Community Integrated Care

Eccleston Court Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place over two days and was unannounced on the 1 June 2017, and announced on the 2 June 2017. The last inspection was completed in May 2015 and was awarded a rating of 'good'.

Eccleston Court is registered to provide nursing and personal care for up to 54 people with physical health needs, or people living with dementia. At the time of the inspection there were 45 people using the service. The service consists of two units, one of which provides nursing support to people who primarily have a physical health need and another that provides nursing support to people living with dementia.

At the time of the inspection there was no registered manager in post within the service. The previous registered manager had left in December 2016. A new manager had started within the service, just prior to the inspection in May 2017.

During the inspection we identified breaches of Regulations 10, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We are taking a number of appropriate actions to protect the people who are living in the service.

People within the service were not always safe. It was standard practice for sluice rooms in one unit to be left unlocked which placed people at risk of harm through coming into contact with hazardous materials. Fluid thickener was kept unsecured in people's bedrooms, which can pose a risk of death if ingested inappropriately. Cupboards containing cleaning materials and alcohol had been left unlocked in the kitchenette in one unit, and staff did not know where the keys were to secure these. An oven was being used to cook people's food in a communal area, and adequate action had not been taken to address the risks around this following a 'near miss' incident that had occurred a short time prior to the inspection visit. This showed poor risk awareness.

People were not always treated with dignity and respect. Staff did not always work in a person-centred way, and we observed examples where people living with a sensory impairment were treated in an undignified manner. People's family members did not always feel welcome within the service, and some of them commented that they felt there may be reprisals from making a complaint. Staff took their breaks in communal areas; these areas were meant for people using the service, which gave the environment a feel of being oriented to meet the needs of staff rather than the people they cared for.

Staff did not have up-to-date training in areas needed for them to carry out their role effectively, and supervisions and appraisals had not been completed. Staff did not always demonstrate a good knowledge around health and safety, or person-centred care which demonstrated a lack of training in these areas.

Care records did not always contain accurate and up-to-date information about people's needs, which meant that relevant information was not available to staff around how to support people. Staff did not

always fill in daily monitoring charts correctly. For example one person's nutritional monitoring chart incorrectly recorded that a person had eaten their porridge, however we observed that they had, in fact not eaten this.

People's confidentiality was not protected. Staff spoke without discretion about people's needs in communal areas, and personal information was not stored securely. Staff confirmed that handovers took place in a communal area, during which personal information about people's needs was openly discussed.

Audits were not being completed by the service. For example, an analysis of information relating to care records, accidents and incidents, pressure wounds had not been undertaken which meant that trends and patterns could not be identified. The registered provider had completed a quality monitoring visit, which had identified areas that required improvement. However, we found that this process had not picked up on other issues. We also found that whilst action had been taken to address some of the issues identified, other areas remained unaddressed, for example staff training.

The registered provider had failed to take the required action in relation to a safeguarding concern as required by the local authority. This had been a recurring safeguarding concern relating to one person, which had occurred four times since December 2015. This showed that lessons had not been learnt, and demonstrated that the registered provider had failed to comply with the local authority's safeguarding procedure.

People commented that they enjoyed the food that was available. We observed mixed examples of good and poor practice by staff during meal times. In one unit staff were attentive to people's needs during meal times. However in the other unit staff were having discussions between themselves, and ignored the needs of one person with a sensory impairment. Catering staff did not have a good knowledge of people's dietary needs, and had failed to ensure diabetic options were available for people's desert.

Mental capacity assessments had been completed for some people and not others. Where people required their medication to be administered without their knowledge, a mental capacity assessment had not been completed and a best interests decision made. We have made a recommendation to the registered provider around ensuring they are compliant with requirements of the Mental Capacity Act 20015.

People received their medication as prescribed. The registered provider had successfully identified some issues around medication and made efforts to make improvements. We checked a sample of seven people's medication and found the stock levels to be correct.

Activities and entertainment were provided to people to help keep them entertained. There were two activities co-ordinators in place to support people, and we observed examples of them doing arts and crafts and spending time with people on a one-to-one basis. However family members of those people living with dementia commented that they did not feel there was sufficient social stimulation for their relatives and that they spent a lot of time in bed.

We observed some examples of good practice amongst staff, where they were attentive and supportive of people. One member of staff showed us that they, along with a colleague made small gifts for the family members of people who had passed away within the service. This demonstrated an example of compassion by some members of staff.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Parts of the environment posed a risk to people. This showed a lack of adequate risk analysis.

Risk assessments were not always completed to ensure people were protected from the risk of harm.

The registered provider had taken action to improve the medication process, and people were receiving their medication as required.

Is the service effective?

Requires Improvement

The service was not effective.

Staff had not received the training they needed to carry out their role effectively.

People did not always receive the support they needed at meal times, and catering staff did not always have a good understanding of people's dietary requirements.

Mental capacity assessments had been completed for people in some situations, but not others.

Is the service caring?

Inadequate

The service was not caring.

People were not treated with dignity and respect, and the rights of people living with a sensory impairment were not upheld.

People's family members did not always feel welcome within the service.

People's confidentiality was not protected.

Is the service responsive?

Inadequate

The service was not responsive.

Care records did not always contain accurate and up-to-date information.

There was a complaints policy in place which people's family members had made use of.

Activities were available to people and we saw examples where people were engaging in these.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager in post, and people did not always know who the manager was.

There was not a positive culture within the service to ensure the delivery of person-centred care.

Audit and quality monitoring systems were not always being completed, or effective at identifying and making improvements within the service.

Eccleston Court Care Home

Detailed findings

Background to this inspection

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

The inspection took place on the 1 and 2 June 2017 and was unannounced on the first day, but announced on the second day.

The inspection was carried out by one adult social care inspector.

Prior to the inspection we contacted the local authority who raised a number of concerns relating to management issues within the service. We also reviewed information on our system, including notifications from the registered provider. The provider had also completed 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 reviewed this prior to the inspection to plan how the inspection should be conducted.

During the inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we spoke with three people using the service and four people's family members. Following the inspection two people's family members contacted us to give us their views of the service, and we contacted another family member by telephone. We looked at nine people's care records, and looked at the recruitment records for four staff. We spoke with six staff, the manager, deputy manager, and one of the registered provider's quality monitoring officers. We also made observations relating to the interior and exterior of the premises. We looked at records relating to the day-to-day running of the service, for example audits and maintenance records.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe within the service. One person who was unable to communicate verbally nodded when we asked if they felt safe, whilst another person commented, "Oh yes I feel safe here". People's family members gave mixed views about their relative's safety within the service. One family member commented, "Yes, I would say [my relative] is safe here", whilst another family member commented, "Sometimes I feel I have to be on my toes. There was an occasion where staff tried to give [my relative] solid food, when they need pureed food". Another family member commented, "I just don't feel like I can switch off. I constantly need to check on [my relative]. I don't have confidence in the support being provided". Another two people's family members also commented that they felt they needed to check to ensure their relatives were safe and well. We raised these concerns with the manager and deputy manager so they could act upon them.

The environment was not always safe. In one unit we identified that the sluice room was being left open. This was a health a safety risk as the sluice room contains hazardous waste materials that may cause people harm. In addition, water temperatures in sluice rooms are kept at higher temperatures to support with cleaning which poses a risk of scalds if these rooms are not kept secure. We asked two members of staff to lock this door, neither of whom took action try and do this. One member of staff told us they did not have a key, whilst another commented that it needed to be left open and told us it did not pose a risk to people. This member of staff also told us that the sluice room was never locked. We raised this with the manager and deputy manager who informed us that the lock was broken. They acted immediately to get this fixed. They told us that appropriate infection control procedures would be discussed with staff. Following the inspection we raised this with the community infection control team who confirmed that sluice room doors should remain secured to ensure people were protected from harm.

Fluid thickener was not stored appropriately. Thickener is used to alter the consistency of people's fluids where they have difficulty swallowing. This needs to be stored securely as it can result in death if people ingest this inappropriately. We found three examples where this was being kept unsecured in people's bedrooms. We raised this with a member of staff who did not agree that the current process posed a risk to people. We did not feel confident that this member of staff would act to place the thickener in a safe place, and therefore asked that the manager take immediate action to ensure all thickener was stored safely. On the second day of the inspection we checked that this had been done and found that it had. The manager made information relating to the risks associated with thickener available to staff immediately. Staff were in the process of signing to indicate they had read and understood the information available.

The kitchenette in one unit was accessible to people. Cupboards in the kitchenette were left unsecured and contained dishwasher tablets, cleaning detergent and three bottles of alcohol. This posed a hazard to people living with dementia who might be at risk of ingesting these during episodes of confusion. The kitchenette was unclean, with dirty dishes left in the sink. The inside of the cupboards were dirty and in need of a clean. We spoke to staff who told us they did not know whose responsibility it was to clean the kitchen, telling us it was a "grey area". Staff did not know where the keys to lock the cupboards were, however these were found later in the day and the cupboards secured.

In one unit a portable oven was being used to cook people's meals. This was placed in the communal area on a daily basis and staff told us this was left on for approximately ninety minutes per day. The placement of an oven in a communal area posed a risk to people living with dementia. An incident form completed by the manager showed that there had been a "near miss" incident on the 12 May 2017 during which a person had knocked a casserole dish off the oven, and was found holding onto the oven. This incident report also stated that another person had been found walking towards the oven at the same time. This had occurred whilst staff had been out of the communal area. The incident report stated that immediate action had been taken to ensure that one member of staff remained in the communal area whilst the oven was in use. However, on speaking with staff and the manager they agreed there may be occasions where they were not able to remain in the communal area, for example in the event of an emergency. During the inspection visit a new process was put in place whereby the oven was placed in a secure room whilst cooking people's food, and then brought back into the communal area when food needed to be served. However on the second day of the inspection the oven was again being used in the communal area. The deputy manager ensured this was moved, and told us the agreed process would be followed in the future.

Risk assessments were not always completed. For example malnutrition risk assessments were not being completed for those people who were at risk of losing weight. Weights were being monitored on a monthly basis and a majority of people had been referred to the relevant health professional where it was identified that they were at risk. In one example however we identified that one person had lost eight kilograms in weight over a period of four months. This person had not been referred to a dietician, or their GP to establish the cause of this. A referral was made immediately to the person's GP after we raised this with the deputy manager. The deputy manager told us that malnutrition risk assessments would be completed in the future, and had developed a new form which required staff to complete this after taking people's weight.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not always protected from the risk of harm, and health and safety procedures were not always robust.

Staff did not have up-to-date training in safeguarding vulnerable adults. However, staff demonstrated that they would be able to identify the different kinds of abuse and how to report their concerns. Staff were familiar with the process of reporting concerns inside and outside the organisation, for example to the local authority, CQC or police. This helped protect people from the risk of abuse. The manager told us that staff would receive training around this.

There were sufficient numbers of staff in post to meet the needs of people using the service. People's family members commented that there was a high use of agency staff being used to fill nursing posts, which the manager confirmed. The manager told us they were in the process of trying to recruit permanent staff, however in the meantime they were trying to use the same agency staff where possible to help develop familiarity between people and staff using the service.

We looked at the recruitment records for four members of staff. These showed that staff had been required to provide two references prior to employment, one of which was from their most recent employer. A check by the disclosure and baring service (DBS) had also been completed. A DBS check informs employers if prospective employees are barred from working with vulnerable adults, or have a criminal record. This helps employers make decisions about the suitability of potential staff for the role, and helped protect people from the risk of abuse.

People were supported to take their medication as prescribed. 'As required' (PRN) protocols were in place for people who required their medication 'as and when', for example when experiencing episodes of pain.

We looked at a sample of seven people's medication to ensure the correct quantities were being kept and found that they were. The registered provider had recently identified that reviews of those people taking their medication covertly had not been taking place. They had taken action to ensure this was done. Covert medication is where people's medication is 'hidden', for example in their food or drink, because they may not be compliant with taking these. These had recently been reviewed and authorised by the GP. Medication administration records (MARs) were being signed by staff, which showed that medication was being given as prescribed. Following the inspection we were contacted by a person raising concerns about medication which we forwarded to the local authority so they could investigate.

Checks were completed on equipment and some parts of the environment to ensure they were safe. Water temperatures were monitored on a monthly basis to ensure these were kept within the required temperature range. This minimised the risk of people scalding themselves, and also helped mitigate the risk of harmful bacteria infecting the water supply. A legionella risk assessment had been completed, and the water had been checked to ensure it was free from harmful bacteria. Water outlets were also flushed on a weekly basis.

A weekly check of the premises was carried out which included an inspection of fire doors, testing fire alarms, emergency lighting and fire fighting equipment. Fire extinguishers had also been serviced in December 2016 to ensure they were in working order. Personal emergency evacuation plans (PEEPs) were in place which outlined to staff how people should be supported in the event of an emergency. This helped ensure people would be protected in an emergency.

Requires Improvement

Is the service effective?

Our findings

People commented that they found staff to be good at their job. One person told us, "They're marvellous", whilst another person nodded to show that they felt safe. The views of people's family members were mixed. One family member told us,"[My relative] has thrived here", and another commented, "Staff are good at caring for [my relative]". Other family members told us, "The nursing staff have changed so much it confuses [my relative]. There's a risk they will provide the wrong support", whilst another three family members told us that staff interactions with their relatives were poor.

Staff had not received the training they needed to carry out their roles effectively. For example training records for support staff showed that nine staff had not completed safeguarding training since 2014 and 22 had not completed this since 2015. Only nine staff had completed fire safety training. 11 staff did not have up-to-date moving and handling training, and no staff had completed dementia training. Observations and discussions with staff showed that not all staff had a good knowledge of health and safety, or person-centred care. The manager, deputy manager and a representative from the registered provider confirmed that training is an area that needs improvement, and that staff will be receiving the training they need.

New staff confirmed that there was an induction process in place which took place over a period of two weeks. This consisted of a period of shadowing experienced members of staff, and four days of training which covered areas such as moving and handling, safeguarding vulnerable adults and first aid. The induction process was aligned to the standards required by the Care Certificate. The Care Certificate is a nationally recognised set of standards that care staff are required to meet. This helped ensure that new staff were prepared for their role.

Staff supervisions were not being completed. This was confirmed by both staff and the manager. This had been highlighted as an issue in a quality monitoring visit that was completed by the registered provider in March 2017. The manager confirmed that there was a plan in place to ensure all staff received supervision. Supervision enables management to monitor staff performance and address any performance related issues. It also enables staff to discuss any development needs or raise any issues they may have. Appraisals were also not being completed. These are used to set goals for the year ahead to ensure staff are supported to develop within their role.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because the registered provider had failed to take action to ensure that staff had the skills and knowledge they needed to carry out their role.

Catering staff did not all have a good knowledge of those people with special dietary requirements. One family member also gave an example where staff had attempted to give their relative solid food, where they required a soft food option due to the risk of choking. We spoke with a member of catering staff did not know which people required a diabetic diet. We subsequently identified that no diabetic desert option was available for those people who required a sugar free option. After we raised this, those people living with diabetes were offered a banana for desert. This was poor practice as it increased the risk of someone

receiving meals that did not meet their needs, which may place them at risk of harm.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because people were at risk of receiving an inappropriate diet which may cause them harm.

People told us that they enjoyed the food that was available. One person commented, "The food is very nice. You get offered different things and there's a lot available", whilst another person told us, "Yes, the food is good". We made observations on the support that was given to people during meal times and found that the standard of this support varied. On one unit the staff sat supporting those people who needed their help. They were attentive and chatted to people whilst doing this, and there was a positive atmosphere. On another unit however, staff were less person-focussed in their approach, and the meal time experience was not as positive, for example staff chatted amongst themselves and did not always pay attention to the people they were caring for.

Some people's family members told us that they did not always believe staff gave their relatives the support needed during meal times. They also commented that they did not believe that their daily intake was being accurately recorded on dietary monitoring charts. In one example we observed a person had not eaten their porridge, however it had been recorded on their chart that this had been eaten. This person's family member raised this with staff who subsequently replaced this meal time chart to reflect that this person had not eaten their porridge.

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).

Those people who required a DoLS had one in place, and the manager demonstrated a good understating of the MCA. Not all staff had completed training in the MCA, and they did not always understand their roles and responsibilities in relation to the Act. However they were able to give appropriate examples around giving people choice and control over their care.

Mental capacity assessments had been completed for some people; however we identified examples where these had not been done. For instance, where people required their medication to be administered covertly a mental capacity assessment and best interest decision had not been completed to determine whether they had capacity to consent to this or not. We raised this with the deputy manager for them to rectify.

We recommend that the registered provider seek advice and guidance from a reputable source regarding meeting the requirements of the Mental Capacity Act 2005.

Because of our concerns we reviewed people's weights to ensure that these were being maintained. In a majority of cases people who were at risk of malnutrition had seen an increase in their weight which demonstrated that people's nutritional intake was adequate. We have reflected our findings around the meal time experience for some people within the 'caring' domain.

Examples were available where people had been supported to access support from health professionals such as their GP. In examples where people were at risk of repeated falls, they had been referred to the relevant health professionals, for example occupational therapist, physiotherapist or their GP to ensure they received the correct support. This helped ensure that people's health and wellbeing was maintained.

Inadequate

Is the service caring?

Our findings

Whilst people commented positively on staff, other comments were not as positive. People's comments included, "Staff are respectful and nice", "They are very nice" and "Staff respect my privacy". People's family members gave mixed views on staff. Some family member's comments included, "Staff are all very dedicated", "Staff are amazing", whilst others commented, "I'm worried if I complain that I might not be let in to visit my friend", "The other day staff were laughing at [my relative] whilst they were confused. It made me so upset to see" and "I'd rather not comment on how welcome they (staff) make me feel". One family member contacted us following the inspection to raise concerns regarding the dignity and respect given to their relative by staff. During the visit, we made observations on staff interactions with people which caused us concern.

People were not always treated with dignity and respect. During the inspection one member of staff laughed whilst we were speaking to a person experiencing episodes of confusion, telling us "good luck" and "good luck getting away". They did this in front of the person, which did not demonstrate a person-centred or caring approach. We observed poor practice during one meal time where a member of staff told a person with a visual impairment to open their mouth for a spoonful of food. However this staff member then put the spoon down and walked off without telling the person who remained sat there with their mouth open. Another member of staff then came to support this person, only for the original member of staff to come back and start having a conversation with them over the person's head. This was poor practice as this person was dependent upon verbal cues, which were being disrupted by the conversation being had between the two staff.

Staff did not always treat the environment with respect. We observed examples where groups of staff were sat taking their break in communal areas meant for people and their family members, instead of using the staff room. This gave the feel that the service was dominated by staff, which may be intimidating for people or their family members. People's family members commented that staff used their phones in communal areas, in particular in the evenings or over the weekends when managers were not in. The minutes from a staff meeting showed that this had been raised by management, however family members commented it was an ongoing issue. This was not person-centred or dignified for people using the service. We raised these issues with the manager and deputy manager for them to address.

People's privacy and confidentiality was not protected. Staff spoke about people's health needs openly and without discretion. In one example a member of staff shouted a question about a person's health needs out to their colleagues in one of the communal areas. All the staff in attendance disclosed personal information about this person without regard for their privacy. The nursing station in one of the units was situated in a public area. Staff told us that handovers took place around the nursing station, during which personal information about people's health needs was discussed. Personal records relating to people's care and support needs were kept on the nursing station and were not stored securely. For example, information about one person's continence needs was on display, whilst information about another person's health needs was also available.

Adequate support was not always given to those people with a sensory impairment or communication needs. One family member commented, "Sometimes [my relative] doesn't have their hearing aid in. Most recently it's stopped working and no one has helped with getting new batteries". People's care records did not include information around how people's sensory impairments impacted upon them, or what action staff needed to take to ensure they were adequately supported. In one example a member of staff commented that one person with a visual impairment "bumps into things sometimes when they are walking about". This demonstrated that staff were not providing the support this person needed to prevent them from injuring themselves whilst walking. In another example one person indicated that whilst they found staff to be kind and caring, they felt staff could do more to meet their communication needs. This person's care record did not demonstrate that any alternative communication methods had been attempted. After we raised this with the manager, a member of staff started putting together a picture board to help aid more effective communication. The lack of knowledge demonstrated by staff, and the poor support given to people with sensory impairments was not kind or caring. This placed people at risk of social isolation, and impacted negatively upon their dignity and wellbeing.

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

People's family members commented that they did not always feel welcome within the service. One family member declined to comment on how welcome they were made to feel, in case of any reprisals, whilst three other family members also told us that they did not feel welcome. Two family members commented positively on the reception they received from staff, referring to them as "welcoming" and "lovely".

Information about people's wishes in the event of their death had been recorded for some people, but not others. Where people had chosen not to be resuscitated in the event of a decline in their physical health, this information was clearly displayed at the front of their care records. We spoke with the manager about the information within care records.

Some interactions between staff and people were positive. For example, one member of staff showed us that they made small gifts for families of people who had passed away within the service. Compliments cards had also been received from some family members expressing gratitude for the support given to people prior to their passing.

Inadequate

Is the service responsive?

Our findings

A majority of people we spoke with could not recall what support was provided to them by staff. However, we observed that people presented as clean and well dressed. One person was able to tell us that they were being well looked after by staff. Family member's views on the support provided by staff varied. One family member commented that their relative's needs were met by staff, whilst another commented that the high turnover of nursing staff in one unit meant that the care provided was not always consistent. Another family member commented, "[My relative's] nails are never cut", whilst another told us, "If I wasn't here so regularly I do not have confidence that [my relative] would receive the support they need", and "[My relative] coming in here was supposed to mean I could have a break. I'm doing more than ever".

Care records were in place for people; however these did not always include all the relevant information about people's needs. For example, in one person's care record we found a recent letter following on from a hospital appointment which showed they had an old shoulder fracture which had the potential to cause them considerable pain. There was no information in care records on how this might impact upon the care being provided to this person, for example during moving and handling tasks. This placed this person at risk of being in pain during, or sustaining injury during interventions.

Staff completed daily records, however the information contained within these was not always accurate or sufficient. In one example we observed a dietary intake chart which stated one person had eaten their porridge, however we observed this person to have only eaten a very small amount of this before it was taken away. In another example, one person's fluid monitoring chart stated that they had been "offered" juice, but not whether the person had drank this or refused. Fluid monitoring charts did not include the total amount of fluid people were required to drink in a day. This meant staff could not be sure that those people at risk of malnutrition had received the fluids they required.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because adequate measures were not in place to ensure that people were being given the support they needed to protect them from the risk of harm.

People we spoke to could not recall whether they had been involved in planning their care needs. However, care records contained some personalised information which showed that people had been involved to some extent. For example personal preferences around their favourite foods was available, and in some instances information about their preferred activities was recorded. People's family members all confirmed that they had never seen their relative's care records, or been involved in the planning of their care. In situations where people do not have capacity to make decisions regarding their care needs and have a legally appointed deputy, it is important that this person be involved. The manager told us that a care review for all people using the service was being planned and that people's family members would be consulted, where appropriate, as part of this.

There was a complaints record in place which some people's family members had made use of. However, three people's family members commented that whilst they had made a complaint they were concerned

that doing so would have reprisals for themselves, or their relatives. One family member commented they had raised concerns and were worried that they would be prevented from visiting their relative by staff. This demonstrated a negative culture within the service, which inhibited people giving feedback.. Those complaints records that were in place showed that a response had been given to the concerns raised in a timely manner, and action had been taken to try and address concerns. However, the changes in management impacted upon the sustainability of any improvements made.

Care records contained personalised information, including details on their life history, likes and dislikes. For examples one person's care record stated that they "enjoy reading newspapers and magazines, and loves watching the TV". Another person's care record outlined their life story, and gave details of significant others in this person's life. This meant that information was available for staff to enable them to get to know the people they were supporting.

There were two activities co-ordinators supporting people to undertake activities. Care records also contained details of the support people had been given to engage in activities, for example hand massages or a chat. During the inspection we observed activities co-ordinators doing arts and crafts with people, and one person told us that staff had taken them out to play bingo which they had enjoyed. In the other unit, whilst we observed activities taking place, people's family members commented that their relatives were often in bed throughout the day and did not feel enough was being done to ensure they had adequate stimulation. We fed these comments back to the manager so that she could act upon this.

Inadequate

Is the service well-led?

Our findings

At the time of the inspection there was a manager in post who had started two weeks prior to the inspection visit, however they were not registered with the CQC. The previous registered manager had left in December 2016. Family members were not always aware that there was a manager in post within the service, whilst others raised concerns regarding a lack of consistency of management. Their comments included, "There isn't a manager in post at the moment I don't think. Let's just say in this respect it's sometimes like the Marie Celeste", "The current manager is great, but who knows if they will stay. There's been no consistency" and, "The staffing levels here are correct, it's just supervision and co-ordination that's the problem. Staff just do what they like". Staff commented positively on the new manager, however told us that previously they had felt unsupported and that responsibility for running the service had been on them.

Throughout the inspection visit we identified examples of poor practice amongst staff that demonstrated there was not a person-centred culture within the service. Staff lacked supervision, co-ordination and were under managed. For example in one unit there was no consistent management presence, however the deputy manager told us that they were going to start being based there in the future. Our observations in relation to the support being received by people who could not communicate their needs showed that this was not in line with best practice. Whilst feedback about the service sometimes varied, there was a consistent view from people's family members that they did not always feel welcome, or able to make a complaint without fear of reprisals against themselves or their relatives.

There were no audit systems being completed in relation to falls, weight loss, pressure wounds, care plans or the environment. The manager told us that whilst information in relation to these areas was being collated, no analysis of this information was taking place to identify trends or patterns. We followed up on these areas to ensure that appropriate action had been taken to maintain people's health and wellbeing, and found that in a majority of cases it had. We identified issues with the information contained within care records, which did not always up-to-date. We also identified hazards relating to the environment which had remained unaddressed at the time of the inspection visit. The manager told us that audits would be implemented, and took immediate action to address specific concerns we had raised.

The registered provider had completed a quality monitoring visit to the service in January 2017 and a follow up visit in March 2017. These visits had identified a number of issues around medication, care records and training. However, other areas around the care and support of people living with a sensory impairment/ communication needs, the environment, the institutional culture amongst staff and failures in protecting people's confidentiality had not been identified. In addition, whilst some improvements had been made, for example in relation to medication and personalised information within care records, staff training had not been addressed. This showed that some aspects of the registered provider's quality monitoring process needed to be improved. It also showed a lack of strong leadership within the service to make the improvements identified.

Prior to the inspection the local authority made us aware of an issue that occurred over a period of time that required investigation. The local authority had required the registered provider to complete an internal

investigation by January 2016. At the time of the inspection visit this had still not been completed. This showed that the registered provider had failed to meet the requirements of the local authority's safeguarding policy. The repeated nature of the concerns also demonstrated a lack of learning which placed people at risk, and reduced their quality of life. The manager confirmed that whilst they had only recently started at the service, they were in the process of completing the investigation.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because quality monitoring systems were not always effective at identifying issues, and action was not always taken to make the required improvements.

The registered provider is required by law to notify the CQC of specific events that have occurred within the service. We compared records that were being maintained by the registered provider, with those on our system and found that this was not always being done. For example, the registered provider showed that there had been 21 deaths within the service between January 2017 and June 2017. However our records showed that we had only been notified of fifteen deaths for this period. This meant that the registered provider was not complying with the law.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, because the registered provider had failed to notify where required.

The registered provider completed an annual survey relating to people and their family member's views on the service. At the time of the inspection visit surveys had just been sent out to people and therefore the results were unavailable. A meeting had taken place with family members and people using the service just prior to the inspection visit. This had been to provide an update on changes within the service and future developments. Prior to this meetings had not been held with people or their family members. This showed a positive change in developing channels of communication, and gaining the views of people and important others about the service.

Staff meetings had been taking place, during which areas of concern that had been identified from complaints had been raised. Following the inspection visit we also received confirmation that a team meeting had taken place with staff to discuss the findings of the inspection. This demonstrated that there was a process in place to keep staff up-to-date on developments within the service.

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 18 HSCA RA Regulations 2014 Staffing The registered provider must ensure that staff receive adequate training and supervision for them to carry out their role effectively.

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 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The registered provider must ensure that there are processes in place to ensure that people within the service are treated with dignity and respect.

The enforcement action we took:

We issued a warning notice to the registered provider.

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	The registered provider must ensure that risks that have potential to impact upon people's health and wellbeing are assessed and adequately mitigated.

The enforcement action we took:

We issued a warning notice to the registered provider.

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	The registered provider must ensure that records are stored securely, and that information kept within records is accurate and up-to-date. The registered provider must ensure that quality monitoring processes are robust and that action is taken to make improvements where issues have been identified.

The enforcement action we took:

We issued a warning notice to the registered provider.