Giltbrook Carehomes Ltd

Giltbrook Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place unannounced on 31 January 2018 and we returned announced on 1 February 2018.

In March 2017 the provider notified us of an incident following which a person using the service died. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However the information shared with CQC about the person's death indicated potential concerns about the quality of care and the management of risk. This inspection examined those risks.

At our last inspection on 17 August 2017, we found the provider was in breach of the regulations and rated them overall as Requires Improvement. This was because the provider did not ensure that medicines were safely managed at the service, nor did they have an effective system in place to regularly assess and monitor the quality of service that people received.

Following the inspection we issued the provider with a requirement notice for the breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment, and a warning notice for the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance. After the inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this unannounced comprehensive inspection on 31 January and 1 February 2018 to check that the provider had followed their plan to meet the legal requirements relating to safe care and good governance. At this inspection, we found that insufficient improvements had been made following our previous inspection. We identified a new breach of Regulation 12 and a continuing breach of Regulation 17.

Giltbrook Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home provides accommodation and personal and nursing care for up to 40 older people, some of whom are living with dementia. The premises are on two floors with a passenger lift for access. The service has a range of communal areas and a secluded garden. There were 19 people using the service at the time of our inspection.

A registered manager was in post. This 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.

Ineffective quality monitoring systems had failed to pick up and address the shortfalls we identified during our inspection. People were not always safe because their risk assessments and care plans did not provide

enough information to ensure staff knew how to keep them safe. When accidents and incidents had occurred, lessons had not always been learnt and improvements had not always been made.

There were ongoing difficulties with the water and heating systems, resulting in water that was either too hot or too cold for people and during our inspection we found that thermostats still hadn't been fitted to all taps and the water system had not been tested for Legionella since 2016. This put people at risk of scalding and infection.

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Not all staff had had the training they needed for their roles. There were gaps and inconsistencies in some people's care plans. People's privacy and dignity was not always respected. The service's complaint procedure needed updating.

Medicines management and staff recruitment practices were safe. The premises were clean. People were mostly protected by the prevention and control of infection. Most staff had been trained in safeguarding and knew how to protect people from abuse.

People were satisfied with the food served. People had access to external healthcare professionals including GPs, dieticians, and mental health specialists. Staff had some knowledge of the Mental Capacity Act 2005 and supported people to have choice and control of their lives.

Staff were attentive to people's needs and had a good rapport with them. People had more opportunities for stimulation than when we last inspected and were seen enjoying activities and social interactions with staff. People, relatives and staff had the opportunity to share their views on the service at meetings or through surveys.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risk assessments and care plans did not provide enough information to ensure staff knew how to keep people safe and protect them from the risk of harm.

The provider had not always learnt from accidents and incidents at the service.

Most staff were trained in protecting people from abuse and knew how to report safeguarding concerns.

Call bells were answered in a timely manner.

Is the service effective?

Requires Improvement

The service was not always effective.

People's needs were assessed before they came to the service.

Staff were trained to support people safely and effectively although some training was overdue.

Staff did not always have the information they needed to enable people to have sufficient to eat, drink and maintain a balanced diet. The recording of one person's weight needed improvement.

Staff understood the principles of the Mental Capacity Act 2005. Some DoLS training and records needed updating.

People were supported to maintain their health and well-being.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not always respected.

Staff supported people to be independent and to make choices.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care plans contained gaps and inconsistencies and were in need of improvement.

The complaints policy did not follow recognised guidance for care homes.

People were supported to be involved in the planning of their care.

Staff knew how to support and care for people at the end of their lives.

Is the service well-led?

Inadequate

This service was not well-led

The governance framework did not ensure that quality performance, risks and regulatory requirements were understood and managed.

The system to regularly assess and monitor the quality of the service had failed to identify shortfalls in the care people received.

Lessons had not been learnt following previous failings and the service had been ineffective in working with the local authority to bring about improvements.

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People, relatives, and staff had the opportunity to provide feedback on the service.

Giltbrook Care Home

Detailed findings

Background to this inspection

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

This inspection took place unannounced on 31 January 2018 and we returned announced on 1 February 2018.

The inspection team consisted of two inspectors, a specialist advisor who specialises in nursing care, and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert by experience had experience of supporting people who are living with dementia.

The service was not asked to complete a Provider Information Return prior to this inspection. This was because the one they submitted on 10 March 2017 was still in date. A Provider Information Return is a document we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We gathered and reviewed information about the service before the inspection, including information from the local authority and the health authority. We looked at notifications we have received from the provider. A notification is information about important events, which the provider is required to send us by law.

During the inspection, we spoke with ten people using the service, three relatives, one nurse, the activities coordinator, five care workers, and the administrator. We also spoke with the provider and the registered manager.

We observed care and support in communal areas. We looked at six people's care records, four staff recruitment records, medicines records, and staff training records. We looked at records relating to the running of the service including audits carried out by provider and the registered manager. We also looked at the environment including bedrooms and communal areas.

Inadequate

Is the service safe?

Our findings

At our last inspection of this service on 17 August 2017, we found a breach of Regulation 12 HSCA RA Regulations 2014 Safe care and treatment. We found that the way medicines were managed at the service was not always safe. We issued a requirement notice telling the provider to address this issue. In response, the provider sent us an action plan telling us what they would do to meet this requirement.

At this inspection, we found the necessary improvements had been made and people's medicines were being managed safely. Processes were in place for the regular ordering and supply of medicines and staff said any issues were resolved prior to the medicines being needed at the start of the next cycle. We did not find any evidence of people missing their medicines due to a lack of availability.

All medicines were stored safely with appropriate stock checks and records in place. The temperatures of the room and refrigerator where medicines were stored were recorded twice daily and were within acceptable limits at the time of the inspection. We observed the administration of medicines and saw staff stayed with people until they had taken their medicines.

An electronic medicines administration record (MAR) system was used. The MAR system contained a photograph of the person to aid identification, a record of allergies, and the person's preferences for taking their medicines. When transdermal skin patches were used, staff recorded the site of application to ensure the site was rotated in line with good practice.

Protocols were in place for most medicines prescribed to be administered when required. However there was no protocol for a sedative medicine prescribed to be administered when required for one person. We mentioned this to a nurse and they said they would ensure a protocol was written as soon as possible.

Risks to people had not always been assessed and people's safety monitored and managed so they were supported to stay safe. People had care plans and risk assessments in place for some aspects of their care however, other areas had not been addressed. During our inspection, we saw a male person enter a female person's bedroom. At the time the occupant was in bed asleep, the male person stood in the bedroom and then left. There were no staff in the vicinity to intervene. We checked the male person's daily notes and saw they had entered other people's bedrooms on at least three occasions in the previous four weeks. Records indicated that the bedrooms had been unoccupied at the time. On one of these occasions, the person was found in the occupant's bed.

One of the quality assurance feedback forms from a relative commented that their family member was 'quite distressed' by the 'nightly visitations' by a male person into their bedroom. This form was undated. The registered manager said it referred to the same person who entered the female person's bedroom during our inspection. The registered manager said that as a result of this feedback she had told the night staff to stay in the corridor at night rather than in the lounges so they could prevent the male person from entering other people's bedrooms. However the incident we witnessed on day one of our inspection visits and the three incidents recorded in the male person's daily notes all took place during the daytime. It is of

concern that there was no care plan or risk assessment in place for this aspect of the person's behaviour, nor had any consideration been given to the possible safeguarding implications of a person repeatedly entering other people's bedrooms.

Following our inspection the provider contacted us to say they had installed safety gates in people's bedrooms, where appropriate, to prevent the person in question from entering them. The provider told us these were installed with the consent of the people affected and/or their relatives and the decision was taken in accordance with people's best interests.

We met a person who was living with a sensory impairment. Their relative told us the impairment had a 'huge impact' on the person's life. A care worker told us the person needed extra support due to the sensory impairment. For example, they said that when the person was eating they described to them what was on their plate and gave them a spoon. They said they then guided the person's hand so they could scoop up the food themselves. We looked at the person's care records and saw the sensory impairment was detailed in their hospital discharge notes and also documented in the providers pre admission assessment. However no care plan or risk assessment was in place to guide staff on how they needed to support the person to eat and drink. Therefore, we could not be sure that all staff, including agency staff, would know how to safely support the person with their nutrition and other aspects of their care.

This person had a care plan for 'disturbed sleep'. It stated 'you only sleep for 1 – 2 hours at a time and then you are awake and wanting to get up'. However, it did not tell staff how to support the person when they awoke. For example, were they to encourage this person to go back to sleep, support them to get up, or take others steps to address the issue? Without this type of information, it was difficult to see how staff could provide the person with the right support.

The person had a document in their care notes called 'This is me'. It included details of their life history, hobbies and interests, and other information that care workers needed to know. In one section, called 'Things that worry of upset me', staff had recorded, 'People who touch me without warning and introducing themselves'. However this information was not in any of the person's care plans or risk assessments, including the one entitled 'Emotional support and comfort', so there were no instructions for staff to follow on how the person wanted staff to approach and communicate with them.

We checked this person's bedroom to see if it was suitable for a person with a sensory impairment. We tried the hot tap in the ensuite and found the water to be so hot that it was not safe for a person to put their hand under it due to the risk of scalding. This put the person, who was mobile at times and had a diagnosis of dementia, at risk. However there was no risk assessment in the person's care records for this. We reported this to the registered manager who said valves to control water temperatures were being fitted on taps that day and would be completed by the end of our inspection visits.

One person had considerable bruising on their arms. The person's records showed they had recently been admitted to the service with bruising on their arms and staff had completed a body map to show this. The registered manager said she had discussed the bruising with the district nurse and the doctor who had said the bruising was due to the person's fragile skin and the medication they were prescribed. We asked the registered manager to ask a staff member to complete a further body map and this showed the person still had extensive bruising on their arms, although in some places the pattern of the bruising was different. There was no care plan or risk assessment relating to the bruising so it was unclear how staff were meant to monitor and address this issue.

The person told us the bruising was caused by staff 'pulling them up the bed' when they [the staff] were 'on

their own at the weekend' and didn't have time to use a slide sheet. The person's moving and handling care plan said two staff should assist this person to move using a slide sheet. We advised the registered manager to refer this issue to the local authority as a safeguarding concern because if incorrect moving and handling techniques had been used this could constitute abuse by way of neglect. This was immediately done by the registered manager. The local authority triaged the referral as not meeting their threshold for investigation and asked the registered manager to complete their own investigation into the matter. The registered manager told us she would investigate and that a care plan and risk assessment would be put in place for the person regarding the risk of bruising. They also confirmed they would raise the issue at staff handover, to ensure all staff followed the person's moving and handling care plan, which stipulated that two staff were needed to assist the person and they would check to ensure staff were following the instructions given. In addition, the registered manager told us they had spoken to the person affected who had told them they did not want to make a formal complaint about the incident.

At the time of our inspection people at the service did not have pressure sores but some people were at risk of developing them. Staff used the SSKIN bundle assessment tool (a five step approach to preventing and treating pressure ulcers) for people at high risk. However, these were not always consistently completed. For example, one person's care plan stated they should be re-positioned every two hours when in bed. Records for January 2018 indicated the person was re-positioned two hourly on the 30th and 31st but there were no forms for the period between the 17th and 30th January and the form for the 16th indicated they were moved at 1am 3am 11(?am) and 3(?pm). On the 15th they were recorded as being moved at 11am, 8pm, and 10pm. This meant we could not be sure that this person's care plan had been followed and they had been re-positioned every two hours as instructed.

Another person's pressure ulcer prevention care plan stated they moved regularly about the premises. However, following a recent discharge from hospital, records showed they often stayed in bed and were not mobile. Staff used a hoist to move them from bed to chair. The had a SSKIN bundle in place which stated that during January 2018 they were moved at the following times: on the 31st at 00.45, 03.45, 05.45, 12.10 (observed at 15:45); on the 30th every two to three hours; and on the 29th two hourly from midnight to 6.40pm then 11.30pm and 3.50am. However, their position was recorded as being the same at several consecutive occasions suggesting staff were recording the person's position but not re-positioning them. This meant we could not be sure this person was being protected from the risk of pressure areas.

When accidents and incidents had occurred at the service lessons had not always been learnt and improvements had not always been made to mitigate the risks. The registered manager told us of a person who had fallen in their bedroom and action had been taken to change an item of equipment to minimise the risk of it happening again. However another person's care records stated they were at high risk of falls and they had a care plan for falls management and prevention. However, the person had fallen twice the previous month and once in the current month and this was not highlighted in their care plan. In the falls audit documentation we could not find any evidence that there was any analysis of the falls to identify possible causes and put in place actions to mitigate the risks of repeat incidents.

The registered persons did not ensure that care and treatment was provided in a safe way, assess the risks to the health and safety of people receiving care, and do all that was reasonably practicable to mitigate any such risks. These issues are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

Some people said they did not think there was always enough staff on duty to meet their needs. One person told us, "Weekends seem to be a problem as there seems to be less staff." Another person said, "There isn't enough staff. They [staff] are rushed off their feet. I have to wait [for care] a little while, but not too long. I

have to wait if they [staff] have one or two more people to see. I have to wait in the mornings."

Some relatives also said they had concerns about staffing levels. One relative, who was assisting their family member at lunchtime, told us, "I've got time to feed my relative they [staff] don't." Another relative said, "There aren't enough staff particularly at weekends." A further relative said, "The staff turnover is high and I wonder how the staff are treated."

During our inspection visits call bells were answered in a timely manner. Staff used teamwork to ensure one of them was always present in the main lounge or dining room when they were being used and to check people in the corridors were safe. However one person was still able to enter another person's bedroom when no staff were present. Staff said staffing levels were usually satisfactory but it was sometimes difficult to get cover when staff were ill or otherwise unavailable. The service sometimes used agency staff to provide cover and there were two agency care workers on duty during our inspection visits.

The registered manager told us that staffing levels were calculated using a dependency tool. This matched the number of staff with the assessed needs of the people living at the home. They said there was sometimes one care worker less at weekends as there were fewer medical appointments so people did not need staff support with these. They said staffing levels were flexible to ensure people's needs were met. For example, on the second day of our inspection staffing levels were increased because a new person was being admitted to the service so an extra member of staff was on duty to help them settle in. The registered manager said they were continually reviewing staffing levels with the provider and would review them further in response to the concerns raised by people and their relatives.

The water test for legionella was overdue and the provider was arranging for a water specialist to complete another test. There was also ongoing difficulties with the service's water system resulting in the water being too hot or too cold in different parts of the premises. Water temperature valves were being fitted during our inspection visits and the provider told us the service water system was being upgraded with a view to making it safer and more efficient.

We looked at how people were protected by the prevention and control of infection. People and relatives did not raise any concerns about the cleanliness of the premises and we observed the premises were clean. Not all staff had been trained in infection control or had attended food hygiene training. The registered manager said this would be addressed.

Emergency contingency plans were in place and each person had a personal emergency evacuation plan (PEEP). This meant in the event of major incident, the emergency services and staff had sufficient information on how to support people to evacuate the building.

Despite our findings, people and relatives spoken with at the time of the inspection said they thought people were safe using the service. One person told us, "I'm not frightened or worried." A relative said, "Yes my relative is safe because there is always someone watching. They have good security here." Another relative told us, "My relative is safe and is looked after alright."

We spoke to two care workers and a nurse about safeguarding. They told us that if they had any concerns about a person's well-being they would immediately report it to the registered manager or the person in charge of the service at the time. A nurse said that if they were the person in charge they would report it to the local authority themselves and they knew where the telephone number to do this was. The service had a safeguarding policy and information on safeguarding was available to give guidance to people's visitors if they had concerns about their family member's safety.

Safe recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service. The files contained all the relevant information to demonstrate that appropriate pre-employment checks had been carried out, to ensure staff were safe to work with people using the service.

Requires Improvement

Is the service effective?

Our findings

Assessments of people's needs were completed in line with current legislation. Where people required specific assessments associated with their health conditions referrals had been made to appropriate healthcare professionals including dieticians, mental health specialists, and community nurses. Staff had used screening tools to complete assessments areas such as malnutrition and skin integrity. This helped staff to achieve effective outcomes for people. Staff provided care to people who had skin damage or were at risk of skin damage in line with current guidance. There were pressure relieving mattresses and cushions in place for people at high risk of developing pressure ulcers and they were functioning correctly.

Staff told us they had induction training that had prepared them for their role. They had access to refresher training to enable them to keep their skills and knowledge up to date. During our inspection, we saw staff support people safely and effectively. For example, staff assisted people to move using appropriate moving and handling techniques and equipment.

Records showed that staff had access to wide a range of suitable training courses including equality and diversity. However not all staff had completed all relevant training for their role, for example some staff had yet to attend training courses on food hygiene, safeguarding, and behaviours that challenge. The registered manager said some recently employed staff had not yet had the opportunity to complete all their required training. She said this was in the process of being addressed and all staff would have the training they needed.

If staff needed extra training to help them meet the needs of particular people using the service this was provided. For example, a dementia outreach team had provided support and guidance to staff on supporting people with behaviours that might challenge.

People said they were satisfied with the food served. One person told us they enjoyed having, scrambled egg on brown toast for breakfast. A relative of another person said their family member had put on weight since coming to the service, which they said was something they had needed to do.

At lunchtime on the first day of our inspection the different food options were plated up so that people could choose what they wanted to eat. Some people were offered aprons to wear to protect their clothes. If people needed assistance to eat their meals staff provided this. This was done kindly, gently and respectfully and staff encouraged people to take their time. One person said they didn't like their meal so the chef brought them a different option which they ate. This was an example of a person's choice being respected.

Records showed that people had nutritional assessments and they were reviewed monthly. People were also weighed at least monthly. However, there was some inconsistency in the recommended frequency of weighing for one person. One record stated the person should be weighed every two weeks and another record stated every month. The person was weighed every month and their recent weight had stabilised. A dietician had been appropriately involved in the support for this person. The registered manager said she would amend their weight charts so it was clear how often they needed to be weighed.

The records for one person with swallowing difficulties, who was at increased risk of choking, included clear guidance for staff on how to support the person to eat and drink. We spoke with a staff member who explained the person's risks in this area and how they supported them. One person was assessed as having high cholesterol when they came to the service, but there was no care plan or nutrition assessment for this. The registered manager said she would ensure this issue was addressed.

Most care plans provided information about the level of support people needed and if they required adapted cutlery or crockery. For example, a person had recently returned from hospital where they had lost a considerable amount of weight. Their care plan review stated they required a lot of encouragement to eat and staff were to offer the person assistance. However, one person with a sensory impairment did not have a care plan that took this into account, although a staff member we spoke with was aware of how to support the people with receiving nutrition.

A local GP visited the service fortnightly to review people's healthcare. A member of staff said they were also able to access other GPs for people registered at different practices where necessary. We saw evidence of the input of community nurses, the dementia outreach team, and speech and language therapists. People were supported to attended hospital and other healthcare appointments. We spoke with a nurse and they had a good knowledge of the people using the service and their health issues.

People's healthcare needs were monitored and responded to appropriately. Records showed people had access to external healthcare professionals as required; however, it was not always easy to find this information. A form had recently been introduced which would allow all external professionals' visits to be recorded in one place in people's care records. Staff worked with external healthcare professionals when necessary and followed their advice to ensure people received effective care and support.

The registered manager told us that the handover of information between shifts of staff took place twice a day and staff had a 15 minute crossover of shifts to allow this to take place effectively. This allowed staff to monitor and respond to any changes in people's needs.

The service was part of the 'Red Bag Pathway' scheme which is designed to support care homes, ambulance services and the local hospital to meet National Institute for Health and Care Excellence (NICE) guidelines when transferring a person between community or care homes and inpatient hospital settings. A red bag is used to transfer standardised paperwork, medication and personal belongings and stays with the person throughout their hospital stay and is returned home with them. The standardised paperwork ensures that everyone involved in the person's care has the necessary information about the person's health including baseline information, current concerns, social information and any medicines they have been prescribed. On discharge the care home received a discharge summary with the medicines in the red bag. This enabled people to receive more effective healthcare.

The premises had been adapted to make them more suitable for people living with dementia and/or limited mobility. Pictorial signs identified bathrooms, toilets and communal areas. Directional signage was also in place to better support people to move around the service independently. There were handrails in corridors, which people used to assist them to mobilise. Since our last inspection items of interest had been placed in corridors and communal areas including scarfs, hats, and tactile objects. This meant that people could collect things as they walked about the premises and we saw people doing this during out inspection visits. The bedrooms we saw were also personalised.

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

giving people choices and respecting them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The requirements of the MCA were being followed. When people were not able to make some decisions for themselves, mental capacity assessments and best interest decisions were made. However, best interest decision making could be better documented to show all the options considered and the clear reasons why decisions were in the best interests of people.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). 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.

Records showed that DoLS applications had been submitted to the local authority and authorisation had been granted in people's best interests. We checked the conditions of the DoLS for one person using the service and found that the conditions of the authorisation were being met. However, the systems to check that DoLS authorisations were still valid were not fully up to date.

Staff had received training on the principles of the MCA and (where relevant) the specific requirements of the DoLS in place for individual people. Not all relevant staff had completed MCA training some staff were unaware of which people using the service that had DoLS authorisations in place. The registered manager confirmed they would review the MCA, DoLS documentation to make sure information was up to date, and inform staff of the specific DoLS restrictions in place for some people using the service.

We checked the care records for people that had decisions not to attempt cardio-pulmonary resuscitation (DNACPR) orders in place and found the DNACPR forms had been completed as required.

Requires Improvement

Is the service caring?

Our findings

People told us the staff were caring and kind. One person said, "[Name of staff member] is a good little carer. A good one. She helps me, is kind and knows what she's are doing and is pretty good." A relative told us, "The staff seem to know what they are doing and they are kind to my relative."

We heard a carer speaking with a person whilst they provided personal care. They were kind and friendly, checking with the person about aspects of their care and whether it was as they wanted it. We observed that people were supported to eat their meals and mobilise independently where appropriate. Staff were attentive to people's needs and had a good rapport with people. When people were anxious and required reassurance staff provided this in a supportive manner.

During the inspection, we saw staff encouraged people to express their views and be actively involved in making decisions about their care and support. For example, one person decided they did not want to have their lunch in the dining room but would rather have their lunch in the lounge on their own. Staff arranged for this to happen and a staff member stayed with the person and assisted them with their meal. Throughout the meal the staff member talked with the person in a kind and friendly way. The person was seen to enjoy their meal and the company of the staff member.

Relatives told us they had the opportunity to be involved with their family member's care and support. On relative said, "I have looked at my relative's care plan and it is written in every day. They [staff] do ring me when they need to, they are very watchful."

Care records contained examples of people and their relatives being involved in their care planning. The registered manager told us staff carried out six monthly care reviews with people and their relatives, where appropriate, and we saw documents showing when reviews had taken place and planned to take place.

People's privacy and dignity was not always respected. During our inspection, we observed one person using the service enter the room of another person using the service when they were sleeping. This was not appropriate. We also heard a staff member using inappropriate offensive language when providing a person with personal care. However, we also observed the same staff member interacting positively and in a caring way with the same person. We discussed these issues with the registered manager who said she would address them.

When people had difficulties in communicating verbally or required support in this area, communication care plans were in place. These provided information for staff on how to understand people's wishes and the strategies staff should use to maximise people's understanding and enable them to indicate their wishes. One person's mental capacity assessment stated the person could communicate verbally. However, their care records stated they had had a laryngectomy and their communication care plan stated their communication was limited as a result and they mouthed words or used hand signals to communicate. This assessment needed amending so staff had the information they needed to communicate with this person effectively.

Advocacy information was available for people if they required support or advice from a person independent of the service. Information was also available to people in different formats, for example large print, on request. We saw relatives visiting people throughout the inspection. Staff welcomed them and helped them to feel at home. Easy read information on visiting was displayed in the reception area.

Requires Improvement

Is the service responsive?

Our findings

People mostly received personalised care that was responsive to their needs. Some relatives expressed how their family members' health had improved since moving in to the service. One relative said their family member had spent a period in hospital and that since coming to the service they were now able to walk. They said, "The staff are doing what they promised they would do." Another relative said that since their family member had come to the service they had seen a big improvement in their mental state, saying they were now 'more alert'.

We identified gaps and inconsistencies in some care plans. For example, a person with a laryngectomy was having difficulties in breathing and sounded as though they had a possible chest infection. They were receiving medication via a nebuliser for this to help their breathing. A member of staff told us they checked the person's oxygen saturation levels and they said the person was better that day than previously. We discussed this with the member of staff and were confident they were monitoring the person appropriately and providing the prescribed care. However, the person did not have a care plan for this with details of their usual oxygen saturation levels and at what stage the GP or emergency services should be contacted. This meant the records did not provide staff with all the information they needed to provide this person with responsive care

Another person's summary of care contained incorrect information, which could have caused distress if a staff member used this information in discussions with the person. The registered manager said she would address these issues.

An initial physical and social assessment was completed before people were admitted to the service. This helped to ensure communication needs associated with their health and well-being were identified and met in a responsive and individualised way.

Care plans were written as though a discussion had taken place with the person about their needs and were individualised and contained a good level of detail. They were reviewed monthly. Communication care plans took into account how people made their wishes known and their preferred methods of communication. Care records contained information regarding people's cultural needs and spiritual beliefs and how staff could meet those needs. The registered manager told us that a church service was held at the home each month for the people who wanted to attend this.

An 'Accessible Information' policy was in place and the registered manager had some knowledge of the Accessible Information Standard. This was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. Some efforts had been made to ensure people with communication needs and/or sensory impairments received appropriate support and this was evident from their care plans. However, one person with a sensory impairment had not had their needs relating to this assessed or planned for. The registered manager said she would address this.

The registered manager told us that staff received equality, diversity and human rights training and were observed while working to ensure that people were not discriminated against. We saw that an equality and diversity and inclusion policy was in place.

Since we last inspected the service an activity coordinator had been employed. They provided people with a full programme of group and individual activities. Relatives told us the activities coordinator had improved people's quality of life at the service. The activities coordinator said, "I'm here to make sure everyone has a smile on their face, I tailor activities to people's needs and aim to bring out people's confidence and improve their wellbeing." They told us they had taken time to get to know about people using the service and what they liked to do.

We observed a group activity in one of the lounges. Staff had laid out refreshments for people including biscuits and fresh fruit and people took part in an exercise class led by the activities coordinator. Other group activities were observed including a bat and ball game. People were seen to enjoy these activities and it was evident the increase in activities had a positive impact on people's well-being.

At other times the activities coordinator worked with people on a one-to-one basis. For example, one person enjoyed looking after a baby doll. We saw the activities coordinator help the person to clean the doll's face with a face cloth and wrap it in a blanket. The person was laughing and smiling and responded positively to the activity.

The activities coordinator showed us photographs of activities people had taken part in. She told us she had organised themed activities that fitted in with people's life experiences and interests. For example, one person had been a painter and decorator so a painting activity was organised for them. The activities organiser had also brought positive changes to the environment by placing interesting and tactile items in corridors and communal areas. We saw people make good use of these.

We looked at how staff listened and responded to people's complaints. A relative told us, "Some clothes used to go astray a bit at one time. I did make a complaint to the owner and it was resolved."

Records showed there had been no formal complaints received by the service since our last inspection. Guidance on how to make a complaint was on display in the main reception area but was not included in the information guide for people using the service. The complaint procedure needed updating so that it included information about the local authority's and Local Government Ombudsman's role in investigating complaints and their contact details. This meant people were not informed of who to go to if they were not satisfied with how their complaints were handled at the service.

People who were nearing the end of their life had care plans, which provided information about their wishes in relation to their care and whether they had a Do Not Attempt Cardiopulmonary Resuscitation (DNA / CPR) order in place. The care plans also indicated who should be contacted and people's chosen funeral arrangements.

The care plans indicated that people would be prescribed anticipatory medicines to enable staff to keep them comfortable. However, it was not always clear when the emergency services should be called. For example one person's care plan stated they wished to remain at the service at the end of their life and that 'unnecessary' admissions to hospital should be avoided. The person had recently been admitted to hospital with a chest infection and it was not clear what was considered a necessary admission. This needed clarification so staff could support people in the way they wanted.

Processes were in place for supporting people with end of life care where appropriate and were being further developed by the service. Policies and procedures were in place and staff received end of life and palliative care training, though not all relevant staff had completed this at the time of our inspection. End of life care plans were in place and the registered manager told us they worked in collaboration with external healthcare professionals in meeting people's end of life needs, wishes and in providing equipment as required. The registered manager also told us that further training would be made available to staff in relation to the use of equipment in this area.

Inadequate

Is the service well-led?

Our findings

At our last inspection of this service on 17 August 2017, we found that the provider did not have an effective system to regularly assess and monitor the quality of service that people received. This resulted in the Care Quality Commission (CQC) issuing a warning notice to the registered provider requiring them to become compliant with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance, by 14 December 2017.

At previous inspections of the service on 18 and 19 May 2015, 20 April 2016 and 4 April 2017 the provider was in breach of Regulation 17 Good Governance. At each inspection they had been issued with requirement actions under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found that although the provider had made some improvements to the way they governed the service their systems to assess and monitor the quality of service had failed to identify shortfalls we found at the inspection. This is the fifth consecutive occasion that the provider has failed to comply with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

Sufficient improvements had taken place to medicines management and the staff recruitment processes. However the monitoring of people's care and support remained ineffective and this had resulted in some people using the service being put at risk of harm or poor care.

The registered persons had failed to put in place care plans and risk assessments to address people's specific needs and meet protected characteristics. For example, a person had been admitted to the service with a sensory impairment and no care plan or risk assessment had been put in place to guide staff on how to safely support the person. The registered manager had audited the person's care plan on 13 January 2018 but the audit had failed to identify the additional support needed to meet the sensory impairment. Another person had been admitted to the service with considerable bruising on their arms. However, no care plan or risk assessment relating to the bruising was in place, so it was unclear how staff were meant to monitor and address this issue.

The registered manager had partially completed an audit of the service on 2 January 2018 known as the 'Home Manager Report'. Although this audit had identified some areas where action was needed it had not identified the ongoing problems with the service's water supply and temperatures. The audit stated that during a check on 8 December 2017 it was established that 'All water is correct at times of checks no concerns with the running of the hot water all sinks in communal bathrooms and residents bedrooms all have TVN valves in place.'

On 30 January 2018 the local authority visited Giltbrook Care Home and had concerns about the safety of the water temperatures. They informed us that the service's own water temperature audit, carried out on 7 December 2017, showed that water temperatures throughout the service ranged from a minimum of 31 degrees centigrade to a maximum of 58 degrees centigrade. The temperature recording template advised

that temperatures must not exceed 45 degrees centigrade on immersion. The Health and Safety Executive have advised that high water temperatures (particularly temperatures over 44°C) can create a scalding risk to people who use care services.

In her water temperature audit on 7 December 2017 the registered manager did not acknowledge that on the previous day water temperatures at the service had exceeded safe limits, indicating a possible issue with the service's hot water systems. Further recorded temperature checks, seen by the local authority and reported to us, showed unsafe water temperatures on 11 January, 18 January, and 25 January 2018. During our inspection at least one person using the service had hot water in their bedroom's ensuite that could put them at risk of scalding. The provider was addressing this issue and effective temperature control valves were being fitted to water outlets while we were at the service. However it was of concern that unsafe water temperatures were identified as a risk on 7 December 2017 but not fully addressed until 31 January 2018.

The provider had carried out an infection control audit on 31 January 2018. This confirmed that, 'Legionella's Control – there is a robust programme in place for the running of unused taps/showers to reduce the risk of growth of Legionella.' However on the same day following a visit to the service the local authority informed CQC that it was unclear whether weekly flushing of little used water outlets was occurring or being recorded and the water test for legionella was overdue as there no record of a water test having been completed since 9 November 2016. Consequently, the provider's infection control audit was ineffective, as it had not identified the failings in the service's maintenance programme to reduce the risk of growth of Legionella.

The provider failed to is demonstrate that systems and processes to assess, monitor and improve the quality and safety of the service were not sufficient. This is a continued breach of Regulation 17 Good Governance. The registered person has not ensure that care and treatment was provided in a safe way, assess the risks to the health and safety of people receiving care, and do all that was reasonably practicable to mitigate any such risks.

The local authority has been carrying out regular quality monitoring visits to the service. On 8 February 2018, they informed CQC they had made the decision to suspend their contract with the provider due to concerns about care planning, people's dignity and choice, the premises, equipment and staffing levels. This showed that the provider had been unable to work successfully with the local authority to address the issues the local authority had brought to their attention.

Some people told us they were satisfied or mostly satisfied with the service provided and knew who was in charge. On person said, "[Provider's name] owns it and [registered manager's name] runs it. I would give it, [the service] five out of five. Pretty good." A relative told us, "I would rate here, eight out of ten because there is room for improvement. I am confident to approach the registered manager."

People had more opportunities for stimulation than when we last inspected and were seen enjoying activities and social interactions with staff. Information about the service was displayed in the entrance hall and included the most recent CQC report, the service's statement of purpose, and photographs of activities and events at the service.

Following our last inspection the registered manager sent quality assurance surveys to relatives. Seven were completed and returned, although they were undated so we could not tell when the service had received them. People were invited to rate areas of the service as 'excellent, good, fair, or poor'. No areas of the service had been rated by relatives as 'poor'. One respondent wrote, they had 'no concerns and overall the care was good'. Another respondent wrote, 'I have observed some real improvement in the past few weeks

and appreciate the staffs attempts to integrate [Name of person] into the home.' Two respondents wrote that the laundry service had improved. One respondent wrote that a personal item belonging to their family member had been lost, and another person wrote that their family member had been 'quite distressed' following an ongoing issue at the service that compromised their privacy and dignity. The completed surveys had been put together in a folder but there was no record of any action taken in response to them. We discussed this with the registered manager who said she would address this.

We saw the minutes of the most recent resident and relatives meetings held on 31 October 2017. These showed that those attending had the opportunity to share their views about the service and gave positive feedback on changes and improvements they had seen at the service.

Some staff said they felt well-supported in their roles but others did not. Most staff told us they received supervision, however, we saw that some staff had not received recent supervision. The registered manager also told us that no appraisals had been completed. They said that a number of staff were relatively new to the service and they planned to start their appraisals when those staff had been at the service for at least six months.

We saw the minutes of the most recent staff meeting held on 30 January 2018. These showed that issues such as record keeping and staffing levels were discussed and those attending were given the opportunity to raise any concerns they might have about the service or discuss any other issues.