Care Quality Commission

HC-One Oval Limited

Greengables Care Home

Inspection report

54 Sandbach Road
Congleton
Cheshire
CW12 4LW

Tel: 01260270030

Date of inspection visit:
09 August 2017
15 August 2017
17 August 2017
25 August 2017

Date of publication:
20 March 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection of Greengables Care Home was undertaken to check on people's safety, welfare and the general management of the home following our receipt of a number of concerns raised on behalf of people who used the service. We visited the home unannounced on the 9 August 2017 and carried out three further visits on the 15, 17 and 25 August 2017. The home was registered in January 2017. The home has operated as a care home for several years and was previously registered as a location under the legal entity of Bupa Care Homes (ANS) Limited. On the 31 January 2017 the home was re-registered as care home with nursing care under a new legal entity Bupa Care Homes Limited.

At the last inspection on 20 July 2016, we found the provider was meeting the requirements of the regulations inspected with the exception that "Medicine protocols were deemed safe but not always followed". An overall rating of Good was awarded by the CQC following the inspection.

Greengables Care Home is a detached, two storey Victorian house standing in its own grounds. It is on the outskirts of Congleton, approximately one mile from the town centre. The home is registered to accommodate up to 30 people who have nursing needs. At the time of our inspection there were 26 people living at the home.

This location requires a registered manager to be in post. A registered manager was in post at the time of our inspection. 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 this inspection, we found that the provider was in breach of regulations 9, 11, 12, 16, 17 and 20 of the Health and Social Care Act Regulations 2014 and regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We found that the service was not safe, responsive or well led and not always effective and caring.
At the start of the inspection we undertook a walk around of the care home and found that rooms in which medicines were being stored were not secure. Vulnerable people had unsupervised access to used hypodermic needles and medicines. This placed people at risk of harm. The registered manager failed to take effective action to address this and at the end of the day we found the first floor medication room unlocked and unsupervised again.

People identified as at risk of known hazards were not adequately protected. Bedrail protective bumpers were ill fitting in two instances and a known tripping hazard had not been removed from the room of a person assessed to be at high risk of falls.

Vulnerable people were found to have access to unrestricted access to the laundry which at times was

unsupervised. The laundry had a sink with unregulated scalding hot water with temperatures in excess of 59 degrees centigrade.

People who were identified as being at high risk of falls were not being reviewed following each fall to mitigate the risks of a reoccurrence. Therefore, the provider was not taking reasonable steps to keep people safe.

Care plans were not person centred and did not always reflect the personal care needs of the individual. One person told us that they were unhappy that they had not received basic levels of care. Their fingernails were dirty and records showed they had not been offered a bath in over a month.

Care staff told us that they had not seen some people's care plans and that they did not get time to read them. Staff support systems including staff training and supervision were found to be lacking or non-existent in some cases. Staff presented with a lack of knowledge about the work they did in some important areas including safeguarding vulnerable adults and the Mental Capacity Act. We also found that managers and staff were not always following the principles of the Mental Capacity Act 2005.

During the course of the inspection, the response and actions of the registered manager, did not demonstrate that that they had the necessary competencies to manage the home safely and effectively.

Quality assurance systems were in place but these had failed to identify uncontrolled risks presented to the people who lived at the home. There was evidence of a failure to notify the CQC of serious notifiable incidences and failure to analyse incidents and learn from experience when things had gone wrong.

Most of the people spoken with during the inspection told us that they received safe and effective care but others raised concerns and highlighted serious deficiencies in the provision of care. The atmosphere in the home was warm and welcoming and we observed some care staff providing care with kindness and sensitivity.

Recruitment and selection of staff was carried out safely with appropriate checks made before new staff started working in the home. This reduced the risk of employing unsuitable people.
People told us they were offered a choice of healthy and nutritious meals. Drinks were available throughout the day and people's dietary and fluid intake was monitored to ensure it was sufficient for good hydration and nutrition. People were complimentary about the meals with several people reporting that the food was excellent.

You can see what action we told the provider to take at the back of the full version of the report. Please note that the summary section will be used to populate the CQC website. Providers will be asked to share this section with the people who use their service and the staff that work there.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location from the providers registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were at risk of receiving poor and ineffective care and their needs not being met because care planning was ineffective and the manager and senior staff lacked oversight.

People were exposed to uncontrolled health and safety hazards that put people at risk of harm.

Medicines were not always managed or stored safely.

There was a sufficient number of experienced staff on duty.

Is the service effective?

Inadequate

The service was not effective.

People did not always receive safe and effective care.

Staff had received training in relevant topics but lacked knowledge and skills in hazard analysis, risk assessment, the Mental Capacity Act and safeguarding vulnerable adults.

Staff were not always following the principles of the mental capacity act 2005 legislation.

People enjoyed a varied and nutritious diet.

Healthcare professionals were involved in people's care.

Is the service caring?

Requires Improvement

The service was not always caring.

Care was not always provided in accordance with the person's assessed needs and care plans did not always contain sufficient detail to enable staff to provide safe and effective care.

Care staff had developed positive relationships with people who lived at the home and provided care with sensitivity and compassion. They took measures to ensure the person's privacy

and dignity were respected, were seen to offer them choice and involve them in decision making.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always reflect people's needs so some people were not always receiving care when they needed it. Staff lacked basic knowledge about people's needs and told us that they had not read care plans.

The management team did not always respond in a timely fashion or appropriately when people made complaints.

Some people had received care that met their individual needs and personal preferences and told us that they were content with the standard of care provided.

Is the service well-led?

Inadequate

The service was not well led.

People were at risk of receiving unsafe and ineffective care because the management team failed to identify, assess and mitigate the risk of harm.

The management team failed to notify the Commission of serious incidences including allegations of abuse.

The registered manager lacked knowledge of their requirements and responsibilities under the regulations. They failed to demonstrate the necessary skills and competencies to manage the home.

Audits of the care home had not identified the concerns we found during this inspection. This was because there was a lack of effective governance and oversight.

Care Quality Commission

Greengables 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 checked 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 took place on 09 August 2017, and was unannounced. Three additional announced inspection visits were undertaken on the 15, 17 and 25 August 2017.

The inspection team consisted of one adult social care inspector and one expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held on the service. This included notifications we had received from the registered provider, about incidents that affected the health, safety and welfare of people who lived at the home, previous inspection reports and a number of concerns raised by staff and a member of the public.

The methods used during this inspection included talking to people using the service, their relatives and friends or other visitors including visiting health and social care professionals. We interviewed staff, undertook pathway tracking, observed care practice, read records including personal care records for four people who used the service, staff recruitment records, staff training records, deprivation of liberty safeguards and mental capacity assessments, and quality assurance records. We also looked at a range of other records associated with the management of the home.

We spoke with a total of 13 people who lived at the home, 12 visiting relatives and 15 members of staff including two regional managers, the registered manager, the deputy manager also known as the clinical services manager, eight care staff, the administrator, the cook and a housekeeper.

Some of the people living in the home found it difficult to tell us what they thought of the care in the home due to their health conditions, so we carried out a Short Observational Framework for Inspection (SOFI),

which involved observing staff interaction with people who used the service.

Prior to and after the inspection we spoke with representatives of the local social services department and gained their views on the quality of care provided at the home. This helped us to gain a balanced overview of what people experienced whilst living at the home.

Inadequate

Is the service safe?

Our findings

We asked people if they felt safe. All the people who lived at the home told us that they felt safe. Their comments included: "It is excellent I have no qualms about living here and I feel safe because I know there is someone there in the night if I need them," "It's very good here honestly I would say if it wasn't and I honestly feel safe here", "I do feel safe because I know they are looking after me," and "I've been here 10 years it's clean they look after me and my health and I feel safe here".
All relatives and friends spoken with had something positive to say about the care staff and the home but their views varied. Two raised concerns about the standard of care provided. One visitor told us that they lacked confidence in the management team to ensure the safety and well-being of vulnerable people.

We found that the management team were not taking effective action to safeguard vulnerable people from the risk of avoidable harm when they were made aware of allegations of abuse.

A visitor told us that one of the people living at the home had made an allegation of physical abuse and a member of staff had been suspended for a period of three weeks earlier in that year. We had not been notified of this incident and looked at the home's adult safeguarding records and found that it had not been recorded there. We saw that the home's safeguarding records included the details of four other allegations of abuse which we had not been told about. We asked the registered manager if the safeguarding tracker was a complete record of all safeguarding incidents since the home was registered. The registered manager confirmed that the safeguarding tracker provided a complete record. We asked the manager why they had not recorded or reported the allegation of physical abuse made by the person in the home that the visitor had told us about. The registered manager told us that they were aware of the allegation but had not recorded it or reported it to the CQC because things had got on top of them.

The incidents outlined above constitute a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009, statutory notifications in relation to abuse or allegations of abuse should be made to the Commission without undue delay.

We found that care was not always provided in a safe way and in a safe environment. At the start of the inspection we found that medicines prescribed for one person were kept in an unlocked medicines fridge in an unlocked hairdressing room. There were no staff in the vicinity of the room which meant that vulnerable people had unsupervised access to medicines that had not been prescribed for them. This presented serious hazards to the health, safety and welfare of the people who lived at the home.

After finding that these medicines were not being stored securely and safely we went to check the medicines room on the first floor. We found that the door to the medicines room was open and the room unattended. A medicines trolley was kept in this room and on top of it was a box of used hypodermic needles, which also presented serious hazards to the health and safety of vulnerable people. Used hypodermic needles present risk of injury and cross infection to vulnerable people if they are not disposed of safely and effectively. Despite reporting this to the registered manager and regional director when we checked this room again at the end of the day we found it was sill open and unsupervised. This again presented serious uncontrolled

risks to vulnerable people and staff.

We carried out a check of the administration and recording of medicines and found that some medicines were unaccounted for. Detailed stock records had not always been made and stock checks of medicines had not been carried out in accordance with the home's policies and procedures.

Before the inspection the registered manager told us that a medication audit had identified that an extremely vulnerable person who was at the end of their life had been administered double the dose of a controlled drug that their doctor had prescribed for pain relief. Records confirmed this. A whistle- blower had also informed us that the home had on occasion run out of a controlled drug for pain relief for the same person and as a result of this the person had suffered unnecessary anxiety and distress. We looked at the home's controlled drugs records and found that the person had been given double the dose of a controlled drug and that on at least one occasion the stocks of the controlled drug had been run down to zero. This meant the person was placed at risk of unnecessary distress, anxiety and pain.

When staff are required to administer medicines on an as and when required basis they are provided written guidance which is referred to as a PRN protocol. PRN is a medical term it means "As and When Required". Because nursing staff must use their judgement it is vitally important that the PRN protocol is sufficiently detailed to ensure the medicine is administered in accordance with the doctor's instructions. We looked at the PRN protocol and found that it did not provide sufficient information or guidance for staff to follow when administering the person's medicines. One person had a palliative care plan in place that had been provided by their doctor but this had not been followed. This had led to a failure to use the full range of pain relief as prescribed by the person's doctor and left the person at risk of unnecessary distress, anxiety and pain.

On the second day of the inspection we found that the laundry door which, is a fire door, was not lockable. We could see that the laundry was not attended by staff in the afternoon. The laundry is located on a corridor which people use to get to the dining room from their bedrooms. Inside the laundry swing door there was a utility sink immediately to the left hand side of the door. Using the home's digital thermometer we tested the temperature of the hot water and found that it was 60 degrees centigrade. . We looked through the home's record system to see if there was a risk assessment which addressed these issues and found that the risks had never been assessed and no controls had been put in place to protect vulnerable people from harm. The registered manager gave assurances that action would be taken to address these risks with immediate effect. When we visited on the third day of the inspection we again found the laundry door open and the laundry unsupervised. There was no apparent evidence of any action being taken to address the concerns we had about the hot water in the laundry.. We asked the nurses on duty what action they were taking to safeguard vulnerable people from accessing the laundry unsupervised and using the hot water. They told us that the manager had not told them that the hot water in the laundry was a scalding risk or given any instruction on what should be done to protect vulnerable people. When we asked the manager why they had not taken any action to protect vulnerable people they told us that they had arranged to have a lock fitted but had not taken any other action to warn staff of the dangers in the meantime. This meant people continued to be placed at risk of avoidable harm and raised concerns about the ability of the manager to respond effectively when people were found to be at risk.

We looked at the records of a person who was the subject of a safeguarding alert, regarding a fall. We were told by a whistle- blower that this person needed a pressure sensor mat in their room to alert staff to when this person was attempting to walk so that staff assistance could be provided. . It was alleged by the whistle-blower that a sensor mat was not provided and that as a result the person had a fall resulting in severe injuries. The manager told us that there was no cause for concern because the pressure mat was not

required during the day time. The manager told us that the pressure mat was a tripping hazard, so on balance it was decided better not to have it during the day. The person's care plan and risk assessment had not been reviewed or revised since the person had the fall and suffered serious injuries other than on the day of the fall a nurse had made an entry stipulating "that a pressure sensor mat was needed during the day time as well as at night". There was no evidence of any consideration being given to alternative methods of alerting staff such as a motion sensor or any action taken to prevent a further occurrence.

We visited this person's room during the day and found that the pressure mat, which the manager had told us was deemed a tripping hazard, was in place but was switched off at the wall. We could see that the pressure sensor mat did present a tripping hazard because it was covered by a door mat which had been damaged and had a raised edge. We spoke with the deputy manager who told us they did not use the pressure sensor mat during the day because it was a tripping hazard so switched it off at the wall. This did not make sense or offer any protection to the person who we saw spent most of their day in their room unsupervised.

We told the manager again and this time the manager rolled up the pressure sensor mat and put it under the person's bed to be used again later. We had to tell the manager yet again that this did not offer any protection to the vulnerable person. This again presented serious uncontrolled risks to the vulnerable person and raised further concerns about the ability of the manager to respond effectively when people were found to be at risk. The regional director gave assurances that the care plan and risk assessment would be reviewed and revised and motion sensors would be provided without delay.

The issues outlined above constitute a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations Safe Care and Treatment.

A member of staff told us that they had reported a serious medication error to the manager but had delayed in doing so for over two weeks. We asked them why they had waited two weeks to raise the issue but they were unable to offer an explanation. Policies and procedures were in place to ensure that staff had guidance and would know what to do in the event of any evidence or allegations of abuse. Training records showed that all staff had received training on safeguarding vulnerable adults. Some of the staff we spoken with however did not know who to report safeguarding concerns to outside of Bupa and did not know they could report any concerns anonymously or about the protections provided Whistle-blowers under the Public Interest Disclosure Act, commonly known as the "Whistleblowing act ". This Act protects workers from detrimental treatment or victimisation from their employer if, in the public interest, they blow the whistle on wrongdoing. We discussed the content of the home's training with the manager and found that the training did not include details of the role of the social services department, who to contact outside of Bupa or the protections provided under the "Whistleblowing act ". The Regional Director advised that this would be raised with Bupa's training department to ensure staff training was revised accordingly.

We looked at staff rotas for day and night staff, ancillary staff and cooks and could see that there were enough staff on duty to provide safe and effective care. Most of the people we spoke with were satisfied with staffing levels.

Recruitment and selection of staff was carried out safely with appropriate checks made before new staff started working in the home. This reduced the risk of employing unsuitable people.

Inadequate

Is the service effective?

Our findings

The atmosphere in the home was relaxed and sociable throughout our inspection. Whilst some people raised specific concerns about the effectiveness of some aspects of their care all had something positive to say about the staff, the food, facilities and services and/ or the standard of care provided. Their comments included: "The food is excellent there is plenty of choice and they come round mid-morning to show the menu and ask what I want", "I cannot fault the staff I think they are trained they are very good with me" and "The food is fine I have my breakfast in my room when they help me get up I like porridge or cereal and lunch is at 12.30 and we have 2 choices and plenty of hot or cold drinks. I had a problem with my stomach and they have given me yoghurt called "Actimel" which has helped so they do look after me and know what they are doing". One person told us that they were dissatisfied because although they wanted to have two showers every week they had not had a bath in a long time and they were concerned about their personal hygiene. We could see that their nails were dirty and their hair did not look as though it had been washed recently. Another person said "There are only two good departments of this home the kitchen and the laundry all the others are a problem".

We looked at the personal care records for the person who had raised concerns about personal hygiene we found that, according to the records, they had not been given a shower or a bath in over a month and they had not received any assistance to clean their nails. We spoke with this person's visiting relative who told us that they were concerned that their loved one had not been given a bath or a shower in over a month and their personal care needs were not being met. We asked the registered manager whether there was any explanation for this person not being offered a bath or a shower or appropriate personal care. They told us that it was on oversight on the part of care staff. Whilst missing one bath or shower in a week might be put down to an oversight on the part of care staff, going over a month without personal care is a failure in managerial oversight. We could see that this person's needs were not met and the registered manager did not have sufficient oversight over the standard of care provided.

This was a breach of Regulation 9 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person-centred care. The care and treatment provided must meet the person's needs.

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 supported to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The 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. On the 9 August 2017 the manager told us that none of the people living at the home were currently subject to a DoLS but applications had been made to the local authority in respect of five people and these were pending approval. We found that care

staff did not know who, amongst the people who lived at the home, were the subject of a DoLS application. They told us that they did not have time to read care plans. Five people were recorded on the home's DoLS tracking records to be subject to a DoLS application. When we asked the manager whether consideration had been given to making applications for a number of other people they told us that no one else would require a DoLS because they had capacity. However, when we looked at the DoLS tracker again later in the inspection we found that a further three applications had been made.

The registered manager presented with a limited understanding of the requirements of the MCA. They told us that one of the people who lived at the home would not be allowed out of the home because they were confused and would not be safe but they had not made an application for a DoLS because the person had mental capacity. We asked then on what authority they had to prevent the person from leaving the home unsupervised. The registered manager then told us that they believed that the person did not have capacity but a mental capacity assessment undertaken by social services some time ago had determined that the person did have capacity. The manager did not understand that capacity can change over time and in the case of a person with a diagnosed dementia it was likely to. The manager had not undertaken a mental capacity assessment when it was clear that they were of the view that this person's capacity to make certain important decision may have changed. The registered manager gave assurances that a MCA assessment would be undertaken and should this indicate that the person did not have capacity an application would be made to the local authority for a DoLS. Care staff told us that they had refused this person's request to go on a day trip which had been made by their relative, They told us that this decision had been made in the person's best interest but there was no MCA assessment or record of the best interest decision making process.

The above comprises a breach of regulation 11 of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014 as care and treatment of service users must only be provided with the consent of the relevant person and the provider must act in accordance with the MCA 2005.

Care and nursing staff told us that they had received training in a range of topics but some staff lacked knowledge in important aspects of care including safeguarding vulnerable people and consent to care and the MCA. They told us that adult safeguarding training had not covered reporting abuse or alleged abuse or suspicion of abuse outside of Bupa. They told us MCA training had not covered how to assess people's capacity to identity the support they may need to make decisions for themselves or how to ensure decisions were made using the best interest decision making processes. The Regional Director advised that this would be raised with Bupa's training department to ensure staff training was revised accordingly.

As detailed in the safe section of this report we could see that people were at risk from unidentified hazards such as unregulated hot water with scalding temperatures, known tripping hazards which had not been removed and people having unsupervised access to used hypodermic needles and medicines. We asked the deputy manager what training they had been given regarding hazard analysis and risk assessment. They told us that they had never received any training in hazards analysis and risk assessment.

Morale amongst the care and nursing staff varied. Some staff told us that they were happy working at the home but others told us that their morale was very low to the extent that they had decided to leave. They told us that they had been victimised and although they had raised concerns with senior management nothing had been done to address their grievances. One staff member said "We are not supported; supervisions are just a sheet of paper we have to read and sign". Another staff member told us that that they had not been offered supervision at all; however we found an unsigned record of a supervision meeting dated 6 April 2017 and a record of an appraisal which had been written up but not dated. We showed these records to the relevant member of staff who told us that they had never seen them before and had not been

given supervision on the 6 April 2017.   The registered manager told us that staff supervision had not been provided as often as it should have been, because things had been getting on top of them.

One of the nurses was subject of a safeguarding investigation because they had inadvertently given a person a double dose of a medicine which was a controlled drug in June 2017. They told us that they had not been offered any further training in the safe administration of medicine or had their competency assessed since this medication error occurred. The registered manager reported this to the CQC in July 2017 but had not taken any action to ensure that the nurse's competency was assessed or to provide any further training that may have been required in the safe administration of medicines.

The issues outlined above constitute a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations Safe Care and Treatment. Staffing. This is because staff had not received such appropriate support, training, professional development and support to meet the needs of people who lived at the home.

Nursing and care staff were patient and sensitive to people's needs modulating their voice to help people who may have had difficulty hearing or absorbing information to understand them.

Some of the people living in the home found it difficult to tell us what they thought of the care in the home due to their health conditions, so we carried out a Short Observational Framework for Inspection (SOFI), which involved observing staff interaction with people who used the service.

We observed mealtimes during the inspection and could see that people enjoyed the overall experience. They told us that their likes and dislikes were catered for, as were specialist diets. Where required adapted tableware was provided which enabled people to remain as independent as possible. This included cups with lids or straws and plate guards.

We observed staff supporting people to eat their meals in a sensitive and caring manner, going at their pace and giving them time to enjoy their meal. People had a nutritional risk assessment in their care records which identified those who were at risk of obesity or malnutrition. People`s weights were monitored frequently to help people maintain a healthy weight.

Requires Improvement

Is the service caring?

Our findings

All the people spoken with during the inspection had something positive to say about the way staff provided care and support. Comments included : "I would rather be at home but I can't live there anymore because I have had some falls but I cannot fault or criticise the way I have been treated while I have been here" , " I've no problem with the care I receive the only thing I complained about was being got up at 10am because that's the day gone for me so I spoke to (Registered Manager) and they sorted it and I get up for my breakfast at 8am which suits me fine now", "The place is clean and the staff are very good and they do what they can for me I couldn't ask for more" and "On the whole the people who look after me are very good . They help wash and dress me and treat me with respect". Some people were unhappy with some aspects of care they had received and told us that there had been times when care provided had not met expectations of what a good home should provide.

Staff spoken with presented with a good knowledge of the needs, likes and dislikes of some of the people who lived at the home but lacked vital knowledge in respect of the care of others. For example some staff were unaware of the people who were subject to a Deprivation of Liberty Safeguard application, or who had a DNACPR best interest decision protocol in place. (A DNACPR protocol is about cardiopulmonary resuscitation only and does not affect other treatment.) Some care staff told us that they had never been asked or advised to read care plans and others told us that they did not have time to. When we asked one of the care assistants what they knew about people's personal preferences and interests they said: "I don't know much about any of them, I never get chance to read the care plans the beeper is always going off".

We could see that some people had not always been involved in decision making about their care, treatment and support and communication between nurses and care staff was lacking. We found there was confusion as to whether a person needed thickener in their fluids to prevent choking. The care plan indicated that they needed thickened fluids at night time due to a risk of aspiration dated 7 August 2017. The deputy manager looked at the care plan and told us that care staff should be thickening the person's drinks to syrup thick consistency and recording that they had done so. However, staff told us that they did not put thickener in the person's drinks and they had not read the person's care plan. It transpired that the person had been taken off thickener some months before as it was not deemed necessary. We could see that the care plan had been reviewed since the person was taken off thickener but not revised and had not involved the person or their advocates. Another person told us that their care plan did not reflect their needs and they had not had any involvement with it. Their relative raised concerns about the arrangements made for the person's care and the frequency at which they were offered a bath. This person's care plan indicated that they wanted one bath a week. The person told us that they preferred to have a shower and wanted to be offered a shower twice a week. Records showed that this person had not been offered a bath or a shower or had their nails cleaned in over a month. We could see that their care plan had been reviewed but the person had not been involved in the process.

We found that errors had been made in the administration of medicines for a person who was at the end of their life. There was a proactive palliative care plan provided by the person's doctor which included a list of various prescribed medicines which could be used but there was no person centred care plan for pain

management. Staff lacked a full understanding of the full range of medicines available for this person and as a consequence of poor and inadequate care planning the person was put at risk of unnecessary pain and distress.

This was a breach of Regulation 9 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person-centred care. The care and treatment must be designed with the involvement of the relevant person with a view to achieving the person's preferences and ensuring their needs are met.

We observed people chatting amongst themselves, with their numerous visitors and from time to time with staff. We could see from our observations that some of the staff were skilled in the way they interacted with people and encouraged their involvement in the home's day to day routines.
This made for a social and welcoming atmosphere in the home. Throughout the inspection the care and nursing staff were observed to provide sensitive and compassionate care. We observed them taking measures to ensure the privacy and dignity of the person, such as opening and shutting bedroom and bathroom doors discreetly to preserve privacy and dignity. People were addressed in the name of their choosing and were offered choice and involved in day to day decision making wherever possible.

We could see that people's privacy and dignity was respected and promoted. We observed the way staff always knocked on bedroom doors and waited a moment before seeking permission to come in.

After the inspection we spoke with a visiting general practitioner. They told us that they had good working relationships with the managers and staff who worked in partnership with them to ensure people's health care needs were met.

Requires Improvement

Is the service responsive?

Our findings

We asked people who lived at the home and a number of their relatives whether care provided was centred on the person's individual needs, whether they were involved in care planning and whether they were confident they could make a complaint if they needed too. Their comments and experiences varied and included: "My family come and visit me all the time and they deal with all the care business but I'm happy enough and I go downstairs for my meals and if there's something on", "I've nothing to complain about but I'm not frightened about having to if needed", "There's plenty of activities to do I'm going to the exercise and bingo today", "The family deal with all the things to do with the Home", and " I have no complaints really the only thing is if I'm downstairs and I need the toilet you sometimes have to wait a bit because they are busy like when I want to go before my dinner".

One person told us that their care had not always met their needs and we could see that their care plan did not reflect their individual needs. Another visitor told us that they had raised concerns about the standard of care provided on numerous occasions dating back to October 2016 but had not received a satisfactory response from the registered manager and remained concerned that the relevant person's needs were not being met. They told us that they had made formal complaints in September and October 2106 and February, April and May 2017.

We looked at the home's complaints records and found that there was no record of the complaints made by the relevant person's visitor in September and October 2106 or April and May 2017 and whilst the complaint made in February 2017 was recorded and an investigation commenced there was no record of any outcome. The registered manager told us that they had investigated the complaint made in September 2016 but found it unsubstantiated so had not recorded it, and had no knowledge of the complaint made in October 2016. The registered manager told us that they were aware of the complaints made in April and May 2017 but had not recorded them because they were out of her hands as the Regional Manager was dealing with them. We were aware that the complaint raised in April 2017 had resulted in a safeguarding investigation which had been investigated by social services and substantiated.

The above constitutes a breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 16 Receiving and acting on complaints.

There was a range of activities on offer morning and afternoons throughout the week which included occasional trips out to the sea side including a recent trip to Llandudno.

Inadequate

Is the service well-led?

Our findings

Most of the people spoken with during the course of the four day inspection told us that the home was well run and they were complimentary about the manager. One person said the "manager is always about and I can speak to her when I want and we have meetings I think there is one tomorrow where we talk about any gripes people have got", another person said "Overall I hated the thought of coming here but I am now happy and settled and my family are more than happy and they visit me all the time". Most relatives were also complimentary about the manager. One visitor said: "I can't speak highly enough of (the manager) we have meetings every so often to discuss how things are going in the home and if anybody wants to bring anything up". Another visitor said, "Overall because it's an old house it's very homely and I am confident that they are looking after (relative) and they are safe and they would complain to me if there was a problem and they keep me informed if there is anything I need to know". Other visitors raised concerns. One visitor told us that (relevant person) lived here happily for years but in the last year there had been problems and although they had raised complaints and concerns with the manager satisfactory steps had not been taken to ensure the safety and wellbeing of (relevant person).

We had received a number of complaints about the home prior to our and during our visit, we found evidence of poor communication between the manager and staff, ineffective practice, a lack of candour and a lack of knowledge regarding the requirements of the regulations designed to ensure safe and effective care. The registered manager responded ineffectively when we highlighted concerns about people's care and did not demonstrate that they had the necessary competencies to manage the home safely and effectively.

The regional director was in the home during our inspection and was auditing various aspects of the service. We could see that the provider had systems in place including monthly audits of differing aspects of the service's performance, monthly medication audits and weekly stock checks of medicines, health and safety audits, infection control audits and additional audits carried out by the provider's quality assurance team. Clinical staff meetings were held, including meetings with the people who used the service and their relatives. Each morning the manager was required to walk the premises to identify any potential health and safety issues. Clinical and care staff had a meeting every morning throughout the week with the manager known as a 'ten at ten' meeting. These were ten-minute meetings held at approximately 10am. At these meetings, staff were expected to discuss any concerns they had about people's health. Daily duties would be discussed and where necessary allocated. However, we could see that these processes and meetings were not always completed satisfactorily and none of these audits and checks had identified the multiple breaches of the regulations and the risks of poor and ineffective care identified during our inspection. This meant the governance systems in place were ineffective in mitigating risks to people's health, safety and welfare.

On the morning of 9 August we found that the previous weeks stock checks of medicines had not been done and medicines were unaccounted for. The manager had not carried out a morning check of the premises. We found that the medicines room on the first floor had been left open and unlocked and medicines were being stored in an unlocked safe in an unlockable hairdressing room on the ground floor. Known tripping

hazards were left where they would cause an accident even after we pointed them out to the registered manager they were still there in the afternoon. We again found the medicines room on the first floor unlocked giving vulnerable people unsupervised access to an open sharps container where used hypodermic needles were kept.

On the 15 August we found the laundry open and unattended. This gave vulnerable people unsupervised access to the laundry which was equipped with a low level sink with scalding water temperatures of 60 degrees centigrade. Records provided by the maintenance person showed that temperatures of hot water at the low level sink were often at or above 59 degrees centigrade yet the potential hazards this presented to vulnerable people had not been identified or controlled. On the morning of the 17 August we found that the registered manager had not held the ten at ten meeting and nursing staff had not been briefed or told about the potential hazards presented by the unlockable laundry and no controls had been put in place to safeguard vulnerable people.

On the 10 July 2017 the registered manager told us that a vulnerable person had been inadvertently given a double dose of a controlled drug for pain relief but on the 9 August we found that nothing had been done to prevent a recurrence of the incident. The deputy manager also known as the Clinical Services Manager had not and had not been asked to review the person's care plans, PRN protocol or risk assessments. The nurse who had inadvertently given the overdose had not been spoken to about the incident, had not had their competency assessed or training needs identified. The manager told us that she had not taken any action in this regard because the nurse in question was already being investigated by a senior manager.

This constitutes a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 Good Governance.

The registered manager had not notified the Commission of recent allegations of abuse made by a person who lived at the home and allegations of neglect made by a whistle-blower as they are required to do in accordance with the requirements of the regulations.

This is a failure to notify the Commission of abuse or allegations of abuse as required in accordance with the Care Quality Commission (Registration) Regulations 2009: Regulation 18.

On the 17 August 2017 two of the nurses told us that the registered manager had told them that social services had wanted them to be suspended pending a safeguarding investigation. We asked the registered manager was this true and they told us it was a fact that social services had asked one nurse to be suspended for a medication error in June 2017 and the other nurse for not reporting the matter without delay. Given the circumstances we deemed such a course of action to be unnecessary and disproportionate and we spoke to the Regional Manager accordingly. The Regional manager told us that the registered manager had told them the same but given the circumstances they too were of the view that such a course of action was disproportionate. We then spoke with the social services department and they told us that they had not asked that these staff be suspended as such a course of action was unnecessary and disproportionate and they found it hard to understand why the manager would say that they had. This raised concerns about the registered manager's ability to report openly, honestly and candidly what other social care professionals had told them.

We found that the relevant people had not been given an apology or an explanation when things had gone wrong including when a person was given and overdose of medication and when an allegation of rough handling was substantiated by social services.

The above comprises a reach of Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 20 Duty of candour as the registered persons had failed to act in a transparent way in relation to the care and treatment provided to service users when things had gone wrong.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care provided was not always person centred and did not always meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person did not act in accordance with the MCA

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not always investigated and necessary and proportionate action was not always taken in response complaints made

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA RA Regulations 2014 Duty of candour the registered persons had failed to act in a transparent way in relation to the care and treatment provided to service users when things had gone wrong.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered persons had failed to notify the commission of allegations of abuse .

The enforcement action we took:

we served a notice of decision to remove the registered manager from the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to the health and safety of service users of receiving the care or treatment were not assessed or mitigated as reasonably practicable.

The enforcement action we took:

we served a notice of decision to remove the registered manager from the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons did not must operate effective systems and processes to make sure they assess and monitor their service against Regulations 4 to 20A of Part 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended).

The enforcement action we took:

we served a notice of decision to remove the registered manager from the location.