We asked for immediate action to be taken to clear corridors.
- People were not adequately protected from risks of leaving the home without escort. Before the inspection, we had been made aware of an incident where a person left the home without staff knowledge. During the inspection we were given assurance that this had been resolved. However, soon after the inspection we were notified of another incident where a person had left the building without staff knowledge. There was no guidance on how to monitor people at risk of absconding. This led to repeated incidents of people absconding and suffering injuries in some cases. We asked the provider to take immediate action to resolve this risk.

● The provider had arrangements to carry out safety checks on electrical and gas installations as well as equipment in use at the home. However, we found areas of the home where repairs were required to prevent harm. For example, in one toilet there was a broken toilet paper dispenser which was detached from its unit and a commode frame was used in place of a raised toilet seat posing risk of injury. The registered manager informed us regular maintenance visits would be carried out by the maintenance man with support from the estates manager.
● People were not adequately protected from the risk of abuse. While people told us, they felt safe and were satisfied with the care and support they received, before the inspection we were informed of safeguarding concerns for neglect which had been investigated by the local authority. This included allegations of neglect by failing to seek medical attention in timely manner and some people having unexplained injuries which had not been reported to safeguarding authorities.
● The procedures in the home did not facilitate the effective sharing of concerns with the provider to ensure they could act promptly. Staff did not fully understand their responsibilities to protect people from avoidable harm or abuse because there had been delays in ensuring people received the care they required and reporting all significant unexplained injuries to people. We spoke to the provider before and during the inspection and they told us they had not been aware of significant concerns to people's care and safety.
● On the day of the inspection relatives told us they had no concerns about the safety of their family members. One relative told us, "Oh yes, definitely safe from other residents and in the communal areas there usually is a least one member of staff in attendance." However, before the inspection we had received concerns from two relatives regarding the quality of the care and lack of privacy. A relative raised concern about people going in their relatives' bedroom and staff's inability effectively deal with this. One incident record we reviewed showed a person was attacked by another as they had entered their bedroom without their permission causing injuries.

There was a failure to assess the risks to the health and safety of service users of receiving the care or treatment. This was a breach of Regulation 12 (Safe care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Protocols and records to facilitate lessons learnt processes were not robust. There was a lack of awareness on the need to complete lessons learnt processes following incidents or adverse events to show how staff learnt from incidents and consider how to reduce re-occurrences. We found a significant number of incidents where lessons learnt processes had not been undertaken. The registered manager assured us that this would be implemented. However, on day three of our inspection we found no action had been taken to learn from significant events in the home.

Using medicines safely
● People's medicines were not managed safely because staff did not follow safe and best practices in medicine, management, storage and administration. Records showed eight people did not receive their medicines in the way prescribed. One staff member recorded that people had received their medicines when they had not been given. Four people were prescribed topical creams to manage sores, skin dryness and infections, however we found their medicines were sealed and unopened, yet staff had signed that they were applying the creams.
● One person had not been given medicines to prevent water retention and topical creams to treat ulcers despite evidence which showed they had an infection and their skin was deteriorating. These people's medicines had been withheld or not given without justifiable reasons or consultation with their GP. We raised safeguarding alerts regarding this.
● Guidance on how to administer medicines prescribed 'when required' was not up to date and medicines

disposal practices were not followed. We found a significant waste of medicines due to poor practices for stock management. For example, we found 500 paracetamol tablets which were being disposed of when they were still in date and still prescribed to the person. This was because there was no system to carryover medicines and to stop ordering medicines if there was enough stock. The receipt and disposal of controlled drugs was poor. We found six morphine tablets that had not been safely disposed of.
● Medicines audits had not been undertaken since January 2019. We found several instances of poor practices which had not identified by the registered provider.
● Two of the seven staff who administered medicines did not have the right competences to manage medicines safely. The registered manager assured us training would be arranged immediately.

There was a failure to manage people's medicines safely. This was a breach of Regulation 12 (Safe care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Improvements were required to the infection control practices. Linen, gloves and soiled underwear were inappropriately stored in communal toilets. There were no hand washing facilities such as paper towels in some of the bedrooms and two communal toilets we checked. There was inappropriate storage of bed pans in toilets. Toiletries and topical creams were also found in toilets. These are poor practices which may indicate that these items were shared and pose a risk of cross contamination.
● Not all staff had completed training in preventing and controlling the spread of infection. They had access to disposable protective aprons and gloves to help reduce the risk of infection. We referred the service to infection control professionals at the local authority.

We recommend the provider consider current guidance on infection prevention and control and take action to update their practice accordingly.

Staffing and recruitment
● The provider followed safe recruitment procedures to make sure staff were of a suitable character to work in a care setting.
●Staff disciplinary procedures were not robust to ensure people received safe care. The provider was aware of concerns relating to unprofessional behaviour such as lack of action to act on concerns about people's welfare. However, these had not been timely addressed. After the inspection the provider informed us they had started to address these concerns.
● People told us the staff responded when they summon them for assistance. One person said, "Usually there is enough staff on duty, there may be the odd occasion when there's not." Another person commented, "By and large I would say yes there are enough staff. There are times when they are stretched." However, one relative said they had been staff shortages on weekends. We shared the concerns with the registered manager who assured us staffing levels were regularly reviewed.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application 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.

- The provider and staff were not consistently working within the principles of the MCA. People's capacity to make decisions was considered as part of their assessment of needs. At the time of the inspection, thirty one applications had been submitted to the local authority for consideration. However, authorisations had not been renewed with the local authority when they expired. In addition, there was no system for reviewing applications when new restrictions had been introduced to people's care.
- We observed staff speaking with people and gaining their consent before providing support or assistance. However, we noted that improvements were required to staff's knowledge and understanding of the MCA/DoLS. Seventeen of the staff had not renewed their training in MCA/DoLS.
- During the inspection, the registered manager told us work had begun to introduce new documentation to ensure the principles of the MCA were adhered to.

There was a failure to ensure care and treatment was provided with the consent of the relevant person. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
- The provider had not ensured that staff consistently received training and supervision. Arrangements to

provide staff with training and supervision were in place. However, there were shortfalls across a number of areas that were deemed by the provider to be mandatory for the roles staff were employed to carry out. Staff had not timely renewed or updated their training to ensure they remained competent in their practices. For example, seventeen out of 43 staff did not have upto date safeguarding training and two of the staff who administered medicines had not renewed their train to maintaining their competences.

● While arrangements for regular staff supervisions were in place, we found staff had not received supervision in line with the providers' policy. Supervision records and our conversations with staff showed supervision had not been provided from April 2018 to January 2019 for the majority of staff. However, the managers audit records consistently stated that staff were up to date with supervisions. We asked the registered manager to take action to ensure all staff received supervisions in line with the organisations' policy. On our third day of the inspection this had not been carried out and the staff who were delegated to undertake the supervisions were not competent to do so as they had not received training to do so and they had not kept upto date with their own training and development.

There was a failure to ensure that all staff had received such appropriate support and training as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● People and their relatives told us staff supported them to live a healthier lifestyle however we found evidence which did not demonstrate this. Comments included; "I feel that staff really understand [relative's] condition and they act quickly to deal with anything that needs to be. Staff are competent and have all the skills. There's very good access to other health service professionals, the district nurse comes twice a day." However, there had been delays in seeking medical attention and to refer people to specialist professionals when their needs had increased or when they had experienced injuries. People could not be assured they could receive appropriate support to meet their healthcare needs. In addition, guidance given was not always followed and some of the medicines prescribed were withheld with no reasons given or because they were asleep.

● People's physical and mental healthcare needs were documented within the care planning process. However, this had not always been used to identify and monitor signs of deteriorating health.

● Staff prepared an emergency care plan for all people admitted to hospital, which provided an overview of their needs and preferences.

● We discussed with the registered manager and the provider the importance of working with other agencies and professionals, so people received effective, timely care. During the inspection the registered manager showed us evidence to show they had started to take action to ensure people who require specialist support were referred.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● The registered manager assessed people's needs before they moved into the home. The assessment was used to form a plan of care. As described in our findings in Responsive the care plans were not robust, and people's needs were not accurately planned for. Best practice guidance was not always followed.

Supporting people to eat and drink enough to maintain a balanced diet

● People were provided with a varied nutritious diet. People told us they were satisfied with the food. One person said, "The food is good and you get a choice. They always ask what you would like" and another person commented, "I like the food in here, it's varied enough and the portions are fine."

● We observed the meal time arrangements on the three days of inspection and noted people had a positive experience. Staff interacted with people throughout the meal and we saw they supported people in a

sensitive way. The overall atmosphere was cheerful and good humoured.

● Staff monitored people's weight and nutritional intake in line with their assessed level of risk and improvements had been to ensure referrals were made to healthcare professionals, as needed. Before the inspection there had been concerns that people were not adequately monitored to ensure they ate enough and to monitor weight loss. We raised concerns regarding this in a meeting with the director and the new manager and they took immediate action to address this.

Adapting service, design, decoration to meet people's needs

● Improvements were required to the adaptation of the premises. Attempts had been made to ensure the premises were suitable for people living in the home. However, there was a lack of suitable and sufficient maintenance to ensure all areas were in good repair. There were communal areas for people to be together. Some bedrooms had bath tubs which were not always appropriate for people who used them and two of the toilets were not easily accessible for people living with dementia.

● We observed a programme of renovations was in progress and the provider had plans to establish storage facilities to reduce the risk of cluttering the corridors. The provider informed us they will be reviewing the toilet facilities and the maintenance work in the home.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People told us, and family members confirmed, they were treated with kindness and were positive about the caring attitudes of staff. Comments included, "All the staff go the extra and they all take an interest in you. I would say they are kind and compassionate and they always treat you with respect. You might find the odd one that's not." And, "On the whole they are kind and compassionate but some more than others. Some of them always go the extra mile, and they always treat my [relative] with respect."
- During the inspection we observed positive and warm relationships between people and staff. They understood, and supported people's communication needs and choices. They maintained eye contact and listened patiently and carefully when speaking with people to ensure their needs were understood and met. However, before the inspection we had received concerns regarding the caring attitude in the home and staff's ability to respond to people's needs and concerns in timely manner. There were also concerns with people not being appropriately dressed. We did not observe these concerns during our visits.
- People, along with relatives, had been given the opportunity to share information about their life history, likes, dislikes and preferences. However, there had been concerns regarding people's privacy. This meant people could not be assured they would receive person centred and dignified care.

Supporting people to express their views and be involved in making decisions about their care

- The provider had processes for seeking people's views through meetings and surveys.
- Whilst people felt they were well cared for, none of the people were familiar with their care plan and could not recall discussing their care needs with staff. The registered provider assured us they intended to develop the care planning process to ensure people were more involved and the information was readily accessible to staff.
- There were mixed responses from people and their family members about their ability to express their views about the care and support provided by staff. Some relatives felt they could express their concerns. However, some expressed concerns that their views were not taken seriously by the management team at the home and they did not feel confident that their concerns would be resolved. We discussed these concerns with the director and the registered manager and they assured us that they will establish an independent enquiry into these concerns.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's care and support was not consistently personalised to meet their needs. Whilst people told us they received the care they needed, and staff responded to their requests made for assistance, we found this had not always happened. Care records were of mixed quality. Some records were written in a person-centred manner and clearly identified people's needs and preferences. However, the majority of the records we reviewed were inaccurate and of poor quality. Known risks were not documented to guide staff.
- Staff had reviewed the care records however the review process was not robust as it had not always identified changes in people's needs. Significant incidents such as falls, and injuries were not reflected in the care plans and in the risk assessments. Review records were not sufficient as they only referred staff to the incident record without providing detail of how the risk could be reduced or how the person could be protected. In addition, some records stated care plan reviewed when there was no care plan to review.
- We also noted some people's care plans contained limited information about their needs and risks. Care records for people on short term care were insufficient and not adequate to provide staff with guidance. People at risk of leaving the home without an escort or harming others did not have risk assessments or protection plans.
- Staff were not always responsive to changes in people's needs. There were cases where staff had either failed to identify a deterioration on people's conditions or failed to monitor people and take action to seek support in a timely manner. We also found cases where staff failed to give medicines to reduce deterioration. For example, two people were prescribed topical creams for sore skin and medicines to prevent water retention however we found both medicines were not given to the person.
- The provider, explained they were due to introduce a new electronic care recording system. They also informed us they had reviewed people at risk and made necessary referrals to other health care professionals. They had introduced a new system for monitoring people's needs however on our third visit this had not been implemented or monitored.

End of life care and support

- People were not supported to plan for their end of life care and share their preferences to ensure they could have a comfortable, dignified and pain free end of life care.
- We discussed this with the registered manager and the provider. They showed us the actions that they were planning to take to support people going forward.

There was a failure to design care or treatment with a view to achieving service users' preferences and

ensuring their needs are met. This was a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People told us they had opportunities to participate in daily activities. Comments from people included, "There's always something going on in here. There are entertainers coming in. Sometimes we have singers in the garden outside. We have trips to local parks and to Southport." And; "I've plenty to do here in my own room, TV, books, crosswords and I do knit for good causes. If you want there's bingo, dominos, skittles, flower arranging, and painting."

● We noted important events were celebrated in the home and professional singers and entertainers were booked on a regular basis. We also observed staff offering people meaningful activities throughout the inspection visit.

● The provider used technology to help with the delivery of care. We noted people were supported by the use of sensor equipment, when they were deemed at risk of falling. The home also had broadband facilities.

Improving care quality in response to complaints or concerns

● The provider had complaints procedure in place which had been shared with people and their relatives. We saw the complaints procedure was clear in explaining how a complaint could be made. Some people were confident they could raise concerns with confidence.

● However, before the inspection, concerns had been raised regarding conflict of interest in the provider's management arrangements and their ability to receive concerns and escalate them to senior management. Two relatives expressed a lack of confidence that concerns would result in improvements or shared with relevant senior managers. The provider informed us that they had made arrangements for independent investigations to be carried out for previous concern. This would give people and staff confidence that concerns will be taken seriously

Meeting people's communication needs

● Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The registered manager understood their responsibility to comply with the Accessible Information Standard and people could access information regarding the service in different formats to meet their diverse needs.

● Staff understood people's communication needs and these were recorded in people's care plans.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There were unstable management arrangements and a high turnover of registered managers. Seven registered managers had been employed in the last five years.
- The provider's quality assurance systems were inadequate. Although there was a governance system and policies and procedures, the provider had failed to effectively implement the systems to support the continuous monitoring and improvement of the care provided.
- There was ineffective management arrangements at the home which were characterised with a lack of questioning culture and a lack of accountability. Instances of poor practice were not challenged which resulted in the deterioration of the standards of care provided.
- The provider had failed to timely identify areas of non-compliance with regulations to ensure prompt action was taken. Our findings throughout the inspection indicated there was a lack of adequate understanding of safe care and regulatory requirements including a lack of competence in regulatory requirements across the management team in the home. The quality monitoring systems in place did not support the delivery of high-quality, person-centred care.
- The provider did not have robust oversight of the registered manager or their staff to ensure accountability and compliance with regulations. A care quality manager had provided regular support visits to monitor the registered manager. In addition, the registered manager submitted weekly and monthly reports to the quality manager. However, these arrangements were not identifying shortfalls and had failed to identify and rectify the shortfalls that we identified.
- The audit system lacked scrutiny. They stated that staff were receiving training and supervision when there were shortfalls and did not fully explore trends and patterns in relation to accident and incidents and whether people were receiving medical care. Medicines audits, Infection control audits and health and safety audits had not been carried out regularly in line with best practice. Care plan audits, managers audit daily walk around and monthly audits had not identified shortfalls that we found.
- Lessons learnt processes were not in place which meant staff could not demonstrate whether they had reviewed what could be learnt from events to reduce re-occurrences.
- During the inspection the provider and the registered manager showed us a remedial action plan which set out how they intended to address the issues identified before and during the inspection. However, on our visit on 13 June 2019 we found none of the plans had been fully implemented. We also found there was no robust commitment to share the concerns with staff and to ensure adequate resources were deployed to

improve the care provision.

Due to poor governance of the service people were placed at risk of harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- The provider's governance arrangements and the culture in the home did not promote the provision of high-quality, person-centred care.
- The provider's management arrangements did not always promote a culture of questioning and openness. We found significant concerns and incidents that had occurred in the home had not always been escalated within the chain of command to ensure transparency and accountability. The provider was not aware of serious incidents that had occurred.
- Some notifications had been submitted to the Care Quality Commission and some safeguarding concerns had been shared with the local authority. However, we identified an incident that had not been reported to safeguarding authorities or CQC. The provider and their representatives were not aware how staff had dealt with the incident. They informed us that they will review the processes for reporting incidents.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The registered manager encouraged feedback from people to improve the service. They held meetings with staff, people and their relatives to share their views and visions.
- The registered manager told us they intended to carry out a survey for people who lived in the home. They showed us surveys that had been completed by the previous manager.
- The systems for sharing information about people's needs was not robust. Staff completed handover records however these were not signed to show whether staff had read the records, or to show who was responsible for completing tasks and whether tasks had been completed. There were no due dates were set for tasks that were time sensitive for example medical appointments. The registered manager assured us this would be reviewed.
- The registered manager told us the home was developing close links and good working relationships with a variety of professionals to enable effective coordinated care for people. This included healthcare professionals such as the advanced nurse practitioners and the local GP, as well as social care professionals such as the safeguarding and social work teams.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to provide person centred care. This was because the care and treatment of service users was not designed to appropriately meet people's needs and reflect their preferences. Care records did not accurately reflect people's care needs -Regulation 9 HSCA RA Regulations 2014 Person-centred care

The enforcement action we took:

Enforcement action was taken by the Care Quality Commission in light of the significant risks identified in the home. We added a condition to the service providers' registration. The registered provider must not admit service users to Courtfield Lodge without prior written permission from the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to seek required authorisations when people were unable to consent to their care arrangements.-Regulation 11 HSCA RA Regulations 2014 Need for consent

The enforcement action we took:

Enforcement action was taken by the Care Quality Commission in light of the significant risks identified in the home. We added a condition to the service providers' registration. The registered provider must not admit service users to Courtfield Lodge without prior written permission from the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that risks to receiving care and treatment were identified and managed robustly. The provider had failed to ensure the safe use of

	medicines. The provider had failed to operate effective systems for the prevention and control of infections. -Regulation 12(2) (a) HSCA RA Regulations 2014 safe care and treatment.

The enforcement action we took:

Enforcement action was taken by the Care Quality Commission in light of the significant risks identified in the home. We added a condition to the service providers' registration. The registered provider must not admit service users to Courtfield Lodge without prior written permission from the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure governance systems were robust and systems or processes were not established and operated effectively to ensure compliance. Regulation 17 (1) (2)(a)(c) HSCA RA Regulations 2014 Good governance

The enforcement action we took:

Enforcement action was taken by the Care Quality Commission in light of the significant risks identified in the home. We added a condition to the service providers' registration. The registered provider must not admit service users to Courtfield Lodge without prior written permission from the Care Quality Commission.