B and E Thorpe-Smith

# Adelaide House Residential Care Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place on 18 April 2018. The inspection was unannounced.

Adelaide House is a care home registered to provide personal care and accommodation for a maximum of 23 older people. People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is located in a residential part of Leamington Spa and the accommodation is set out over four floors. There were 19 people living at the home at the time of our visit, some of who were living with dementia.

We last inspected Adelaide House in November 2016 when we rated the service as 'Good' overall. However, at that inspection we found some improvements were required in the leadership of the service. At this inspection we found improvements had not been made and a lack of proactive management and leadership had affected the quality of the service. Checks and audits were not effective which impacted on the safety, effectiveness and responsiveness of the care people received.

The service had a registered manager. This is a requirement of the provider's registration. 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.

The registered manager was also one of the providers and had acknowledged improvements were needed to ensure people received consistently high quality care. A new manager had been appointed, who was to apply to be registered with us and take over the management of the service.

There were enough staff to meet people's needs and people told us they felt safe with the staff who supported them. However, the provider's investigations into safeguarding incidents were not robust enough to ensure people were protected from the risks of harm. Where people had been involved in incidents or accidents, these had not been reviewed to identify patterns or trends across the service, or for individuals. People were not always protected from environmental risks or individual risks to their wellbeing.

People were supported to eat and drink enough to maintain their health and when a need was identified, they were referred to other healthcare professionals. However, medicines were not consistently managed and administered safely.

People's mental capacity to consent to their care had not been assessed effectively and there was conflicting information in people's care records about what decisions they could make. Some staff practices meant people were not given maximum choice and control over how they lived their lives. The physical environment was not supportive of people living with dementia because it did not enable them to move

around the home independently.

Staff tried to work in a person centred way and shared information about changes in people's needs. People demonstrated a high satisfaction with the caring nature and understanding attitude of staff, and we saw friendly and caring interactions between staff and the people they care for. However, staff lacked support and training to ensure they had the skills and knowledge to carry out their role effectively.

People felt able to share any concerns, but the process for obtaining people's views needed to be improved so people were empowered to provide feedback and share their experiences to ensure the service met their preferred wishes. The new manager was open and transparent about the challenges and improvements required to ensure people received person centred care that met their individual needs and preferences.

You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

The provider's safeguarding procedures were not sufficiently robust to ensure people were protected from the risk of harm. Medicines were not consistently managed and administered safely. Risks to people's health were not always updated to reflect changes in people's health and needs. There were enough staff to support people and people felt safe living in the home.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

People's mental capacity to consent to their care had not been assessed effectively and staff did not always work within the principles of the Mental Capacity Act 2005. Staff were not given consistent support and training to carry out their roles and responsibilities. The environment was not supportive of those people living with dementia and did not accord with good practice. People were supported to attend healthcare appointments and encouraged to eat and drink enough to maintain their health.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

Some staff practices meant that people were not always supported to make their own choices and have maximum control of their lives. Despite these issues, people demonstrated a high satisfaction with the caring nature and understanding attitude of staff. Interactions between people and staff were pleasant and friendly. Staff welcomed people's visitors into the home.

### Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

Staff tried to work in a person centred way, but some practices meant people's preferences were not always met. There was a

lack of guidance for staff regarding how people wanted their care to be delivered. The provider had a complaints procedure which was available to people and their visitors.

## Is the service well-led?

**Requires Improvement**

The service was not well-led.

Effective systems were not in place to enable the provider to identify where quality and/or safety were being compromised so they could respond appropriately without delay. There was a lack of proactive management and leadership which affected the quality of service. Improvements were needed in the management and storage of records in the home.

# Adelaide House Residential 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.

This responsive, comprehensive inspection took place on 18 April 2018 and was unannounced. The inspection was conducted by one inspector, an assistant inspector 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 service.

We had not asked the provider to complete a Provider Information Return (PIR), because this ratings inspection was undertaken sooner than our agreed methodology. We conducted the inspection because we had received information of concern about the service. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information we held about the service. We looked at information received from the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

During the inspection we spoke with seven people who lived at the home and two relatives. We spoke with the deputy manager, three care staff and two non-care staff about what it was like to work in the home. We spoke with the provider, the registered manager and the new manager about their management of the home.

Some of the people living at the home were not able to tell us about how they were cared for and supported because of their complex needs. We observed care and support being delivered in communal areas and we observed how people were supported to eat and drink at lunch time.

We reviewed four people's care plans and daily records to see how their care and treatment was planned and delivered. We reviewed management records of the checks the registered manager and provider made to assure themselves people received a safe, effective quality service.

Requires Improvement

# Is the service safe?

## Our findings

At our last inspection we rated the safety of the home as 'Good'. At this inspection we found improvements were needed to ensure people consistently received safe care and the rating is now 'Requires Improvement'.

The provider's investigations into safeguarding incidents were not robust enough to ensure people were protected from the risks of harm. For example, in a recent investigation into a safeguarding issue, conclusions had been drawn by the provider, which were not corroborated by the evidence. Conversations with staff had not always been formally recorded and they had not been asked to provide a written statement. The provider had failed to report further concerns raised within the investigation to the local authority safeguarding team or ourselves, in accordance with their legislative responsibilities. Staff understood their responsibilities to report any concerns about people's wellbeing, but some did not feel confident concerns would be listened to.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding people from the risk of harm.

We looked at how medicines were managed in the home and found improvements were required. This was because medicines were not consistently managed and administered safely.

Medicines were stored in a locked trolley in a locked medicines room. However, the key to the room was left on a small 'shelf' by the door and the keys to the trolley had been left in the lock. There was also an unlocked and open cupboard in the room which contained other prescribed medicines. Some people were able to move around the home independently and had access to this area. This meant medicines were easily accessible to anyone in the home, including people and their visitors.

Medicines have to be kept at recommended temperatures to ensure they remain effective. Most medicines need to be stored below 25 degrees centigrade and some medicines have to be kept in a fridge. The temperature of the medicines trolley was consistently recorded as being between 23 and 25 degrees centigrade which meant the provider needed to ensure the temperature was kept within safe range and take action when it was not. The temperature of the medicines fridge was not recorded consistently to ensure it remained within the identified temperature range.

Most medicines were delivered in 'bio-dose' packs with all the medicines that should be administered at the same time of day in pre-packed pots. These were supported by medicines administration records (MAR) which detailed when people were required to take their medicines. Staff recorded when medicines were administered on the individuals MAR sheets which showed that medicines were mainly signed for as 'administered' in accordance with people's prescriptions. However, medicines which had not been dispensed in the bio-dose pots (boxed medicines) were not regularly checked so any discrepancies or errors could be quickly identified. One staff member confirmed, "I haven't checked them as often as I should". Three of the medicines we looked at had different stock amounts to what should have been present. This meant we could not be sure people had received their 'boxed medicines' as prescribed.

Some people were prescribed medicines on an 'as required' basis (PRN) for anxiety and agitation. There were no written instructions as to when the medicine should be given. This meant the medicine may not be given consistently by all staff and may be given when not required. When we asked one staff member how they knew if a person required PRN medication they said, "I know [person] well, and we judge it based on our knowledge of them. Sometimes it is attention seeking so we sit with them and reassure which usually works after 10 minutes."

Staff who administered medicines had not been trained sufficiently and some staff had not had their competency to give medicines safely formally assessed. One staff member told us "When I started here I gave my manager certificates from my old job and they watched me, but I don't think this was written down anywhere. I have requested some training." We saw how this lack of up to date training impacted on staff practice when they gave people their medicines. One staff member dispensed a tablet into their own hand rather than into a pot, and proceeded to put the tablet into the person's mouth without wearing gloves. The staff member said, "I know, I'm naughty." We also saw an occasion when the member of staff took two people their medicines in the same hand which meant there was a risk they could give the medicine to the wrong person. Another staff member confirmed they had not followed the provider's policy for returning unused medicines to the pharmacy.

Records showed most incidents and accidents were documented by staff. We asked one member of staff what they would do if someone sustained an injury or bruising. They responded, "I would document it and then ask all the staff and investigate it. It could be poor manual handling so the staff member may need more training." However, we found evidence that some injuries were not being recorded on accident and incident forms. For example, one person had a body map for bruising to both knees, but an accident and incident form had not been completed. There was no evidence this had been investigated to identify a potential cause or whether it needed to be reported as a safeguarding concern.

The provider was unable to show us any recorded audits of incidents or accidents, and we did not see any evidence these had been used to identify patterns or trends across the service, or for individuals.

Some people at high risk of developing skin damage had pressure relieving mattresses on their beds. We observed that the settings on pressure relieving mattresses were not regulated dependent on people's weights as guidelines recommend. For example, one person's pressure mattress was set at 125kg when their actual weight was 37.8kg. Another person's mattress was set at 75kg and their last recorded weight was 46kg.The incorrect settings could increase the risk of skin damage for people.

One person occasionally smoked. There was no risk assessment to inform staff how this should be managed to support the person to smoke safely.

People were not always protected from environmental risks. On the first floor, we saw exposed hot water pipes which provided a risk if someone with fragile skin fell against them. There was also a free standing heater present in one of the bedrooms. This presented as a trip hazard and we could not find a risk assessment to support its safe use. A door in a corridor leading down to the basement was left open at various times of the day, despite having a note on it advising staff that it should be kept shut.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We were aware there had been concerns that the provider's policies and procedures did not protect people from the risks of infection. At the time of our visit, the provider was working to an action plan to ensure the

home was cleaned thoroughly, there was a clear flow from 'dirty to clean' in the laundry and staff followed good infection control practice. Some improvements had been made, but further improvements were still required.

On entry to the home it appeared clean and tidy, but at various times there was a strong odour in some areas. For example, in one bathroom there was an unpleasant smell which the new manager felt was due to the floor being partly carpeted. They told us they were going to discuss this with the provider so more appropriate flooring could be installed. Cleaning products were stored in the basement in a lockable cupboard, but the keys had been left in the lock. Staff assured us people could not access this part of the building, but this did not accord with safe practice.

Staff were responsible for tidying the home on a daily basis and domestic staff completed 'deep cleans'. Domestic staff told us they did not have cleaning schedules, but kept personal notes of what tasks they had completed to ensure all parts of the home were regularly cleaned. Night staff had cleaning schedules for the kitchen and communal bathrooms.

Domestic staff explained how they kept the home clean and hygienic. For example, they used colour coded mops and cloths for different areas of the home to reduce the risk of cross infection. Personal protective equipment (PPE) such as plastic gloves and aprons was available in all areas of the home. Staff were aware of where this was situated, but we observed occasions when staff attended to people's personal care without wearing a disposable apron and handling medicines without wearing gloves.

Risks to people's health were identified and plans put in place to manage those risks. However, risk assessments had not always been reviewed and updated to reflect changes in people's health and needs. The new manager told us they planned to review each person's risk assessments, to ensure staff had the information they needed to provide care and support in accordance with people's individual needs and in the safest way possible.

People told us they felt safe at Adelaide House. Comments included: "I came here because I felt I needed some support; just someone to be there when needed. I feel safe here", "I love it here. You feel secure", "They know how to handle me well for moving" and, "My valuables are very safe here."

There were enough staff to respond to people's individual needs for practical and emotional support. Staff told us there were enough staff, which minimised risks to people's safety. During our visit, one person's emergency alarm was activated. Staff were available and responded quickly to keep the person safe.

Requires Improvement

# Is the service effective?

## Our findings

At our last inspection we rated the effectiveness of the service as 'Good'. However, at this inspection we found staff training had not been maintained and people were not always supported within the principles of the Mental Capacity Act (MCA) 2005. The rating is now 'Requires Improvement'.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

A proportion of people who used the service were living with dementia and required support to consent to their care at the home. People's mental capacity to consent to their care had not been assessed effectively and there was conflicting information in people's care records. For example, one person's care records stated they had a 'good memory', 'adequate understanding of current affairs', 'understands, date, place and time' and 'can easily express themselves'. However, the registered manager had submitted an application for a DoLS to restrict the person's liberty, despite evidence within their care plan they had capacity to make their own decisions. When we discussed this with the registered manager they told us the person could be 'forgetful' and 'confused', but there had been no assessment of the person's capacity as to what decisions they were able to make and where they may need support to make a decision. There had been no assessment as to whether they were under constant supervision or control or not free to leave.

We discussed this with the new manager who confirmed there were no formal decision specific capacity assessments within people's care records. This meant people were at risk of not consenting to their care and support when they were able to, as their assessed needs were not recorded correctly.

From our conversations with people and staff, it was clear that staff were not always working within the principles of the MCA. People were not given choice about what time they got up in the morning and sometimes staff encouraged people to get up when they had indicated they did not want to. One person told us staff assisted them to go to bed earlier than they wished to. This meant people were receiving care interventions they did not really want, and staff were not always working in people's best interests. When we asked one staff member if their actions complied with the spirit of the MCA, they responded, "No."

These issues constitute a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Consent

The new manager had identified the issues around the application of the MCA within the home. They told us mental capacity assessments needed to be completed to ensure staff had all the information they needed to give people maximum choice and control of their lives in the future.

Despite the issue of people's choices not being respected about what time they got up and went to bed, we saw staff offered people choices and sought their consent throughout the rest of the day. Staff respected people's right to refuse their support. For example, staff asked for people's consent before they did tasks for them. They asked, "Can I tuck you in", "Would you like me to open the windows" and, "Can I put this on you to keep you clean?" When one person declined to go to the dining room for lunch, staff respected that decision.

Staff did not have an effective induction into the home. Staff told us they did not have opportunities to work alongside more experienced staff so they got to know people's individual care needs and preferences before working alone with them. Comments included: "I came in and just got started" and, "Nobody has an induction." However, staff did have a probation period to ensure they demonstrated the right qualities and values to work in the home.

Staff had not been given regular training opportunities to maintain their skills and knowledge and ensure they consistently followed best practice. One staff member told us, "There is no training here." This staff member felt staff needed training in caring for people living with dementia so they could support those people more effectively. Another member of staff told us they could not remember when they last had training but, "I do my own independent research." A member of non-care staff told us they had not received training in safeguarding, even though they had daily contact with vulnerable people. During our visit we saw how a lack of training impacted on people when two staff members failed to follow safe practice when giving and disposing of medicines. Some staff told us they had completed training in their previous employment, but when we checked their file, we could not see any certificates to evidence this. This meant there was a risk that staff may be performing tasks they were not trained to do. We discussed training with the registered manager who told us, "There has been a lot of training, but those people have now gone."

Staff told us and records demonstrated that staff did not have regular formal opportunities, such as supervision, to discuss their training and development. Supervision is a meeting between the manager and member of staff to discuss the individual's work performance. However, one staff member told us they felt able to ask for support and said, "If I need training or feel unconfident about anything, they help."

The new manager had already identified staff needed more support to carry out their role and responsibilities effectively. They told us they were sourcing a new training provider and had already identified some 'essential' training, such as supporting people to mobilise safely and safeguarding, which needed to be completed as a priority. This training had already been booked and was due to take place within a week of our inspection visit. The new manager was also a 'train the trainer' in person centred and dementia care and planned to deliver this training to all staff in the coming months.

In respect of supervision, the new manager told us, "They have not been happening. I was told they were happening verbally, but they were not being evidenced." They told us they had started to meet with staff so they could identify what training and support they needed. For example, one new member of staff was going to be enrolled for a qualification in health and social care to support their personal development.

The environment was not supportive of those people living with dementia and did not accord with good practice. NICE guidelines state; 'When organising home placements for people with dementia, health and social care managers should ensure that built environments are enabling and aid orientation. Specific, but not exclusive, attention should be paid to: lighting, colour schemes, floor coverings, assistive technology, signage, garden design, and the access to and safety of the external environment'. We found that the environment did not support people to orientate to their surroundings and move easily from their own bedroom and around the communal areas of the home. People did not have aids on their bedroom doors,

such as photographs or memory boxes, to help them find their room more easily. There were no directional signs to help people find their way around the home without the support of staff. The carpet in the corridors was heavily patterned which made it difficult for people to differentiate between a flat service and steps. The new manager acknowledged this was an area that needed to be addressed and was in their plan of action.

We were told the menu was created by the registered manager and chef based on people's known preferences and nutritional content. Meals were prepared in the home from fresh ingredients and people told us the food was very good. Comments included: "It's very good food. I like the cottage pie and lamb chops", "I think the food is very good" and, "The food is good. Sometimes they ask if you have a preference, but not every day. In the morning there's a choice of porridge or cereals, then I have poached egg on toast."

The chef worked five days a week and on the other two days a member of care staff prepared the meals. We spoke with that member of staff who demonstrated a good knowledge of which people had to have a special diet because of nutritional risks. For example, some people were at risk of choking and had their food pureed and other people had their puddings prepared separately because they were diabetic.

At lunch time people were supported to move to the dining room to eat together and make lunch a sociable event. One person preferred a vegetarian diet and we saw they were given a meal that met their preferences. One person was not eating very much. Staff recognised this and gently encouraged the person to eat more. People were offered a drink with their meal and their glasses were topped up regularly.

People were also offered drinks and snacks during the day. The cook had made fresh biscuits for 'elevenses' and one person commented, "I love their homemade cookies."

People's needs were assessed before they moved to Adelaide House to identify what support they needed with their every day care and to maintain their health. This ensured Adelaide House could provide the appropriate level of care required.

People were supported to maintain their health. People's records showed other health professionals, such as GPs, chiropodists, district nurses, opticians and dentists were involved in people's care when needed. People were happy their medical and health needs were met and told us, "I get the GP. He comes regularly on a Thursday, but also any other time you need him", "The district nurse comes every morning to do my dressings" and, "The optician has been in and I've got new glasses here on my table." A visiting healthcare professional told us staff were good at sharing information with them and that they, "Felt part of the team."

The registered manager explained that if people needed to attend a hospital appointment, staff would support them if family were unable to. This ensured people were supported to share information about their concerns and staff could also offer support and reassurance if people became anxious.

Requires Improvement

# Is the service caring?

## Our findings

At our last inspection we rated this key question as 'Good'. At this inspection, we found people were as happy living at the home as they had been during our previous inspection. However, people's choices were not always listened to and the rating is now 'Requires Improvement'.

Some staff practices meant that people were not always supported to make their own choices and have maximum control of their lives. People told us, and this was confirmed by staff and daily records, that people were not given the choice to wake up or get up when they wanted to. When we asked one person what time they got up they replied, "Six o'clock, isn't it disgusting? No I don't choose it. I get up because I've usually wet the bed by then. They don't change the pad, they get me up and dressed." This person went on to tell us, "I think I go to bed around 9.00pm but they insist it's closer to 10.00pm. It feels too early sometimes." A relative told us, "[Person] prefers to get up at 10.00am in the morning, but they persuade them to get up for breakfast between 8.30am and 9.00am."

Staff confirmed people were woken up in the morning. One staff member told us, "I have to get people up in the morning. I feel they are not given any choice." We asked what this staff member did if people said they did not want to get up. They responded, "I would say, 'come on you need to get up now'." Another staff member confirmed that when they came on shift at 8.00am, "There are only between six or nine people for us to do in the morning." This was because night staff had already got the other people out of bed. This was confirmed by the provider's own daily records.

The new manager had already identified this as an issue. They told us, "Some people are woken up." They assured us they were beginning to address this with staff through supervision. A member of staff confirmed, "[Name of new manager] has said, 'if they don't want to get up, leave them'." However, it was clear that waking people up was still accepted practice within the home.

Despite these issues, people demonstrated a high satisfaction with the caring nature and understanding attitude of staff. Comments included: "They are brilliant staff, very caring and friendly", "All the carers are lovely. They are no problem" and, "The staff are all pleasant." One person told us they preferred to spend time in their bedroom and told us, "I get plenty of company up here, the girls all chat to me as they pass through."

A visiting healthcare professional spoke highly about the warm and welcoming atmosphere in the home. They told us, "This is very relaxed. It is very much a home from home for residents. I feel it is all focussed around the residents. It is their home and we are invited in."

Throughout our visit we saw some pleasant, friendly interactions between staff and people. For example, one person was quite withdrawn. A member of staff sat on the floor in front of the person and asked, "Is there anything I can do? Can I hold your hand?" The person was still not engaging, so the staff member started talking about what they had being doing that morning. The person began to engage a little with the conversation, and for that moment, appeared less withdrawn. One person started to cough a little during

lunch. Tissues were offered and the meal was taken away at the person's request. We saw one staff member woke someone up by gently stroking their arm.

Staff told us there was a nice atmosphere in the home. Comments included: "It is good here because all the staff are very friendly" and, "It seems a nice and happy home." All the care staff appeared open, confident and wanted to please people. They were able to converse with people well, even when there was little response. They chatted with people as they moved around the home and at lunch time they joined people at the table to stimulate conversations. Staff routinely used people's preferred names to give them a sense of personal identity.

People felt staff promoted their independence and respected their dignity. One person told us how staff supported them to manage one aspect of their personal care, but otherwise respected their wish to retain their independence in this area. They told us, "They are kind and keep my privacy as much as possible."

Relatives and visitors told us they could visit whenever they wanted and said staff always made them feel welcome. During our inspection visit, relatives and visitors arrived at the service and spent time talking to the people they came to see. One relative arrived during lunch and joined their family member in the dining room. They were welcomed and acknowledged by all the staff.

Requires Improvement

# Is the service responsive?

## Our findings

At our last inspection we rated the responsiveness of the service as 'good'. At this inspection we found the care people received was not consistently responsive to their individual preferences and the rating is now 'requires improvement'.

At the start of our inspection the new manager told us they were aware people's care plans needed to be reviewed and updated. They said this was necessary to ensure care plans provided staff with all the information they needed to provide care that met people's individual needs and preferences. They explained, "All the care plans need to change because they are not person centred." They told us daily records also needed to be improved because they did not demonstrate that people were being given choice or control over how their care was provided. For example, the new manager was confident people were given the choice of whether to have a bath or a shower, "But it is not evidenced because it is not written down."

We looked at one person's care plan who could become anxious during personal care. Their care plan stated the person needed the support of two staff 'to prompt them in their best interests'. There was no information about how staff could distract this person to reduce or ease their anxieties around personal care. One senior staff member confirmed, "We are trying to make the care plans clearer for the staff. Someone coming from outside would be confused."

During our conversations with staff it was clear they tried to work in a person centred way. They understood people should be treated as individuals and that the more they knew about a person, the better equipped they were to understand them and provide for their individual needs. However, we found that some of the practices within the home did not always support person centred care. For example, people's preferences for when they got up in the morning were not recorded or respected.

People were supported to remain in the home at the end of their life if this was their wish. People's care plans included some information about their future wishes, in the event they became unable to express their preferences. However, we found these could be more detailed to include information about any preferences for music, people, flowers, or whether they would like to be alone or surrounded by family or staff at the end of their life.

People's care plans included the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) form. This plan provides clinicians with information about whether attempts at resuscitation should be undertaken for the person.

Information about changes in people's health was shared with staff at a 'handover' between shifts. Each person was discussed during the handover so staff knew how to support them to ensure their needs were met. For example, it was shared in handover that one person was losing weight and needed encouragement to eat. We saw staff encouraging the person to eat their meal at lunch time. Another person had fallen the previous night and the doctor had been contacted for a referral to the falls clinic. We saw staff discussing the

referral with the doctor later in the day. However, when changes in people's needs or abilities were identified, their care plans were not always updated.

There was no dedicated staff member responsible for organising and supporting people with their hobbies and interests. However, care staff designated time during the day to do a variety of activities with people. On the day of our visit, one staff member offered people a manicure and in the afternoon some people joined in a board game of 'ludo'. There was also a person who visited regularly to provide people with an opportunity to join an 'exercise class' and various entertainers visited the home to perform for people. Comments from people included: "A man comes every week to do light exercise with us" and, "A couple of weeks ago there was a Sinatra singer and a fitness bloke comes weekly."

However, it was less clear what activities were available to people who chose or needed to stay in their rooms because of ill-health. We also found that for some people a lack of stimulation meant they slept or watched each other or staff. One staff member felt this could be an area that could be improved, especially if people were given more opportunity to visit the local park or to go shopping into the local town. We shared this with the registered manager who assured us people went out more in the warmer weather. They told us people were taken to the local pub for lunch where they were known and welcomed.

The provider had a complaints procedure which was available to people and their relatives. Nobody we spoke with had ever made a complaint but said they would talk to the registered manager if they were not happy. One person commented, "The manageress is a good person. I've got no complaints." Staff said they would support people to raise their concerns. One staff member explained, "That is their right and we inform the management. We need to resolve their problems."

We looked at the record of complaints and found the one complaint the provider had received had been responded to in line with their complaints procedure.

Requires Improvement

# Is the service well-led?

## Our findings

At our last inspection we found quality assurance within the home required improvement. At that inspection we reminded the provider we expected to see improvement in the completion of audits and checks to ensure the health and safety of people living in the home. At this inspection we found the required improvements had not been made which impacted on the safety, effectiveness and responsiveness of the care people received at Adelaide House.

The provider had not followed the latest regulations in line with the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. For example, the Care Act expects providers to work within a very definite set of mandatory requirements around adult safeguarding and the Mental Capacity Act 2005. The provider had not investigated safeguarding issues appropriately and when new issues emerged, they had not been referred as required to the local authority safeguarding team or to us. People's capacity to make decisions had not been assessed to ensure staff were acting in the least restrictive way possible and always acting in people's best interests.

Speaking with the registered manager and reviewing their audit systems, we identified a lack of proactive management and leadership which affected the quality of service. For example, we looked at the processes used to ensure people received safe and effective care, from staff who were trained and qualified to provide that care. Staff had not consistently received the support and training to carry out their roles effectively and safely. For example, medicines were not always being managed safely and staff had not received the training and checks required for the provider to be assured staff were safe to administer medicines.

We looked at the management checks and audits that monitored quality and safety at the home and found they were not effective. For example, checks of medicines had not been effective in identifying the issues we found with medicines management. Environmental checks had not identified risks in the environment such as exposed hot water pipes and the keys to the medicines room being within easy reach of people who lived in the home. Some people had been identified at risk of skin damage and had pressure relieving equipment to reduce the risks. There were no effective checks and information to ensure the registered manager and staff knew what the right settings on pressure relieving mattresses should be, and how to check.

At our last inspection visit we identified accidents and incidents were not being analysed to identify any trends or patterns. At that visit, the registered manager agreed it was important to analyse incidents so people's care plans and risk assessments could be updated where needed. They assured us they would develop a system for auditing incidents and accidents to ensure they had oversight of risks across the service. At this inspection we found the registered manager had not taken the action they had assured us they would take. Effective systems were not in place to enable the provider to identify where safety was being compromised so they could respond appropriately without delay.

We found improvements needed to be made in the records relating to staff recruitment and employment. For example, we looked at one staff member's employment file and found it was disorganised and there was no contract of employment. Two members of staff confirmed they did not have contracts of employment.

Improvements were also needed in relation to the management and storage of other records in the home. Some documents we asked for were not available because we were told they were stored 'off site'. The provider was not able to provide assurance that the storage area had been risk assessed to ensure people's confidentiality was maintained and records were protected against any environmental risks such as flooding or a fire.

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

The provider and registered manager acknowledged that improvements were required in the leadership within the home. The provider had appointed a new manager who was applying for registration with us, to replace the current registered manager. The registered manager told us they were supportive of the changes and explained that the care and support they provided was sometimes at the cost of record keeping and the day to day management and checks of the service provided. They said, "I concentrated more on the care. My residents mean everything to me. I will gladly step down and support [new manager] all I can. We are now beginning to see the wood for the trees."

The new manager had been in post for three weeks and was very open and transparent about the challenges they faced. They were aware of the issues within the home and told us their priority was staff training, record keeping and ensuring people received personalised care that met their individual preferences. When we raised various concerns with the new manager, they were able to show us documents they intended to introduce to ensure they met their legislative responsibilities under the Health and Social Care Act 2008. They had already introduced some new procedures to keep people safe, such as monitoring people for 24 hours after they had sustained a fall.

Staff spoke positively about the new manager. One staff member told us, "She needs time to read the care plans but she is helping us and she listens to the problems." Another staff member expressed confidence in the new manager because, "I think she will change things." One person who lived in the home told us, "[Name of new manager] is great. She's very understanding."

There were no 'relatives or residents meetings', but people were invited to share their views on a day to day basis. People, relatives and professional visitors to the home had been asked to complete a quality questionnaire in November 2017. The provider told us the results had been favourable, although we were unable to view copies of the completed questionnaires during our visit. However, we found the process for obtaining people's views needed to be improved so people were empowered to provide feedback and share their experiences to ensure the service met their preferred wishes. For example one relative told us, "We did have a questionnaire a couple of years ago asking what we wanted. I requested day trips but it's never happened."

There is a regulation, which came into force on 1 April 2015, that says providers must 'conspicuously' and 'legibly' display their CQC rating at their premises and on their website. When we arrived for our inspection, we saw the provider was displaying their CQC rating from our previous inspection visit.

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 | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider was not acting in accordance with the Mental Capacity Act 2005. Mental capacity assessments had not been completed when there were concerns that people were unable to consent to aspects of their care. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Where care records evidenced a risk to the person or to others, the provider had not always assessed the risk or produced a plan for managing the risk. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider's safeguarding processes were not operated effectively to investigate any allegations of abuse. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider's systems and processes to monitor the quality and safety of the service were not effective. |