H Plus Care Ltd

Larchfield House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Larchfield House is a care home with nursing that provides care and support to people living with dementia, learning and physical disabilities. At the time of our visit there were 72 people living in the home.

The registered manager had recently left the service and an interim home manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our previous inspection on 29 February 2016 and 3 March 2016 we found breaches of Regulations 9, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action to make improvements in the areas of person centred care; management of medicines and governance of the service. This was because minutes of best interest meetings did not evidence any involvement from other health professionals or people's representatives. Best interest decisions were not reviewed for their effectiveness. Staff did not follow policy and procedures in regards to recording medicines and reporting medicine errors. The service did not ensure there was sufficient details in care plans to enable staff to care for people. Systems and processes that enabled the service to identify and assess, monitor and mitigate risks to people's health, safety and welfare were not effective. After our visit the provider sent us an action plan by the required deadline which stated the required improvements would be made by 30 September 2016.

During our most recent inspection we found the requirements from the previous inspection had not been met.

People were at risk of harm because staff did not understand how to complete nutritional assessments correctly. This resulted in people experiencing unplanned weight loss which was not being identified. People were not always protected from the risk of health and safety associated with the premises because the provider failed to act in a prompt and timely manner when issues had been identified.

People were not protected against the risks associated with medicines. Medicine errors were not responded to appropriately and the provider did not have appropriate arrangements in place to manage people's medicines safely. Where people were identified at risk of choking, risk assessments put in place did not accurately detail how prescribed medicines should be administered.

A review of the service's infection control and prevention systems showed cleaners' trolleys were not lockable, and left unattended for a period of time. Chemicals which posed a risk to people were stored on the top or side of the trolleys. This risk had not been identified by the provider and we have made a recommendation for the service in this area.

There was a high use of agency staff within the service which meant people did not always receive care from consistent staff familiar with their individual needs.

We found the service's safeguarding policy and procedures contained missing information. This meant there was a potential for people to receive unsafe care because staff were not aware of correct working practices.

People were not consistently treated in a caring manner. The delivery of kind and compassionate care was variable throughout the home. We have made a recommendation for the service in regards to dignity and respect.

People's nutritional needs were not always met and where people had special dietary needs their food was not always prepared in line with specialist nutritional advice. We observed some people waited a significant length of time to be served or to be assisted to eat their meals. The rate of staff training, supervisions and performance appraisals was inadequate. End of life care plans did not capture all of people's preferences and wishes. We have made a recommendation for the service regarding end of life care plans.

The provider had consistently failed to work in accordance with the Mental Capacity Act 2005 (MCA). Documentation related to the application and authorisation of Deprivation of Liberty Safeguards required improvement. We have made a recommendation for the service in regards to DoLS.

People were supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service (do not) support this practice.

It was not always possible to establish whether care delivered was responsive to people's needs as relevant records relating to people's wishes and specific care needs were archived by the service. We found people's choices were restricted in regards to various aspects of care.

We spoke with people and their relatives in regards to their views about management and leadership of the service. We found some people and their relatives were aware of the change of management but others were not. This meant where there were significant changes that affected people who used the service the provider did not have effective system to communicate with them.

Systems failed to effectively assess; monitor and improve the quality and safety of the service provided. We saw a consistent theme of insufficient and inaccurate record keeping related to care and the management of the service.

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, they 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 a set timeframe.

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

inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

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?

Inadequate

The service was not safe.

People were placed at risk of harm because staff did not understand how to complete nutritional assessments correctly.

Medicine errors were not responded to appropriately and the provider did not have appropriate arrangements in place to manage people's medicines safely.

Care records did not have sufficient information to enable staff to deliver safe care.

People were not satisfactorily protected against abuse or neglect.

Is the service effective?

Requires Improvement

The service was not effective.

People's nutritional needs were not always met.

The service did not act in accordance with the MCA 2005 as best interest meetings that took place did not evidence any involvement from people's next of kin or other health professionals.

The provider had consistently failed to work in accordance with the Mental Capacity Act 2005 (MCA).

Is the service caring?

Requires Improvement

The service was not always caring.

End of life care plans did not capture all of people's preferences and wishes.

People were not consistently treated in a caring manner.

People and their relatives felt staff who provided care and support had a good understanding of their care needs and knew them well.

Is the service responsive?

Requires Improvement

The service was not responsive.

It was not always possible to establish whether care delivered was responsive to people's needs as relevant records relating to people's wishes and specific care needs were archived by the service.

We found people's choices were restricted in regards to various aspects of care.

People and their relatives said they knew how to raise a complaint. We heard mixed views on whether they thought their complaints were satisfactorily resolved.

Is the service well-led?

Inadequate

The service was not well-led.

Over the last three years of inspecting the service we found the provider's compliance with the regulations has progressively deteriorated.

Where there were significant changes that affected people who used the service the provider did not have an effective system to communicate with them.

Systems failed to effectively assess; monitor and improve the quality and safety of the service provided. We saw a consistent theme of insufficient and inaccurate record keeping as it related to care and the management of the service.

Larchfield House

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 was an unannounced inspection which took place on 27 & 28 February 2017. The inspection team consisted of two inspectors, a pharmacist, a specialist advisor who was a dietitian and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed all the information we held about the service. We looked at notifications the provider was legally required to send us. Notifications are information about certain incidents, events and changes that affect a service or the people using it.

For this inspection we did not ask the provider to complete a Provider Information Return (PIR). This 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 also looked at all the information we have collected about the service.

We carried out observations of care throughout our visit.

We spoke with eight people who used the service; six relatives and one friend; 15 care staff ; two maintenance staff; a chef, an activities co-ordinator; business support staff; a consultant; the interim home manager and the proprietor. We looked at 14 care records; five staff records; 30 medicines administration records; three topical medicine administration records and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

At our previous inspection on 29 February 2016 and 3 March 2016 we found a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff did not follow policy and procedures in regards to recording medicines and reporting medicine errors. We issued a requirement notice against the provider and requested an action plan. After our visit the provider sent us an action plan by the required deadline which stated that required improvements would be made by 30 September 2016.

At our last inspection, we noted that competency checks of registered nurses who were responsible for ensuring the safe management of people's medicines required improvement. During this inspection, we found the service's frequency of competency checks for registered nurses with medicines was meant to be carried out on a six monthly basis. A review of these checks showed this did not consistently occur. This meant people were placed at risk of medicines errors, because the service did not regularly ensure staff responsible for handling medicines were effectively skilled to perform the task.

The effectiveness of medicines was not appropriately monitored. We reviewed medicine and administration records (MAR) for two people prescribed medicines that required blood monitoring. These records contained test results, subsequent scheduled tests, and the exact dose to administer. However, two care plans for the management of behaviour that challenged did not describe when to use the prescribed medicines. Therefore, we were not assured that staff would respond consistently when faced with behaviour that challenge.

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

We looked at the use of nursing risk assessments related to people's health and saw appropriate types of assessment tools were in use. For example, we saw falls risks were assessed; people's risk of pressure ulcers was recorded using Waterlow scoring (this gives an estimated risk of the development of pressure ulcers) and documentation about the risks of moving and handling was available. However, we found people were placed at significant risk of harm because staff did not understand how to complete nutritional assessments correctly. For instance, this was found to be the case for people who were malnourished or were at risk of being malnourished. The service used a Malnutrition Universal Screening Tool (MUST) to assess peoples' risk in this area. We noted MUST scores were incorrect for six people whose care plans were reviewed, because unplanned weight loss that had occurred over and longer than one month had not been identified. This meant that some of these people were recorded at a lower risk of malnutrition than they really were which could mean that their malnutrition was neither recognised nor treated. We saw these errors had been repeated for one person whose recorded MUST score was only correct once between June 2016 and February 2017. For another person, their weight in August 2016 was recorded as 45.2kg and in September 2016 as 38.5kg. This apparent loss of 6.7kg (one stone) in 1 month was not queried on either their weight chart or their MUST chart, and no subsequent weight or MUST score was then recorded in the person's care record until November 2016. This meant people were placed at risk of harm because their nutritional needs

were not accurately assessed.

All reviewed care records were logically presented, with all weight and MUST charts and care plans in the same section in each person's folder, however in some care records, parts of the MUST tools were missing which would make accurate completion of MUST (weight loss charts) more difficult for staff. A staff member advised that staff had received training on MUST completion but the staff member admitted not understanding MUST completion themselves and was unable to show us how to calculate the weight loss score. This meant people were placed at risk of harm because nutritional assessments were not carried out by staff who had the required skills and knowledge.

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

We spoke with the chef who demonstrated some knowledge of how to fortify food to increase its calorie content. The chef reported that they were informed of people with food allergies or conditions such as diabetes. The chef demonstrated a good understanding of the consistency of pureed food as advised by speech language therapists (SLT), which they reported having gained from attending local training. However, none of the pureed food we observed at lunchtime was of the correct consistency which they had described. The chef reported having prepared all the pureed food himself. Provision of incorrect consistency pureed food can significantly increase the risk of aspiration for people with dysphagia, either because it contains lumps (observed for pureed meat and pudding) or because it is too runny (observed for potato and carrots). The chef also reported only fortifying some of the pureed food with high calorie ingredients, thereby missing an essential opportunity to improve and maintain people's nutritional status. This meant peoples' nutritional needs were not always met and where people had special dietary needs their food was not always prepared in line with specialist nutritional advice.

The chef said they had prepared smoothies and milkshakes for people who were losing weight however, they stated they used artificial sweetener instead of sugar in the smoothies. This was also the case when preparing pudding for people who used the service (including people with diabetes). This reduced the potential nutritional content which was a concern for people who were at risk of malnutrition.

Peoples' medicine administration records (MAR) or care plans contained details of any allergies, information about medicines to be taken on a 'when required' basis and if thickened fluids were required. However, plans lacked information on "how I like to take my medicines". Information about how much their fluid should be thickened and the person's ability to communicate their need for a 'when required 'medicine was variable. Therefore we were not assured that people would consistently receive when required medicine or fluids appropriately thickened. We noted fluid thickener was prescribed for 10 people. Two types of thickener with very similar names were prescribed (one starch based and one gum based) and neither a nurse nor a team leader was aware of the difference between the two thickeners. We observed three units in the service had both types of thickeners prescribed. Both staff reported using a method to mix thickened drinks which was not in line with directions for these thickeners.

Several peoples' care records contained a 'Choking and aspirating' risk assessment. These were mainly clearly written but contained some information which was contradictory with other information found in peoples' care records. For instance, one person's 'Choking and aspirating' risk assessment contained a hand written (undated and unsigned) addition stating "[Name of person] has two scoops of thickener in all drinks." We found this to be unclear as it did not state the volume of fluid that this amount of thickener related to. Information recorded on another person's 'Choking and aspirating' risk assessment and in a letter from their Speech and Language Therapist (SLT) were contradictory. The person's 'Choking and

aspirating' risk assessment dated 15 April 2016 stated "Ensure his drinks are thickened to stage one." A letter from his SLT dated 6 July 2016 stated the person required stage two thickened fluids. Both staff we spoke with confirmed they were aware that the person required stage two thickened fluids but there was no evidence to show other staff were aware because the information had not been updated.

We found MAR folders for people for whom where thickener was prescribed had an "Alert" laminated sheet next to their MAR which stated that the person needed thickened fluids. This was a good idea but would have been better if the "Alert" sheet had also stated what consistency of fluid people required. No "Alert" sheets were seen in one of the units in the home where thickener had been prescribed.

We found people were at significant risk of choking because information contained in 'Choking and aspirating' risk assessments were unclear, contradictory, not kept up to date and staff did not always follow instructions when preparing thickeners.

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

We looked at how people were protected against risks from the building and equipment. The service employed two maintenance staff who were responsible for routine repairs; dealing with external contractors and managed documentation related to the building and equipment. We saw evidence of checks on moving and handling equipment such as hoists used with people; window restrictors and the temperature of water delivered from taps and baths.

We found a number of risks to people from the building and equipment were not satisfactorily managed. When we viewed the Legionella risk assessment for the service, we found this was dated 30 March 2015 and not updated. This was despite the provider's knowledge of Legionella presence in the water system of the service continually since May 2016. The service had taken actions to attempt to control Legionella in the water system. This included the total disconnection of all showers and baths in the building since 3 June 2016. This took away people's choice to have baths or showers and limited their hygiene to bed baths only.

The service provided an updated Legionella risk assessment to us on the second day of the inspection. This was from the service's contractor and dated as the prior day of our inspection. The contractor had not visited the service on the first day of the inspection, and sent the report without reviewing the risk on site. We reviewed the content. We found the risk from Legionella was sustained and required further controls to prevent harm to people.

When we looked at the latest available water sample results from 11 February 2017, we found Legionella was present in the water supply in a number of locations. This included in the hairdressing salon at a level harmful to older adults. The actions taken by the provider were not sufficient and meant that people were still at risk of harm from developing a serious type of pneumonia that is caused by Legionella. We pointed this out to the provider on the first day of our inspection. On the subsequent day of our inspection, the water supply in the salon was disconnected. When we spoke with the hairdresser, they confirmed they were never informed that Legionella was present in the water supply used to wash people's hair. They had commenced the use of bottled water from the time of our inspection.

We have reported our concerns regarding the persistent presence of Legionella in the service's water system to Public Health England.

We asked to see other evidence to show whether people were protected from risks related to the premises.

These included the fire risk assessment, gas safety certificate and checks of the passenger lift. We were provided with a fire risk assessment which was out of date for more than a year, and no recent record that the passenger lift was checked in line with the relevant regulations. When we pointed out to the provider that a number of risks were identified in the fire risk assessment from 26 June 2015, they were unable to produce evidence that the risks to people and others had been actioned prior to our inspection. There was no record that maintenance staff or managers had considered the findings and taken or documented remedial actions to protect people. After we pointed this out, the provider supplied evidence to us on the second day of the inspection they had taken actions to mitigate risks documented in the fire risk assessment.

We wrote to the provider after our inspection to request further documents related to premise's risk management. We received a current gas safety certificate, periodic fixed wiring certificate and portable appliance testing report. The service failed to demonstrate that thorough examinations of the passenger lift had occurred on a six-monthly basis, as required by the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). The service was unable to provide this to us. However, the provider wrote to us after the inspection to tell us that a LOLER check on the passenger lift was arranged.

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

People and their relatives spoke about how safe the service was. We heard various comments such as, "Never had any concerns about her (family member's) safety, "Sometimes there are a few ups and downs but mainly I feel safe", "Yes definitely, the security and familiarity are good for him (family member)", "I think so yes (feels safe). There is someone here who can help me if I can't do something myself", "Definitely, they (staff) help me into my wheelchair. I don't have any concerns", "Absolutely; mum has one to one care. I would be the first to raise a concern", "Yes and no. I haven't come across anything to indicate he is not safe", "I feel very safe, I was prone to falling, in a world of my own. Here there are always people around", "It is quite safe due to the number of people who provide care for my wife", "Yes I do feel safe. I did fall and hurt my arm but I'm okay. No, it was my fault" and "There was a concern. [Name of person] had some bruising. It wasn't a major thing but there was no explanation."

We found people who used the service were not satisfactorily protected against abuse or neglect. We reviewed the service's policies for safeguarding and whistleblowing. We found the policies contained missing information, such as the contact telephone number for the local safeguarding team, and contact details for after-hours reporting. The policies also failed to mention the 'Berkshire Safeguarding Adults Policy and Procedures'. This is a set of steps implemented by the six local authorities located within Berkshire for consistently dealing with allegations of abuse or neglect. We saw policies and procedure folders were positioned at the reception desk and available to all staff. However, out of 75 staff, only seven had signed a record sheet to demonstrate they had read them or had knowledge of their existence.

We looked at safeguarding and whistleblowing information available to staff who worked in all four units of Larchfield House. In one unit, we found a poster with a flowchart of steps for staff to follow. We found the information on the poster was not aligned to that in the service's policies or with the Berkshire Safeguarding Adults Policy and Procedures. This meant staff could have used the incorrect information to manage allegations of abuse or neglect. People were at risk because steps for staff when dealing with safeguarding were not consistent throughout the service. Information for staff about how to be a whistle-blower and who to contact was only displayed in the staff room of the basement. Whistleblowing information in the staff room was out of date and not detailed enough. For example, if a whistleblowing allegation was about the manager of the service, there was no information about who to contact in this instance. Whistleblowing

information was not displayed in all four units of the service.

We contacted the local authority to obtain a list of safeguarding referrals they had received since our last inspection. We correlated this with information held at the service. We found there was a high number of safeguarding referrals about people who used the service. With further examination, we found many of the referrals did not meet the threshold for a safeguarding enquiry and were closed by the local authority after they noted the content. However, in the case of more serious allegations, the service could not show us what steps they had taken to investigate concerns and protect people from harm. When we asked the management of the service about this, they told us the former registered manager had continually stated there were no known issues. This meant people were not protected from abuse or neglect because the provider had not checked the accuracy of what the former registered manager had told them.

This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) 2014.

We found the service had safe deployment of staff that provided care for people. The service was able to demonstrate how they calculated minimum staffing requirements for each shift in each unit. We saw this was based on people's assessed dependency for care rather than on ratios. There was a dedicated staff member who reviewed the dependency assessments monthly and calculated the number of staff that were rostered. We noted the absence of a deputy manager or clinical lead in post, but were told that recruitment for suitable candidates was underway. We examined rotas for January and February 2017. We were concerned with the high use of agency staff within the service. We found that on some occasions, more than 25% of staff in a 24-hour period were agency staff. This meant that people did not always receive care from consistent staff familiar with their individual needs. We saw however that agency usage was slowly declining. The management team were able to tell us about their efforts to recruit permanent staff and about staff who had recently started or about to commence.

We found the service took steps regarding safer recruitment practices in line with the recommendation we made at our prior inspection. We examined recruitment procedures of recent staff who had commenced at the service. We found a consistent, safe approach in appointing new staff.

We checked the service's infection control and prevention systems. Our inspection team's observation of the premises was that it was clean and odour free. We spoke with the housekeeper and cleaners for the service. They were knowledgeable about infection control and prevention procedures. The housekeeper and cleaners were aware of the national colour coding scheme for cleaning materials and equipment in care homes. We observed throughout the inspection the cleaning staff followed the correct procedures when using mops, buckets and cloths for cleaning different areas in the service.

We noted that cleaners' trolleys were not lockable, and chemicals were stored on the top or side of the trolleys. The health and safety risk assessment for the management of chemicals at the service did not include that the chemicals were not locked away, and the potential risk of harm to people if they were to ingest any substances on the trolleys. We observed that cleaning staff had the trolleys close by to them when they performed their roles. However, at times we noticed that there was no direct supervision of the trolleys' content by the staff whilst they were busy, such as cleaning inside a person's bathroom. The housekeeper was able to show us safety data sheets for the chemicals that were in use. These were up to date and cleaning staff had the knowledge of how to readily locate the information. The folder the documents were kept in was damaged by fluids, and the housekeeper agreed that a better method was needed to protect the documents so they remained readable by staff.

We recommend that the service seek current guidance on risks associated with the use of chemicals.

We noted throughout the inspection that a number of staff wore jumpers or other clothing items with long sleeves in conjunction with their assigned uniform. This increased the risk for cross infection of illnesses between people who used the service, as microorganisms could contaminate the long sleeves and be passed onto others. We brought this to the attention of management during our visit.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection on 29 February 2016 and 3 March 2016 we found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because minutes of best interest decision meetings did not evidence any involvement from other health professionals or people's representatives. We also found best interest decisions were not reviewed for their effectiveness. We issued a requirement notice against the provider and requested an action plan. After our visit the provider sent us an action plan by the required deadline which stated the required improvements would be made by 30 September 2016.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

In the service's action plan dated 21 June 2016, the former registered manager wrote, "Where there is no involvement in decision makings (sic) we will be inviting residents', resident's relatives, care managers, advocates, social services and general practitioners to take part in these meetings." The service had set a date of 30 September 2016 to achieve compliance with the regulation. A high percentage of people who used the service were diagnosed with dementia. This meant some people were unable to make decisions for themselves. In line with the MCA and the provider's own action plan, best interest decisions were required for some people.

We obtained a list from the service of people who were unlikely or not able to make decisions on their own. We then looked at some of these people's care documentation. We found limited evidence that best interest decision making had either occurred or was appropriately documented. This meant decisions were made on behalf of some people without the relevant process in place. In people's files where we found best interest decision making was recorded, staff who were involved had not signed the documents to demonstrate the decision made for the person was the best outcome.

This is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with a number of staff about consent and mental capacity. In particular, we discussed this with

registered nurses who were responsible for the care provided each shift in all four units of the service. Overall, staff's understanding of the principles of consent and mental capacity was unsatisfactory. We found two staff members had a good knowledge of consent and mental capacity and were able to explain how the process worked. Other staff members displayed limited knowledge about the principles of the MCA, even when prompted by the inspection team.

We looked at how people provided various types of consent especially related to care. We noted the inclusion of consent to care form in some people's documentation, but were not able to locate it in all files we looked at. Due to the high number of people who lived with dementia at Larchfield House, many were unable to consent to care themselves or sign the form. When we looked at the forms, we found examples where relatives or other people had signed the consent forms on behalf of the person. Where the relative or other person was not an attorney or court-appointed deputy, the consent provided was not legally obtained or provided.

We reviewed the MARs and care plans for three people receiving medicines covertly (disguised in food or drink), including one person who was receiving their medicines and nutrition covertly via a PEG tube (a feeding tube used to deliver specialist liquid feeds when people cannot take food orally). We were unable to find best interest meetings for either person relating to medicines. The need for covert medicines had not been reviewed and there were no records when medicines were stopped and started in line with best practice.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In accordance with the MCA, the service appropriately made applications for DoLS when people's liberty was restricted. Examples of when this happened if the person had bed rails installed or the person was not free to leave the premises on their own. The service had appointed a senior care worker to manage the standard DoLS application process. In conjunction with this staff member, the administrator maintained a spread sheet of people's DoLS application; authorisation and expiry dates. We found the senior care worker and administrator had worked well together to ensure that referrals were made to local authorities for people who required DoLS authorisations.

Documentation related to the application and authorisation of DoLS required improvement. When we looked at records with the senior care worker, we found some relevant documents were only stored centrally, some were only stored in the person's care folder on the unit and a small number had the documents in both places. Without the documents in people's care folders on the units, staff were unable to read the content and understand any conditions of the DoLS. At the staff station on each unit, there was a list of people who had standard DoLS authorisations in place, but this did not detail what the authorised restriction was for or any conditions associated with it.

We recommend that the service provides on-going protected time for relevant staff members to fully coordinate the documentation associated with the DoLS process for all people.

People and their relatives gave various comments about their nutritional and hydration needs. A friend of one person attended the service every morning to assist them with their breakfast. They told us the food seemed plentiful and they noticed no weight loss. The visitor went on to comment, "They (Staff) give her cakes and bananas between meals." Other comments heard included, "There are plenty to drink during the day, tea, squash and biscuits. They (Staff) bring it around all the time. The food is good, there is a variety and there are set mealtimes", "He (family member) will refuse to eat sometimes but he is usually persuaded.

Mostly he eats whatever is put in front of him (the person told us the food was not as good as his wife's.) They keep sandwiches in the fridge for people if they are hungry. Drinks are offered regularly and there is always a jug of water in his room", "He (Family member) hasn't been eating very well. He has had a chest infection and has been on supplementary drinks", "She (Family member) does have problems chewing. I'm here 99% of the time and help her with her lunch", "The food is not good. Yes there are drinks throughout the day but food is tasteless and uninspiring" and "She (Family member) doesn't eat very much. She drinks a bit and mainly has smoothies and squash."

During the lunch period we observed some people waited a significant length of time to be served or to be assisted to eat their meals. One person was seated in the dining room 30 minutes before the first meal was served. Meals appeared to be served to most people and then if they required assistance, those sitting in the dining room received assistance first. During the lunch service a nurse undertook a medicine round. One person who was sat in the lounge appeared to struggle to initiate feeding themselves. Both their main course and their pudding were served to them at the same time at about 1.20pm and both dishes were left uncovered. Between 1.38pm and 1.55pm the person was provided with intermittent assistance by three different staff members. This assistance included the nurse who was undertaking the medicine round who stopped to assist the person for about five minutes in the middle of the medicine round. The meant people did not always receive appropriate support at meal times; food was not always presented in a timely manner and food temperatures were not always maintained.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people and their relatives felt staff were sufficiently skilled and experienced to provide care and support. We heard various comments such as, "Yes, I can find no fault with them (Staff)", "I don't know, they (Staff) are quite attentive", "Yes they (Staff) look after me very well", "Yes they (Staff) are (skilled and experienced), they do move around a bit. I know a few quite well", "Absolutely, no doubt in my mind. I am five minutes from the home, any problems they (Staff) will ring me", "Oh yes, they (Staff) are very good and helpful", "They (Staff) certainly seem to be", "Oh yes, they are very good and helpful" and "Not all of them (Staff), some lack anything other than basic skills."

The rate of staff training; supervisions and performance appraisals was inadequate. We looked at records kept since our last inspection to the date of this inspection. We found that in 2016, just 11 staff out of approximately 75 staff had completed a performance appraisal. There were a very small number of staff supervision sessions recorded; with some staff having none documented whatsoever. In January 2017, all of the cleaning staff had completed supervision sessions, but only two staff who cared for people had a supervision meeting. In February 2017 only one staff supervision was documented in the service's records. The service had completed a number of performance appraisals in February 2017. We noted the staff supervision matrix showed some planned performance appraisals for May but there were no scheduled supervisions for the entire period ending 31 July 2017. This meant staff did not receive the support they needed via supervisions and appraisals to perform their roles well, which could have reflected in the care people received.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also looked at the service's training matrix. We saw that staff were expected to participate in a range of training related to their roles. The service used computer-based learning, as well as practical training techniques. This included some mandatory topics like fire awareness, safeguarding older adults, moving

and handling as well as subjects to help support people's care such as dementia and challenging behaviour management. The provider showed us a copy of a training programme for the remainder of 2017 which covered a range of topics relevant to people's care.

Overall the training rate of staff that used computer-based learning was good. However, the rate of staff who completed practical training was unsatisfactory. We noted a large portion of staff who had no recorded fire training. This meant staff may not know what to do in the event of an emergency. In addition, nearly half of all staff had not completed basic first aid, health and safety or the management of chemicals training. Some staff who worked with people that needed assistance with eating and drinking had not completed food hygiene training. This meant people were placed at risk because some staff were not equipped with the necessary knowledge and skills to provide effective care.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to appropriate support from healthcare professionals. People and their relatives confirmed this. Comments included, "I think they come quite regularly. Staff took her (Family member) to the opticians. They arrange any appointments and would call a doctor if she was unwell", "He (Family member) saw the Parkinson's nurse a month ago. No he hasn't seen anyone else" and "The GP came in this morning." We saw evidence within people's care documentation of recorded visits and notes from GPs, dieticians, speech and language therapists and community mental health nurses. We found less information was retained within people's care documentation from health specialists such as opticians or dentists. This was because not everyone who used the service was seen by these healthcare professionals. People with dementia and who were not able to speak for themselves were reliant on staff organising appointments with various healthcare professionals.

Requires Improvement

Is the service caring?

Our findings

End of life plans were in place. We heard various comments as to whether people or their relatives had the opportunity to discuss their preferences in regards to end of life with staff. Comments included", "I don't know. She (person who used the service) may have done", "Not really. Hope I just go", "I'm not sure", "I don't know" and "Not as yet." Some relatives confirmed their family members had; do not resuscitate orders in place (DNR). This was supported by what was viewed in peoples' end of life care records. However, apart from the end of life care plans which identified whether people had DNRs in place or not we saw little or no information as to other aspects of end of life care such as people's preferences for burial and whether or not they had any specific requirement due to their religious beliefs.

We recommend the service seek current guidance on what information should be contained in end of life and advance decision care plans.

During our visit we observed some good interactions with staff and the people they cared for. For instance in one unit we saw a person was highly distressed who expressed this by screaming out loud. A staff member was observed patiently speaking to the person in a calm and reassuring voice which eventually caused the person to settle down to a point where they were able to explain what had upset them. However, in another unit we heard a person shouting and crying out in an indistinguishable language. We noted no members of staff took any notice of the person although there were several staff present in the lounge and dining room. In one unit we observed staff assisted people with their meals in a caring manner and talking with people whilst carrying out this task but in another unit, although there appeared to be enough staff in both dining and lounge areas, people were seated either sleeping or were seated with minimal interaction with the staff who were present. This was also observed during the breakfast period where several people were being supported with the meals. This meant people were not consistently treated in a caring manner.

People and their relatives spoke positively about the caring nature of staff. We heard a variety of comments such as, "On the whole most of them (staff) are quite caring. Never really thought about it", "They (Staff) are friendly, approachable, very caring and considerate", "They (Staff) are very kind and caring, if you ask for anything they do it, they start a sentence with, ' I know you like…", "Oh yes, they (Staff) take care of her and love her. It is very much a home from home", "Certain ones (Staff) are (Caring). A lot of them are here just to work", "I think they (Staff) are. I feel it is time I went (implied they had lived too long). One of the male carers is very good. He will find me a pretty top to wear. I was a tailor and a PT instructor in my youth"; "I find them (Staff) friendly helpful and polite. (Family member) spends most of their day in the day room. Staff try to interact with them but they're quite deaf and don't communicate", "Very much so, in their manner and the way they talk to (Family member) and "Most of them are fine."

People and their relatives felt staff who provided care and support had a good understanding of their care needs and knew them well. We reviewed a record of acknowledgement by a relative in regards to a care plan meeting held with staff on 22 September 2016. The relative commented, "I would like to say a special thank you to [Name of staff] who has taken a lot of time getting to know my father and understand his way." This was further supported by our discussion with staff who explained what people's care and support needs

were and family histories. Care records for the people referred to confirmed what staff had told us (we noted peoples' family histories were not consistently recorded in their care records).

People and their relatives said they were involved and supported in planning and making decisions about their care. Comments included, "I make the decisions but we make them together if you understand", "Yes at the moment my cousin deals with all my finances. I am capable of making decisions about my care. For instance, they (Staff) know I prefer to be in my own room and respect that", "I am solely responsible for his (Family member's) care. Yes they (Staff) discuss things with me. He is quite lucid at times but not always", "I am her (person who used the service) advocate. Although we involve her I make decisions about her care", "As her next of kin I make decisions on her (Family member's) behalf. She is no longer able to express her views" and "I have had a couple of care plan meetings which have resulted in his care package being escalated." We found evidence of people or their relatives involvement in decisions in regards to care documented in care records however, this was not consistently recorded.

People and their relatives said they were treated with respect and their dignity was preserved. Comments included, "She (Family member) has help in the shower and to change her pads. They (Staff) always close bathroom door. She is dependant on them for her cleanliness and they give her privacy if she wants it", "Very respectful. They (Staff) always call him (family member) and me (relative) by name and keep him covered when giving him personal care and keep doors closed. "I have a bed bath and all the doors are closed and they put a poster on the door so no one comes in." This was supported by staff members. We heard comments such as, "Every time personal care is being administered, a sign has to go on the door. This prevents anyone from walking in whilst the door is closed." This was observed during our visit. Care records instructed staff how to ensure people's dignity and privacy were protected when personal care was being carried out.

The service had signage displayed which showed 'The Dignity Do's'. This outlined what the service did to ensure people received high quality services that respected people's dignity. For instance, the service had zero tolerance for all forms of abuse; to treat people as individuals by offering a personalised service. The home had two dignity champions. We spoke with one of the dignity champions who told us they had attended training that covered areas such as how everyone should be treated as individuals and how people's choices and rights should be taken into consideration. However, the staff member stated the dignity champions were not as yet providing support to staff.

We recommend the service make use of their dignity champions to ensure staff know how to staff apply dignity and respect to their work practice.

Requires Improvement

Is the service responsive?

Our findings

Pre-assessments were carried out to determine peoples' care and support needs. This ensured care delivered was centred on peoples' individual needs. We noted some peoples' pre-assessment information were not available in all the care records viewed. We were told by staff they had been archived in order to create space in peoples' care records. However, this made it difficult for us to establish if the care delivered was responsive to peoples' needs as we could not determine whether care plans were developed based upon their wishes and specific care needs. We brought this to the attention of management.

Some people and their relatives felt the service delivered care and support to meet their specific needs, whilst others felt this was not their experience. Comments included, "They (Staff) take care of me very well", "Yes I believe so (the service meets their specific needs)", "It's not too bad, they (Staff) will use antiseptic wipes on his face when he is eating", "There are often little problems, nothing major. I never go without anything but it could be better. I would like to have a good shower more than once a week", "We had to ask to see the GP. Although staff had been in to see him they hadn't recognised that he was unwell. They don't take things seriously"; "I am not often showered due to the number of people. I can manage to wash and dress myself, but need help in shower" and "I haven't seen a GP so far but have complained about my eyes and ears. I asked to see GP a week or so ago but not seen him so far. I don't think they have taken notice." Whilst seated in the nursing unit we heard a nurse speaking to another staff about the person's ears. The nurse proceeded to make a call to the GP. However, we did not know if the person had received an update as to the result of the telephone call.

Peoples' choices were restricted in regards to various aspects of care. On the first day of visit we were informed by a member of the management team that all showers were not permitted to be used due to building works. On the second day of our visit we learnt that this was due to the detection of Legionella in the service's water system (however, this had not been communicated to people or their relatives). This meant people's preferences were not always met.

Care records did document people's care and support needs and instructed staff how to carry them out. There were records for various aspect of care delivered for people's specific needs. For instance one person had a history of strokes, the care record documented the signs staff should look for associated with strokes. Reviews of care were undertaken. We received mixed feedback from people and their relatives with some confirming they had attended a meeting whilst others did not know if their care plan had been updated. We found reviews of care meetings were not carried out consistently. We noted there were no records to confirm reviews of care meetings had taken place in 2016 for some people and no indication of subsequent meetings booked for them in 2017. This meant people could not be confident the service would respond appropriately to any changes in their care needs.

People had a range of activities they could be involved in. People who attended the activities (whether in a group setting or on a one to one basis) were positive about their experience. For instance, one person commented, "I don't like to get involved with other people. I have a one to one with the activity girl." We observed the activity co-ordinator whilst they carried out a session. We saw good interactions between them

and the people they engaged with. The activity co-ordinator told us they spent the first part of the mornings gathering people to get them involved in the scheduled activity. On day one of our visit we observed an 'arts and crafts' activity and on day two, 'music and movement'. Care records reflected people's leisure and lifestyle choices. These documented people's hobbies and interests and how staff should support them. This showed the service improved people's social wellbeing and prevented social isolation.

People and their relatives said they knew how to raise a complaint. We heard mixed views on whether they thought their complaints were satisfactorily resolved. Comments included, "No (Had not made a complaint) but I would bring things to their (Staff's) attention if necessary", "Yes (Had made a complaint), mainly about the showering problem. Nothing has changed", "Not had to so far but I would have no hesitation if I needed to", "Only once when he (Family member) wasn't being shaved and about his laundry. It was addressed and is all sorted", "Only about the laundry. Mum likes nice soft things and they wash everything too hot, so I take her laundry home", "Just about calling a doctor. They (Staff) don't take anything seriously"; "I was soaking wet this morning. They (Staff) made me comfortable again", When we have brought up a concern or complaint it has always been dealt with, explained and corrected", "There has never been a need" and "Just about seeing a doctor, nothing has materialised thus far."

Staff told us they would first try and resolve any concerns raised but if this was not possible, they would refer people or their relatives to senior staff. We reviewed the service's complaint register and saw no evidence of the concerns people had spoken to us about documented. This showed when people raised complaints to staff these were not always documented.

The service had a complaints policy and procedure in place. A poster of the complaints policy was displayed in the reception area however, because it was situated very high up on the wall, it was not clearly visible. Throughout the units we saw no clear signage displayed in an easy read format on how people should raise concerns. This meant people were not always given information in a format they could understand.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our previous inspection on 29 February 2016 and 3 March 2016 we found breaches of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff did not follow policies and procedures in regards to recording medicines and reporting medicine errors. The service did not ensure there was sufficient details in care plans to enable staff to care for people. Systems and processes that enabled the service to identify and assess, monitor and mitigate risks to people's health, safety and welfare were not consistently effective. We issued a requirement notice against the provider and requested an action plan. After our visit the provider sent us an action plan by the required deadline which stated the required improvements would be made by 30 September 2016.

During our most recent inspection we found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 and continued breaches in Regulations 9, 12, 17. Over the last three years of inspecting the service we found the provider's compliance with the regulations has progressively deteriorated.

Before our visit we were notified by the Local Authority of a safeguarding incident that related to a medicines error. We spoke with the registered manager to establish what had occurred and they provided us with the relevant information. We attended the Local Authority's 'Serious Concerns' meeting on 31 January 2017 and found the service had not worked in line with its medicines policy and procedure and safeguarding policy and procedure. During this visit we saw no documentary evidence or analysis about any shared learning from medicine incidents.

Care records still lacked important information to ensure people's welfare and safety. This was evidenced in nutritional records, medicine records and risk assessments, best interest records. For instance, nutritional records lacked important information relating to prescribed thickeners. Staff incorrectly completed people's nutritional assessment which resulted in significant weight loss not being identified. Medicines were stored securely and were within their recommended temperatures. Information to support the administration of medicines was available, however lacked sufficient detail. Best interest meetings were not documented prior to administering medicines covertly.

Information contained in completed nursing risk assessments showed some people were at high risk for injuries that could be avoided or mitigated, such as falls. However, nursing staff had not satisfactorily detailed in the care documentation what steps were implemented to reduce the potential risk of such injuries. For example, one person's risk of falls was assessed as rising from low to high over a short period of time. The entry in the records stated to reduce the risk of the person falling, there should be 'constant monitoring and review'. No other examples of how the person's risk of falls were considered or arranged. A number of other nursing interventions could have been arranged for the person to reduce their risks. This meant records relating to care and treatment were not always fit for purpose.

This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the service's systems and process to see if they were robust in their assessment, monitoring and mitigation of risks to people's health, safety and welfare. We found these systems remained ineffective. For instance, the service had not considered the high number of falls by people as an area of concern which required relevant action to prevent further harm. There was no evidence that common causes of people's falls was assessed or mitigated. For example, there were no referrals to community falls assessment teams, the consideration of changes in people's medicines, referrals to occupational therapists or physiotherapists. The service had failed to ensure that a robust system was in place to prevent and reduce people's rate of falls.

Risks to people who used the service were not continually monitored and appropriate action was not taken in a timely manner. This was evident in how the service dealt with the servicing of the lift and the detection of Legionella. This meant people continued to be placed at risk of harm or sustain harm when appropriate action could have been taken to reduce injuries.

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

The service had a 'Clinical Governance Policy and Procedure'. This outlined the service's objectives which included ensuring evidenced based care was used to continually improve quality; to review and learn from adverse events, complaints and to ensure auditing and managing of clinical governance issues were effective, robust and clear. We found the service did not work in line with this policy. Regular audits were undertaken by the service. The home showed us their four most recent medicines audits. The home's community pharmacy had undertaken a medicines audit within the last six months. However, an action plan had not been developed and implemented in response to the community pharmacy's audit nor had the home's audits identified the concerns we found during this inspection. Care plan audits were undertaken; we saw evidence of these in people's care records. We noted these audits failed to identify the concerns we had found during this visit.

Staff who cared for people at the service reported incidents and accidents appropriately. Staff used the accident report book to complete details of events, and then provided the form to the management team of the service. We found that the incident and accident reports were filed accordingly and examined the content. We noted no evidence of management reviewing the content. When we asked the management about this, they could not provide us with evidence that investigations had taken place for serious events. A consultant had compiled a list of the incidents and accidents since the commencement of 2016. The list showed a high frequency of falls with people unexpectedly found on the floor by staff. We saw it was documented that some people had sustained no harm, but others had experienced bruising, bleeding or required GP or hospital visits. This showed the service did not analyse; respond to information gathered and take appropriate action to ensure peoples' welfare and safety.

Information gathered by the service was not effectively analysed and used to drive improvement to the quality and safety of the service and the experience of people who engaged with the service. There were no records to show outcomes of learning. This was evident when we reviewed the complaints register; safeguarding incidents and the 'Relatives and Residents' survey dated January 2017.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services are required to notify us of certain incidents about people's care 'without delay'. These are sent to us via statutory notifications. We were concerned that we received a large volume of notifications from the

service shortly before our inspection. We examined the content of notifications sent to us since our last inspection. We found the service had failed in multiple ways to follow the requirements set for reporting incidents about people's care to us. The service had not sent all necessary notifications to us. This particularly applied in situations where a safeguarding allegation was raised about a person and when a standard DoLS authorisation was approved by a local authority. When we spoke with one staff member about why the notifications were not sent they told us, "The (former) manager told me not to send them. I knew this was incorrect."

We checked the dates of serious injury notifications received from the service and compared them with the date the injuries had actually occurred. Since our last inspection we had received 11 notifications for serious injuries. Out of these notifications, seven were delayed reports, two of which were reported more than six months after the injury had occurred. This meant the service had not reported serious injuries in a prompt manner and that people were at risk because we were not informed in a timely manner.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Services are required to comply with the duty of candour regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' in relation to care and treatment. It also sets out some specific requirements that services must follow when things go wrong with care and treatment. This included informing people about the incident, providing reasonable support, providing truthful information and providing an apology (including in writing).

At the time of the inspection, the service had an appropriate duty of candour policy in place. The document set forth clear steps for the management to follow when the duty of candour requirement was triggered by safety incidents. However, we found that Larchfield House had failed in the duty of candour requirement. No training was provided to the management or staff about duty of candour and how to undertake steps required after 'notifiable safety incidents'. Since our last inspection there were safety incidents where the duty of candour process was required at the service. Examples included one person who sustained a fractured hip from a fall, and two people who developed pressure ulcers. The service had reported to us in statutory notifications of the events that duty of candour was used. When we asked for evidence that the service had used duty of candour in relation to these safety incidents, they were unable to provide this. This meant that people who used the service, and others, had not received information or apologies when they were involved in relevant safety incidents.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services are required to display our prior inspection ratings conspicuously, both within the building itself and on any website they use. At the commencement of this inspection, we were unable to locate the ratings poster from our previous inspection within the building. The inspection team asked the management to demonstrate the presence of the ratings poster. We were told it was in a folder on a desk where visitors signed on upon arrival to Larchfield House. When we checked the folder, the ratings poster was not present. Instead a copy of our last report was printed out. In addition, we checked the provider's website for evidence that our previous inspection ratings were available to the public. The website failed to display the rating, our website address or provide a functional link to our last inspection report.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service has had several changes in management over a short period of time. The registered manager had left the service before we visited and the provider appointed an interim home manager, who was present throughout our visit. We spoke with people and their relatives in regards to their views about management and leadership of the service. We found some people and their relatives were aware of the change of management but others were not. We heard comments such as, "It is very good. It changed in June last year. The man in charge is very nice, genuine. First class." and "They are very good. I would give them a gold star for how the place is run." Although the home manager was able to introduce themselves at a 'relatives and residents' meetings, we noted not everyone who used the service was in attendance. This meant where there were significant changes that affected people who used the service the provider did not have effective systems to communicate with them.

Staff said management were always visible and accessible. Some staff spoke about the change in management. We heard comments such as, "We need a strong manager, deputy manager and clinical lead. We could be doing better at the moment."

Staff team meetings and 'residents and relatives' meetings were undertaken regularly. One staff member commented, "They (Management) give us information and ask us for ideas for working better." We noted team meetings documented quality assurance was discussed with staff. Minutes clearly recorded staff member's input into the meetings. This was also evident in 'residents and relatives' meetings. One relative commented, "I did go to a residents meeting. Things were definitely addressed when [Name of former registered manager] was about."

People and their relatives felt they could provide feedback about the service. Comments included, "Yes I have filled in various comment forms and yes they (management)" and "I have a meeting with [Name of staff] to check how I am settling in." This meant people; their relatives and staff were encouraged to provide feedback about the quality of care provided and overall involvement with them.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The service had not reported serious injuries in a prompt manner and CQC were not informed of these events in a timely manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff members displayed limited knowledge about the principles of the MCA. Where the relative or other person was not an attorney or court-appointed deputy, the consent provided was not legally obtained or provided. The need for covert medicines had not been reviewed and there were no records when medicines were stopped and started in line with best practice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People did not always receive appropriate support at meal times; food was not always presented in a timely manner and food temperatures were not always maintained.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints When people raised complaints to staff these were not always documented. Information on how to raise a complaint was not given in a format people could understand.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA RA Regulations 2014 Duty of candour People who used the service, and others, had not received information or apologies when they were involved in relevant safety incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People were placed at risk because some staff were not equipped with the necessary knowledge and skills to provide effective care.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care We found limited evidence that best interest decision making had either occurred or was appropriately documented. This meant decisions were made on behalf of some people without the relevant process in place. Staff who were involved had not signed the documents to demonstrate the decision made for the person was the best outcome.

The enforcement action we took:

Imposed a condition on the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were placed at risk of medicines errors, because the service did not regularly ensure staff responsible for handling medicines was effectively skilled to perform the task. Medicines to manage behaviour that challenged did not describe when to use the prescribed medicines. People were placed at risk of harm because their nutritional needs were not accurately assessed and were carried out by staff who did not have the skill or knowledge People were at significant risk of choking because information contained in 'Choking and aspirating' risk assessments were unclear, contradictory, not kept up to date and staff did not always follow instructions when preparing thickeners.

We found a number of risks to people from the building and equipment were not satisfactorily managed.

The enforcement action we took:

Imposed a condition on the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service could not show us what steps they had taken to investigate concerns and protect people from harm.

The enforcement action we took:

Imposed a condition on the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Records relating to care and treatment were not always fit for purpose. People continued to be placed at risk of harm or sustain harm when appropriate action could have been taken to reduce injuries. Systems in places to monitor and asses the service was ineffective.

The enforcement action we took:

Imposed condition on the provider.