Indigo Care Services Limited

Lymewood Court Nursing Home

Inspection report

Piele Road
Haydock
St Helens
Merseyside
WA11 0JY

Tel: 01915493950

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 28 February and 01 March 2017. This first day of the inspection was unannounced.

Lymewood Court is a purpose built service, all bedrooms and communal areas are located on the ground floor. The service is registered to accommodate 46 people, there were 45 people living at the service at the time of this inspection.

A registered manager was in post at the time of the inspection visit. They were registered with the Care Quality Commission in June 2016. 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 absent from work at the time of our inspection. However in February 2017 an interim manager was appointed to manage the service in the absence of the registered manager.

The last inspection of the service was carried out in September 2016 and found that the service was not meeting all the requirements of Health and Social Care Act 2008 and associated Regulations. We asked the registered provider to take action to make improvements in relation to people's safety, dignity and respect, management of medicines and quality monitoring systems. We received an action plan which showed all actions would be completed by 31 December 2016. However at this inspection we found that the registered provider had not met these legal requirements and we found further breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC are now considering the appropriate regulatory response to the concerns we found. We will publish the actions we have taken at a later date.

The management of medication was unsafe. Some people did not receive their prescribed medication because stocks had run out and other people did not receive their medication on time. Medication administration records (MARs) for some people had been signed to indicate they had received prescribed medication which was not given. One person had been administered eye drops which had passed their use by date. Handwritten MARs had not been signed by two staff to ensure the accuracy of the information recorded. There was a lack of advice sought from healthcare professionals about the possible effects on people when they did not receive their prescribed medication. This put people's health safety and wellbeing at risk.

Although some improvements had been made to the environment there were ongoing concerns which put people's safety at risk. Some remedial work had been carried out on fire doors; however they did not provide people with full protection in the event of a fire. Some failed to close properly, others were damaged and a fire door to a bedroom which was occupied was held open with boxes. Trailing wires and equipment

obstructed pathways to external fire doors. We alerted the Fire Safety Authority about our concerns following the inspection.
Equipment used to help people with their comfort and mobility was not clean which increased the risk of the spread of infection.

The recruitment of staff was not safe and thorough. The required checks had not been carried out on staff before they started work at the service. Staff were allowed to start work without some of the appropriate checks having been obtained on their character and suitability to work with vulnerable people.

There was a high use of agency nurses at the service. Agency nurses were called upon to ensure that people were supported by the right amount of suitably skilled staff. However the system for communicating people's needs onto agency nurses was inadequate which lead to people receiving ineffective care and support.

Assessment's carried out to plan people's care were not always reflective of people's needs. Charts which were in place to monitor aspects of people's care such as fluid intake, weight, positional changes and air flow mattress settings did not provide specific details of the care people required. Some charts had not been completed to show that appropriate care was provided.

Staff did not receive an appropriate level of supervision for their roles and responsibilities. Some staff had attended group supervisions; however the last one took place over six months ago. There was no evidence to show that staff had been given opportunity to discuss on a personal level matters about their work such as their performance and personal development. Clinical supervision for nurses had not taken place.

People's confidentiality, dignity and privacy were not respected. Some people's bedrooms overlooked the car park at the front of the building and people in bed were on view. Although bedrooms were fitted with curtains there were no nets curtains or blinds which could be used to promote people's privacy when they occupied their rooms with their curtains open. Personal records belonging to people were left unsupervised in communal areas which were accessed by visitors to the service.

Although there was a comprehensive system in place for checking on the quality and safety of the service, it was ineffectively used. Many checks which were required had not been carried out when required, and senior managers who were aware of this failed to act upon it. Action plans which were set to address improvements which were identified at the service were not followed. The plans were not monitored by senior managers or the registered provider to ensure appropriate action was taken to mitigate risks to people.

People who lived at the service were safeguarded from abuse and potential abuse. Staff had completed safeguarding training and they had access to information about how to prevent abuse and how to respond to an allegation of abuse. They recognised the different types and indicators of abuse and were confident about reporting any concerns they had.

Staff received the training they needed. Training relevant to people's needs was provided to staff on an ongoing basis and their competency was checked to make sure they understood and benefited from the training undertaken.

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.

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.

Prescribed medication was not given to people when they needed it because it was not available or given at the right times.

Parts of the premises were unsafe and equipment used by people was unhygienic.

Recruitment procedures did not safeguard people from the risk of unsuitable staff being employed.

Is the service effective?

Inadequate

The service was not effective.

Care records lacked information about people's needs. Appropriate medical advice was not sought for people.

There was a lack of effective communication amongst staff about people's needs.

People received care and support from staff that had not received an appropriate level of support for their roles.

Is the service caring?

Inadequate

The service was not caring.

People's confidentiality was compromised because their person records were not always securely stored.

Some people's bedrooms were overlooked from public areas which compromised their privacy.

Prior to meals being served people were left for long period of time in the dining room without little stimulation and staff interaction.

Is the service responsive?

Inadequate

The service was not responsive.

People's need were not properly assessed and planned for.

Complaints were not properly dealt with.

People had the opportunity to engage in activities which they enjoyed.

Is the service well-led?

Inadequate

The service was not well-led.

Systems for assessing and monitoring the quality and safety of the service were ineffective.

The failure to monitor actions plans resulted in a lack of improvements being made across the service. The service lacked scrutiny by the registered provider.

Records required by regulation were not securely stored, maintained and kept up to date.

Lymewood Court Nursing 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 registered 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 over two days, the first day was unannounced. Two adult social care inspectors carried out the inspection.

We observed the interaction between people who lived at the service and staff and we spoke with ten people and six family members. We spoke with the interim manager, area manager, deputy manager and staff who held various roles including, care staff, kitchen staff and domestic staff.

We looked at areas of the service including communal lounges, dining room, bathrooms, bedrooms, the kitchen and the laundry.

We reviewed a number of records, including care records for six people who lived at the service and four staff files. Other records we looked at which related to the management of the service included quality monitoring audits and safety certificates for equipment and systems in use at the service.

Before our inspection we reviewed the information we held about the service including notifications that the registered provider had sent us. We also looked at information we received from the local authority and members of the public. This included concerns which they raised with us about the service. We looked at those concerns as part of this inspection.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe living at the service. Their comments included, "Yes I feel safe here" and "I have no worries about my safety". Two people told us they did not always get their medication on time.

At our last inspection in September 2016 we asked the registered provider to make improvements to people's safety in relation to the environment and the management of people's medication. Prior to this inspection we received concerns from commissioners, and members of the public about people's safety in relation to; the environment, management of medication and staffing levels. As part of the safe domain we followed up on the requirement actions given at the previous inspection and looked at the concerns we received.

The management of medication was unsafe putting people's health, safety and wellbeing at risk. Prior to our inspection we were notified that a number of people who lived at the service had not received their medication as prescribed by their doctor. On the first day of our inspection the morning medication round continued up until 1 pm. This meant that some people who required breakfast time medication did not receive it at the right time. We found two examples where people had not received their prescribed medication because stocks had run out. One person had not received their prescribed medication for three days and another person had not received theirs for two days. We were told that those people had not received their medication because the items were not available at the service. At 12:45pm on the first day of our inspection one person told us that they had not yet received their prescribed medication for Parkinson's disease, this was despite their medication administration record (MAR) showing that they were to be given it at 7 am. The person told us that they had not received this medication until 1 pm the day before. This put the person at risk of experiencing unnecessary side effects and symptoms including increased tremors, depression, anxiety or pain. A MAR for one person had been signed to show that they had been administered eye drops and when we checked the person's medication we found that it had expired two weeks prior. All the required medication for people was obtained and available at the service at the time of our inspection.

We checked a sample of blister packs from the previous month's medication cycle which were being returned to the supplying pharmacist and found multiple examples were packs contained items of medication. We checked the corresponding MARs for these and found that whilst some MARs indicated people had refused to take their medication the majority of them had been signed to show that the medication had been given. The omission of medication put people's health safety and wellbeing was put at risk.

Prescribed medication was not safely stored. We saw many examples where large amounts of prescribed food supplements, creams and ointments were stored indiscreetly in bedrooms which people occupied. Large boxes containing food supplements were piled up on bedroom floors next to warm radiators and creams and ointments were left on top of cabinets. Prescribed thickener for one person was left on a tea trolley which was unsupervised.

Items of medication and instructions for use had been handwritten onto some people's MARs. However we found examples where some hand written MARs had not been signed by two members of staff to check the accuracy of the record made. On the first day of our inspection the interim manager made a safeguarding referral in respect of a number of people due to the concerns we found in relation to medication.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people using the service were not protected from the improper and unsafe management of medicines.

Since the last inspection improvements had been made to areas outside of the service which posed a trip, slip and fall hazard. Some pot holes on pathways surrounding the building and on the car park had been repaired and cleaned following a build-up of moss. In addition some remedial works had been carried out on internal fire doors, which included the replacement of seals around doors. However a large number of fire doors to bedrooms remained faulty because they failed to close tightly into the recess. A fire door to a linen room had a hole in it and a fire door to an occupied bedroom was held open with two large boxes. This was despite the bedroom door being fitted with an automatic closure device which was in good working order. Electric heaters were mounted on the wall in two bathrooms, however neither of the bathrooms had a fire or heat sensor fitted and they were not fitted with a fire door. This meant that full protection was not guaranteed for anyone in the event of a fire.

Equipment such as wheelchairs and hoists were stored behind seating in communal lounges. Most of the equipment was safely stored, however a lifting hoist was stored in the pathway to an external fire door in one lounge and in another lounge there were trailing wires on the floor near to both external fire doors. Staff cleared these obstructions after we raised it with them. We contacted the Fire Authority following our visit to raise our concerns.

There were no records to show that cleaning schedules had been followed for equipment which people used to help with their mobility and comfort. Wheelchairs which were in use were heavily stained with dried food debris and spillages and hoists and stand aids were dirty and dusty. Pressure cushions being used by three people were stained and two of the cushions displayed names which did not correspond with the person using them. A member of staff confirmed that the cushions belonged to people who were no longer living at the service. One person in bed was using an over bed table which had a urine bottle next to their breakfast dish and drink. This increased the risk of the spread of infection.

Recruitment of staff was not safe and thorough. Appropriate checks had not been undertaken on applicants before they commenced work at the service. One member of staff had started working at the service prior to the receipt of a satisfactory check carried out by the Disclosure and Barring Service (DBS). A DBS check consists of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. The registered provider's recruitment policy stated; that only once a DBS first check is completed and clear can a potential new employee start work. This was also confirmed by the area manager. Recruitment records for three members of staff showed that reference checks had not been obtained in line with the registered provider's recruitment procedure. The procedure stated a minimum of two references were required and that it was mandatory for a reference to be obtained from the applicant's most recent employer if recently employed. However we saw two examples where staff employed had provided details of their most recent employer/s but detailed other contacts for reference checks. The reason for this had not been explored and reference checks which were obtained for those staff employed were not in line the registered provider's requirements.

This is a breach of Regulations 12 and 19 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014, as people using the service were not protected from unsafe premises and the risk of the spread of infection. Safe recruitment procedures were not followed to ensure the suitability of persons employed.

Checks had been carried out by a suitably qualified person on systems and equipment used at the service to ensure it was safe to use and a record of the checks were kept. This included checks on the gas and electricity systems and appliances and hoists.

There was a system in place for reporting and recording any accidents or incidents which occurred at the service. The records were analysed on a regular basis as a way of identifying any trends or patterns and they were used to learn lessons and help prevent any future occurrences.

There were enough staff to support people in the event of an emergency. All staff had received training in topics of health and safety such as first aid, fire awareness and evacuation procedures and they were aware of their responsibilities for ensuring people's safety in the event of an emergency.

Personal evacuation plans (PEEPs) were in place for each person who used the service. Prior to our inspection PEEPs were reviewed and updated by the interim manager because some of them were out of date. Copies of the PEEPs were located near to the main entrance of the service making them easily accessible to staff in the event that an evacuation of the building was required. The PEEPs provided instructions about the assistance people needed to evacuate the building safely, such as any equipment and the number of staff to help with their mobility.

Staff had completed safeguarding training and they had access to the registered provider's safeguarding policy and procedure and those set out by the relevant local authorities. Staff also had access to a step by step guide describing what they were required to do if they witnessed, suspected or were told about abuse. Staff knew the different types and indicators of abuse and they said they would not hesitate to report any concerns they had. The interim manager had a good understanding of how to manage allegations of abuse or suspected abuse. They knew that they were required to inform relevant agencies such as the local authority safeguarding team, police and the Care Quality Commission (CQC). Records showed that safeguarding concerns were dealt with promptly and that appropriate action had been taken to reduce further risks to people.

Inadequate

Is the service effective?

Our findings

At the last inspection in September 2016 we made a recommendation about the maintenance of records in relation to monitoring aspects of people's care. This was because monitoring charts which were in place at the time did not include the required information about how to meet people's needs effectively.

Prior to this inspection we received concerns that people's needs were not being properly met because of a high use of agency staff that had little knowledge and understanding of people's needs.

People did not always receive effective care and support because of a lack of communication amongst the staff. Discussions with the interim manager and area manager confirmed that there had been a shortage of permanent nurses working at the service. They confirmed a high use of agency staff in order to ensure that the right amount of nurses were on duty to support the needs of people throughout the day and night. The interim manager told us that every effort was made to use agency nurses who had previously worked at the service because they were familiar with the layout of the building and the people supported. However there were occasions when people's care needs were not met in a timely way because some agency nurses were not familiar with people's needs and the layout of the environment. We evidenced examples where people did not receive the right care and support due to a lack of robust communication about people's needs during handovers to agency nurses. For example, people had not received their medication on time because an agency nurse was not alerted about time specific medication. In addition one person who used the service told us that they quite often did not get their medication until after midnight because agency staff were not familiar with the process.

We were told by staff that a specific handover document was to be completed by the nurses leaving their shift to pass onto the nurses commencing the next shift. This was to communicate important information about the events of the previous shift and to highlight any relevant information about people's needs for the next shift. Records of handovers completed prior to our inspection could not be located therefore we were unable to review them. An agency nurse that had not previously worked at the service confirmed to us that they did not receive a formal handover in the form of a written record. They said they received some verbal information which they wrote down on a piece of paper and that throughout the course of the morning they had added to their notes based on observations and discussions with other staff. The interim manager confirmed to us that a recruitment drive was underway to employ permanent nurses.

At this inspection we found that charts to monitor aspects of people's care still failed to provide adequate information to ensure people received effective care and support. As previously found at the last inspection, fluid intake charts did not identify the recommended amount of fluid people were required to consume in a 24 hour period and this information was not recorded in the person's care plan. We looked at fluid intake charts for three people, each which covered a period of four consecutive days. The amount of fluid each person consumed on a daily basis varied quite significantly, for example one person's records showed they consumed 300 mls one day, 370 mls the following day, 960mls on the third day and there was no fluid intake recorded on the fourth day. The lack of information available with regards to people's fluid take meant there was no way of knowing whether they had consumed the right amount of fluid to keep them hydrated. This

meant people were at risk of receiving unsafe and ineffective care.

We looked at the care records for five people who had an air flow mattress on their bed to minimise the risk of developing pressure ulcers. There were no records in place for three of those people to show that their mattress setting had been monitored to ensure it was correctly set to provide them with effective relief. There was a 'Daily mattress check' chart in place for the other two people, however the chart for one person was blank and the chart for the other person had not been filled in since December 2016. We found an example were one person's air flow mattress was incorrectly set. This increased the risk of people developing pressure ulcers.

Care records which we looked at for three people showed that when in bed they required assistance with regular positional changes to reduce the risk of developing pressure ulcers. Each positional change needed to be recorded onto a positional chart to evidence the care given. One person's positional chart failed to record details of the position the person had been moved to and there were no positional charts in place for the other two people. Whilst we did not find any negative impact on people as a result of these records not being kept, it could result in people not receiving the right care and support.

People did not always receive the healthcare they needed. GP's or other healthcare professionals had not been contacted for advice regarding the possible effects on people who did not receive their prescribed medication at the right times. People's health, safety and wellbeing was put at risk because of this. The interim manager ensured this was done after we raised our concerns with her.

This is a breach of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as risks to people were not assessed and mitigated and records were not appropriately maintained.

There was a policy in place set by the registered provider for staff supervision; however it was not being followed to ensure staff were appropriately supervised for their role. The policy stated that all staff should have the opportunity to attend a supervision session at least four times a year and an annual appraisal. The policy defined supervision as both one to one and group sessions. Records held in the four staff files which we looked at showed one member of staff had attended a group supervision in February and April 2016, a second member of staff had attended a group supervision in August 2016 and a third member of staff had attended a group supervision in September 2016. There were no records available for a fourth member of staff who was a trained nurse, to show that they had attended any form of supervision including clinical supervision. There were also no records to show that any of the staff had received an appraisal of their work. The area manager confirmed to us that the registered manager was responsible for conducting clinical supervision with nurses. They also confirmed that there were no records available to evidence that staff had received an appraisal or any form of supervision since a group supervision which last took place in September 2016. A lack of regular supervision and appraisal meant staff did not have the opportunity to discuss matters relating to their work, including their role and responsibilities, their performance and personal development.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as persons employed did not receive appropriate support, supervision and appraisal for their roles.

Training for all staff was ongoing. This included refresher training in topics covered during induction and others topics relevant to people's needs. For example Dementia awareness, fire safety, infection control, emergency first aid and diet and nutrition. Training was delivered in a number of ways including face to face training delivered by accredited trainers and e learning (on a computer). Following each training session

staff underwent a competency check to test their knowledge and understanding of the training completed. If staff failed to meet the requirements of the competency check, they were required to undertake the training again. Training records showed that the majority of staff had completed all the relevant training required of 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 people lack mental capacity to make particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA 2005. The application procedures for this in care homes are called Deprivation of Liberty Safeguards (DoLS). We checked that the service was working within the principles of the MCA 2005 and found that they were.

There were processes in place to protect the rights of people living at the service. Staff had undertaken training in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and they knew how to apply the main principles of the act to their day to day practice. Staff were observed giving people choices and obtaining their consent prior to any intervention. Relevant staff including the interim manager and deputy manager understood their responsibilities and the process for making appropriate applications if they considered a person was being deprived of their liberty. Applications for a number of people who lived at the service had been made to the relevant supervisory body, and authorised at the time of our inspection.

Inadequate

Is the service caring?

Our findings

People told us that the staff were kind and caring. Their comments included "They [staff] are kind and helpful", "I am treated very well" and "They [staff] do knock on my door before coming in".

During the last inspection we found a lack of respect for people's confidentiality, privacy and dignity. During this inspection we found that some improvements had been made, however we found ongoing concerns.

People's confidentiality was not fully protected. There were secure offices and lockable filing cabinets located at both sides of the service for the safe storage of personal records. The offices were kept locked throughout this inspection visit. However, we noted that two files containing people's personal records were left on top of a cabinet in a communal lounge. In addition there were other people's personal records stored in a rack, fixed to the wall in another communal lounge. The records included information about people's weight, personal care routines and care interventions. This put people's confidentiality at risk because their personal records were accessible to those who did not have the authority to access them. This included none care staff, contractors who were at the time of our inspection carrying out repairs at the service, and visitors who met with their relatives in the lounge areas.

People's privacy and dignity was not fully respected and promoted. People's bedrooms looked directly onto the car park which was also the pathway towards the main entrance into the building. Other than curtains the windows did not have any other privacy screening such as nets or blinds, which people could choose to use to maintain their privacy during the day when their curtains were open. When we crossed the car park we viewed people who occupied their rooms including some people who were asleep in bed. We raised this as a concern at the previous inspection. The action plan which we received following the inspection stated that people were consulted about the use of nets or blinds on their windows and following consultation, blinds or nets would be provided for those people who chose to have them. However, there were no records to evidence the discussions which we were told had taken place. In addition three people told us that no one had discussed this matter with them. One person stated, "I like looking out, I like to see all the comings and goings, but I wouldn't mind some blinds. I'll still be able to see out but it will stop others from looking in". Another person said, "Blinds would be nice".

People were escorted into the dining room and left sat at tables for up to half an hour before the lunch time meal was served. Staff continually popped in and out of the dining room to seat others however they engaged in little conversation with those who had been seated for some time. For example people were not offered a drink or any reassurance about the timing of their meal. This meant that people did not have a positive experience at mealtimes.

Since our last inspection improvements had been made to enhance the gardens and seating areas surrounding the building. Patios had been cleaned and cleared of rubbish and flower beds had been cleared of large weeds. Additional improvements were needed to further enhance the outside areas for people to use as there were broken flower pots and untidy flower beds. Other parts of the environment undermined people dignity. There were three clocks in one of the two main lounges which showed different times and

only one of them showed the correct time. This included a clock that displayed the date which was also incorrect. Clocks in other communal areas including the activities room and the reminiscence room were also incorrectly set. There were two televisions in use at the same time on different channels in one of the main lounges. This lack of consideration had the potential to distract and confuse people, particularly those living with conditions such as memory loss and hearing difficulties. A questionnaire completed by a family member in January 2017 included comments about the gardens being very unkempt and about the use of two TVs in the one lounge. Despite this nothing had been done in response to the comments made.

This is a continued breach of Regulation 10 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people were not treated with dignity and respect and confidential records were not securely stored.

People were encouraged to personalise their bedrooms as they wished such as with family photographs and ornaments. Some people had pieces of furniture in their bedrooms which they had brought from their previous home. One person told us how important it was for them to have items of familiarity around them as they like to spend most of their time in their room. They said there had been no limitations placed upon them with regards to what items they had in their room.

One person was receiving end of life care at the time of our inspection. We observed that the person was in receipt of appropriate care which was compassionate. An appropriate end of life care plan was in place and being followed to ensure the person remained comfortable and kept free from pain at all times. Facilities were provided for the person's family to enable them to visit and spend as much time with their relative as they wanted. Family members were kept up to date with any changes in their relative's condition which was closely monitored by staff. Family members commented that they were very happy with the care their relative was receiving.

Some people had a 'do not attempt resuscitation' (DNACPR) order in place which had had been authorised by their GP. These were put in place where people had chosen not to be resuscitated in the event of their death or in cases where they cannot make this decision themselves. A GP and other individuals with legal authority had made this decision in a person's best interests. DNACPR certificates were placed at the front of people's care file so it was clearly visible.

Inadequate

Is the service responsive?

Our findings

People told us that they were invited to take part in activities at the service. Comments people made included; "I enjoy the days when we make things", "I'm not interested in the activities. There is no one to one time, but occasionally people [staff] come in to chat" and "I tend to like staying in my room to read rather than joining in activities. I do not feel pressured into joining in".

Before our inspection we received concerns that complaints had not been listened to and acted upon. We looked at those concerns as part of the effective domain.

A variety of assessments were used to obtain an understanding of people's care and support needs and to plan for them. Assessments and care plans which were to be reviewed and updated each month covered areas such as skin integrity, mobility, moving and handling and nutrition. However we found examples where outcomes of assessments and care plans did not accurately reflect people's needs. For example a nutritional assessment for one person indicated a score which put them at low risk, but the calculation failed to take account of previous weight loss which if correctly calculated would have put the person at medium risk. An assessment for a second person showed that they were not at any risk of weight loss despite previous records showing that they were vulnerable to weight loss. The weight chart for this person had not been completed since December 2016. A nutritional assessment for a third person showed that they had gained over 7 kg of weight within a period of a month, however other relevant sections of the assessment had not been completed as required to reflect this change. The assessment required the completion of further sections when a weight gain of over 3 kg was noted, however these were left blank. A pressure ulcer prevention assessment for a fourth person showed that they were at high risk of developing pressure ulcers. A record to monitor the person's skin integrity was in place, however the last entry made onto the record on the 06 December 2016 showed that the person had a skin lesion at the time. We found many examples where relevant sections of assessments had not been completed to indicate outcomes of assessments. Sections of assessments which were incomplete included people's height, body mass index (BMI) and skin condition. In addition sections of assessments had not been signed by the assessor as required. This put people at risk of receiving unsafe and ineffective care.

There was a lack of evidence to show that people and/or their representatives had taken part in the assessment, development and reviewing of people's care. Assessment and care planning documents included a section for people and or their next of kin to sign to show that they had taken part in the planning and reviewing people care. These sections had not been signed on any of the records we looked at. Two family members who we spoke with told us that they did not recall ever being invited to discuss their relatives care.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people's care needs were not appropriately assessed and planned for.

Complaints were not always listened to and dealt with appropriately. The process for making and responding to a complaint was clearly set out in the registered provider's complaints procedure. The

procedure clearly stated that all complaints would be recorded, acknowledged and investigated and the findings shared with the complainant. When we checked the complaints log we found a record of complaints made and dealt with since the appointment of the interim manager in February 2017. However there was no record of any complaints made prior to this, this was despite us being made aware of a number of complaints raised with the registered manager. The area manager confirmed that the complaints had not been dealt with in line with the registered provider's procedure.

People were given opportunities to engage in both one to one and group activities. An activity co-ordinator was employed at the service that organised and facilitated a range of activities, including art and craft, board games, reminiscence and relaxation sessions. There were dedicated areas at the service where organised activities took place or where people could spend time alone if they wished. This included an activities room which was equipped with various items including books, board games, a key board and art and craft materials. There was also a room which had been designed to replicate an early twentieth century kitchen, dining room and lounge. The room which was used by people to reminisce was furnished and displayed ornaments and other items to remind people of their past.

Inadequate

Is the service well-led?

Our findings

People and family members were aware that there had been some changes to the management of the service, however they were unsure about whom to approach should they need advice or guidance. One family member said, "It's all a little confusing at the moment".

The service had a registered manager however; prior to the inspection we were notified that the registered manager was on a period of absence and that an interim manager had been appointed in February 2017 to oversee the day to day management of the service. There was an area manager who had responsibility for oversight of the service.

During the last inspection in September 2016 we found a breach of Regulations 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the systems in place to monitor the quality and safety of the service and make improvements were ineffective. Following the inspection we received an action plan detailing how and when the required improvements would be made. However during this inspection we found the required improvements had not been made and we found other concerns in relation to good governance.

The registered provider failed to take appropriate action to meet the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 following our last inspection. An action plan completed by the registered manager on 02 December 2016 was sent to us outlining how and when the requirement actions would be met for breaches of regulations found at the last inspection. The action plan showed all actions would be completed by 31 December 2016. However during this inspection we found little evidence of improvements made. We found ongoing concerns and other concerns regarding the management of people's medication and medication administration records (MARs), the safety of the environment and people's privacy and dignity. This was despite the action plan stating that measures had been put in place to ensure people's privacy and dignity and that checks were taking place to ensure the safe management of medication and the safety of the environment.

There had also been a failure to act upon areas of improvement which were identified during a quality monitoring visit on 17 January 2017 carried out by a Compliance Officer employed by the registered provider. The visit report which was made available to the registered manager provided comprehensive information about the findings. An action plan which was attached to the report listed 24 actions which were required across the service for improvement and the person responsible for the actions and timescales for completion. The last date given for completion of actions was 21 February 2017, despite this only four actions were identified as having been completed. Improvements which were required in relation to medication, care planning documentation, the safety of the environment, leadership, and privacy and dignity remained outstanding at the time of our inspection visit.

A medication audit which was carried out by the registered manager in January 2017 highlighted a number of concerns with regards to the management of medication. An action plan was put in place to address the concerns. However there was no evidence to show that the action plan had been monitored and concerns

which were identified during the audit remained outstanding, including a shortage of medication for people.

Our findings during this inspection further demonstrated a lack of action taken to make the required improvements set out in the registered provider's action plans, details of which are included within the relevant sections of this report. The safety of people and others was put at risk because the registered provider failed to monitor progress against plans to improve the quality and safety of the service.

The system for assessing and monitoring the quality and safety of the service and for making improvements to the service people received were ineffectively used. The registered provider had in place a comprehensive framework with clear guidance, for assessing and monitoring the quality and safety of the service and for making improvements. The registered manager or someone nominated by her was required to carry out checks at various intervals on aspects of the service including the environment, systems and equipment, care planning and medication. Records to reflect the findings were to be completed and any faults or concerns identified during the checks were to be reported to the relevant department for action. Records of the checks carried out prior to January 2017 were not available and the area manager told us that they had been archived at the service. We asked the area manager on a number of occasions throughout the inspection visit to locate the records for us to examine, however they failed to produce them.

Records of checks completed in January and February 2017 for daily, weekly and monthly checks at the service were incomplete. This included checks on the environment, fire alarms, lighting, water and room temperatures and the nurse call system to ensure they were safe. The area manager was responsible for the oversight of the service. This included ensuring that the registered provider's quality monitoring systems were fully implemented at the service. However, they confirmed to us that the records were incomplete because the checks had not been carried out as required. Despite knowing this the area manager had failed to take any action. Risks to people and others were not identified and mitigated due to a failure to carry out the required checks across the service.

A lack of scrutiny by the registered provider meant there was a delay in identifying ineffective systems to assess and monitor the quality and safety of the service.

Records were not securely maintained, complete and kept up to date. The registered provider had a number of policies and procedures in place to support staff in relation to good record keeping, including confidentiality and maintenance of records. In addition there were systems in place for the safe storage of records. However the storage of records did not support people's confidentiality in line with the Data Protection Act (1998). Records pertaining to people's care were not kept secure and were at risk of being accessed by unauthorised people. Care records and other records required for the management of the service were incomplete and some were unavailable at the service. This included supplementary records for monitoring aspects of people's care, quality monitoring, maintenance and staff recruitment records. The quality monitoring systems for checking records failed to identify a lack of appropriate record keeping.

This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as systems and processes in place to monitor the quality and safety of the service, make improvements and ensure compliance with the requirements of regulations were ineffective. Records were not kept secure or maintained.

The registered provider had a comprehensive set of policies and procedures for the service which were made available to staff. Policies and procedures support effective decision making and delegation because they provide guidelines on what people can and cannot do what decisions they can make and what

activities are appropriate. However people and others were put at risk because not all the registered providers policies and procedures were being followed as required. This included complaints, monitoring the quality of the service, record keeping and supervision of staff.

The rating following the last inspection was prominently displayed near to the enterance of the service making it accessible for all to see. The registered provider had notified the Care Quality Commission (CQC) of significant events which had occurred in line with their legal obligations.

Within 48 hours of our inspection we received information from the registered provider confirming that some immediate action had been taken to ensure people's health and safety. This included a full audit of medication and associated records, the completion of quality monitoring checks and a restructure of the management team. Other plans to further improve the service were also shared with us and we were assured that they were being closely monitored by the registered provider. Since the inspection the interim manager and the registered provider have sent us regular updates of the progress made.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users were not treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment procedures were not followed to ensure the suitability of person's employed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Persons employed did not receive an appropriate level of supervision and appraisal to carry out their duties.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People did not receive safe care and treatment.

The enforcement action we took:

A warning notice for regulation 12 safe care and treatment was issued to the registered provider with a compliance date of the 14 September 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems and processes in place to monitor the quality of the service, make improvement and ensure compliance with the requirements of regulations were ineffective.

The enforcement action we took:

A warning notice for regulation 17 good governance was issued to the registered provider with a compliance date of the 29 September 2017.