St George's (Liverpool) Limited

St George's Care Homes

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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

St George's Care Home provides accommodation for people who require nursing or personal care. The home can accommodate up to 60 people. At the time of our inspection, there were 45 people living in the home.

There was a registered manager in post at the time of our inspection. This registered manager had been employed by the provider for eight months at the time of this inspection. A different registered manager was in post at the time of our previous inspection in June 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in June 2016, we identified breaches of regulations 10, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to dignity and respect, the management of the service and staff training and support. At this inspection we followed up these breaches and found that the provider had not taken appropriate action to address all of our concerns. Breaches in respect of regulation 10, dignity and respect and regulation 17, good governance had not been addressed and we also identified additional breaches of Regulations 9, 11,12,13,17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at seven care plans. We found people's needs and risks had not been properly assessed and managed. Information in relation to people's care was confusing, contradictory and difficult to follow. It was difficult to determine from people's care plans what their needs and risks were and the care they required. When we looked at the records in relation to people's daily care we found gaps in the care people received. This meant there no consistent evidence that people received the support they needed.

The management of medication was not always safe and records showed that people did not always receive the medication they needed to maintain their well-being.

Accident and incidents records showed that support was not always provided in a safe way. Some people sustained injuries during the delivery of personal care and some accidents occurred as a result of faulty equipment. This did not show that the service provided safe care at all times.

We found that some incidents of a safeguarding nature had not been appropriately identified, responded to, documented or reported in accordance with local safeguarding procedures and the legal requirements of CQC. This meant the provider did not have a robust system in place to protect people from the risk of abuse.

Some of the people and the relatives we spoke with told us that there were not enough staff on duty to meet their needs at all times. We found that multiple incidents of a safeguarding nature and a significant number of accident and incidents had occurred as a result of people not receiving the level of support they required.

This indicated that the number of staff on duty was not sufficient to ensure people were kept safe and well.

People's ability to make decisions about their care had not always been assessed in accordance with the Mental Capacity Act 2005. For instance some people shared a bedroom with no evidence that they had consented to or had their capacity to consent to this living arrangement assessed to ensure it was in their best interests. We also saw that people had bed rails on their beds without evidence that they had consented to this or their capacity to consent to this decision explored. We found evidence to show good practice with regards to the application of the Mental Capacity Act for those people who needed to be deprived of their liberty to keep them safe.

Staff were observed to support people in a kind, patient manner but we found they did not always refer to people's needs in a respectful or confidential way. For example, some staff referred to people who required support from staff at mealtimes as 'feeders' and some staff were overheard talking about people's needs and care in front of the person and their peers. This did not show staff respected people's right to have this information remain private.

People told us they got enough to eat and drink but people's comments about the quality and choice of food on offer was mixed. We saw that lunchtime was a relaxed, unhurried affair. Two menu options were available for people to choose from and the chef told us that they often made alternatives to the menu for people who wanted something different. The chef had a good knowledge of people's special dietary requirements.

Records showed staff were recruited safely and had received supervision in their job role. Staff appraisals and training were ongoing but improvements in both of these areas had been made since our last inspection.

The provider had audits in place to check the quality of the service but these were ineffective. For instance the inadequacy of people's care planning information had not been picked up. Trends in accidents and incidents and incidents of a safeguarding nature had not been picked up and addressed. The provider's medication audits failed to identify that the management of medication required improvement and there was no evidence that people views about the quality of the service had been sought.

This service was not well-led. At the end of our inspection, we discussed the concerns we identified during the inspection with the manager. They acknowledged and accepted the concerns we had raised with regards to the service.

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.
-□
Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their

registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The assessment and management of people's risks was poor and did not protect people from avoidable harm.

Safeguarding allegations were not always properly documented, investigated, reported or responded to by the provider.

Staff recruitment was satisfactory.

Staffing levels were insufficient to meet people needs in a timely manner.

Some people had not received the medication they needed to keep them safe and well. Stocks of thickening agents were not available for everyone who needed them.

Parts of the premises and equipment were unsafe and unclean.

Is the service effective?

Requires Improvement

The service was not always effective.

People's ability to make decisions was not always assessed in accordance with the Mental Capacity Act.

Staff training was in progress and staff had received supervision in their job role. Staff appraisals had commenced but not all staff at the time of this inspection had been appraised.

People told us they got enough to eat and drink but comments about the food was mixed. People's special dietary requirements were catered for.

Is the service caring?

Requires Improvement

The service was not consistently caring

The majority of people said the staff were kind and treated them well.
Some of the language used by staff to describe people's needs

was inappropriate and disrespectful.

Staff did not always respect people's right to privacy and dignity.

People's wishes in relation to their end of life care were poorly documented. Care staff were not trained in end of life care.

Is the service responsive?

Inadequate

The service was not responsive.

People told us that their support was not always provided in accordance with their wishes or needs.

People's preferences were not always documented but people felt staff knew their likes and dislikes.

People did not always receive care and treatment that met their needs.

People had access to activities to occupy and interest them.

Formal complaints were responded to appropriately but there was no system in place to record and monitor people's verbal complaints.

Is the service well-led?

Inadequate

The service was not well led.

The service was rated requires improvement at our last inspection. We found no effective action had been taken to improve the service after this inspection.

The quality assurance systems in place were ineffective and failed to identify and mitigate risks to people's health, safety and welfare.

There was no evidence that people's satisfaction with the service was sought. This meant the provider could not be assured people were happy with the service provided.

St George's Care Homes

Detailed findings

Background to this inspection

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

This inspection took place on 24 and 29 August 2017. The inspection was unannounced. The inspection was carried out by two adult social care inspectors and an expert by experience. An expert by experience is person who has personal experience of using or caring for someone who uses this type of service.

Prior to our visit we looked at any information we had received about the service and any information sent to us by the provider since the home's last inspection. We also contacted the local authority quality assurance team, environmental health and the NHS infection control team for their feedback on the service.

During the inspection we spoke with five people who lived at the home, eight relatives, a visiting health care professional, the registered manager, a nurse, a care assistant, the chef, a kitchen assistant and the activities co-ordinator.

We examined a range of documentation including the care files belonging to seven people who lived at the home, four staff files, staff training information, a sample of medication administration records and records relating to the management of the service. We also looked at the communal areas that people shared in the home and visited some of their bedrooms.

During the visit we observed people's day to day care and their interactions with staff.

Inadequate

Is the service safe?

Our findings

We spoke with five people who lived at the home. The majority said they felt safe and that staff treated them well. People's comments included "Oh yes I do (feel safe)"; "Yes I do, it's great here. They are lovely" and "They are not too bad". All but one of the relatives we spoke with told us they felt people were safe.

Three of the people who lived at the home and two relatives voiced concerns about the number of staff on duty. They felt that the number of staff on duty was not sufficient. One person said "Not sure if there are enough staff". The second person said "Yes I feel safe, but not enough staff on" and the third person told us "No, not really (enough staff on). One relative said "The staff are very good but very busy". Another relative said "No (not safe), people have to wait for the toilet (as not enough staff) that's not right".

During our visit, we too had concerns about the number of staff on duty. For example, we saw that some people who required staff to monitor their well-being for their own safety and the safety of others were not always provided with this support. Records showed there were several instances were staff members who were supporting people with one to one care needs failed to turn up for their shift. This left people who required one to one assistance without the support they needed to keep them safe.

We looked at the provider's safeguarding and accident and incident records. We found that multiple incidents of a safeguarding nature had occurred as a result of people not receiving the support they needed. We also saw that a significant number of accident and incidents had occurred, which were potentially preventable had people received adequate support from staff. These incidents were indicative that the number of staff on duty and their deployment was insufficient to protect people from avoidable harm.

We looked at how the provider ensured staffing levels were safe. We asked the manager if they or the provider undertook any formal analysis of people's dependency needs when determining how many staff should be on duty. They told us the provider did not have any system in place to do this. This meant the provider had no systematic approach to determine the number of staff and the range of skills required in order to meet the needs of people who lived at the home and keep them safe at all times..

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured that there were sufficient staff on duty at all times to ensure people's needs were met.

We looked at the provider's safeguarding records. We found concerns with the way the manager and provider had identified and responded to incidents of potential abuse. Records showed that there had been multiple incidents of a safeguarding nature which were not properly identified, documented or investigated. Some of the safeguarding incidents had also not been reported to the Local Authority in accordance with local safeguarding procedures or the Care Quality Commission (CQC) in accordance with legal requirements.

For example, accident and incident records showed that a significant number of people had experienced

unexplained bruising. Unexplained bruising under safeguarding procedures is considered a potential safeguarding event and should be investigated and reported to the local safeguarding authority and CQC. When we checked the provider's safeguarding records, we could find little evidence this action had been taken or even that the cause of people's unexplained injuries had been investigated. We saw that the manager had sent a memo to all staff reminding them of their obligation to report and document such injuries through the safeguarding and duty of candour procedures. Despite this, the manager and staff had not followed this instruction. This meant they failed to take appropriate action to protect people from the risk of abuse and improper treatment.

We saw that some people had exited the building unsupervised. One person had managed to exit through the fire escape. Another person had exited through the front door and was found on the slope outside of the home. We also saw that other people had been placed at risk of injury by other people's challenging behaviours that had not been managed safely by staff at the home.

We saw that one person's care plan stated the person was not to be left alone "Under any circumstances" and must have staff one to one support at all times. Despite this, there were six occasions during June, July and August where the person did not receive this support. This meant the person had not been safeguarded from improper treatment. The manager had taken no appropriate action to rectify this or put contingency plans in place so that this situation did not happen again.

We identified that approximately eleven people who lived at the home did not have accessible call bells in place to enable them to call for help when they needed it. There were no risk assessments in any of the care files we looked at to show people had been assessed as not being able to use a call bell and no risk management plans in place to show how staff were managing people's safety in the absence of a call bell.

Not having an accessible call bell in place for people to use to summon help is a safeguarding concern as it can be an indicator of neglect. We referred all of the people we identified without a call bell in place to the Local Authority. Subsequent to this, we received confirmation from the Local Authority and the manager that appropriate action had been taken to address our concerns.

This evidence demonstrates a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have robust procedures and processes in place to prevent and protect people from the risk of abuse.

We looked at seven people's care files. Some but not all of the risks in relation to people's care were assessed and not all of the risks identified had suitable management plans in place for staff to follow. The risk management plans that were in place were poor. This was because they failed to provide staff with sufficient guidance on how to prevent or mitigate the risk from occurring.

For example, one person had a catheter in place but the risks associated with this had not been assessed or a care plan put in place for to follow when monitoring the person's catheter care. This meant there was a risk that staff would not understand how to identify signs of a blockage or infection or the action to take to prevent avoidable harm.

Two people had complex nursing needs that meant they were at risk of seizures. We found the risk of a seizure occurring had not been assessed or management advice put in place to guide staff on how to respond to a seizure if one occurred. This meant that staff had no information on the typical early warning signs displayed by each person just before a seizure was to occur. They had no information on the type and duration of any potential seizure and no guidance on what to do should to protect the person from harm.

One person had swallowing difficulties that placed them at risk of choking and aspiration pneumonia. Aspiration pneumonia occurs when a foreign body, such as a small piece of food goes 'down the wrong way' causing a chest infection to develop. We found that neither of these risks had been assessed. A letter from the speech and language therapy team gave staff specific advice on how to manage this person's swallowing difficulties but the person's care plan did not reflect this advice. This meant staff that had no guidance on how to prevent the risk of the person choking or the action to taken should a choking incident occur.

One person displayed behaviours that challenged. We found this person's behaviours had not been assessed to determine the level of risk to the person or to others. Staff had no risk management advice to follow to ensure any potential risks were mitigated and the person's care plan failed to advise staff how to support the person appropriately when these behaviours occurred. This placed the person at risk of receiving unsafe and inappropriate care. We saw that the person had been involved in multiple incidents of a safeguarding nature. This indicated that the way service supported the person was unsafe as the support provided failed to protect the person and other people who lived at the home from avoidable harm.

We looked at this person's daily care charts. We found discrepancies between what support the person should have received compared to what they actually received. For instance, staff were advised to monitor and record this person's behaviour every 15 minutes to maintain their safety and the safety others, but records showed prolonged gaps in the support this person received from staff. This meant person had not always received the support they needed every 15 minutes. There was also no evidence that the behavioural information collected was used in any way to identify potential triggers to the person behaviour or plan appropriate support to alleviate their distress. We asked the manager to ensure this person's needs were re-assessed by social services as we had concerns about the ability of the service to meet this person's needs.

Accident and incidents were recorded. Records showed that staff took appropriate action immediately after the accident or incident to ensure people received any medical support they needed. Records showed however that support was not always provided in a safe way. This was because some of the accidents and incidents were caused by staff during the delivery of personal care and some accidents and incidents occurred as a result of faulty equipment. This did not show that the support provided by the safe was safe at all times.

These incidences were a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured the risks to people's health, safety and welfare were appropriately assessed and managed.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, we found that staff did not always receive the training they needed to do their job role effectively. The provider was found to be in breach of Regulation 18 of the Health and Social Care Act Regulations. At this inspection, we saw that the provider and manager had taken action to address this.

Staff training records showed that the staff were in the process of completing training in dementia awareness, equality and diversity, fire safety, first aid, health and safety, infection control, moving and handling, safeguarding and food hygiene. Some staff had also attended training on tissue viability, dysphagia (swallowing difficulties), medication administration and diabetes. This showed that positive progress had been made to ensure staff had the skills and knowledge to provide effective care.

We were provided with a copy of the home's supervision and appraisal schedules. These showed that staff had received supervision. We saw that some staff had received an appraisal of their skills and abilities but others had not. We saw that this was a work in progress.

Most people we spoke with said they were given enough to eat and drink and had a choice. One person said "There is plenty" and another person said "Yes they ask (what I want). Yes we do (get plenty)". People's opinion about the food was mixed. One person said "Food not very good really, no choice". A second person told us "Food not bad, a lot of chips" whereas a third told us the food was "Excellent".

Relatives we spoke with told us that people's special dietary requirements were catered for and felt that the person was given sufficient food and drink. One relative said "They (the person) have a soft diet, they are well accommodated for". Another said "I have just supported them (the person), there was plenty for them" and a third relative told us "Yes, they (the person) scoff everything".

We observed the serving of lunch. We saw that there were menus on the table for people to look at and napkins and condiments for them to use. The food served looked appetizing and was well presented. Additional portions were provided to people on request. Lunch was homemade soup and sandwiches or sausage rolls with beans. The main meal was provided early evening. There was a relaxed atmosphere at lunch and the meal was unhurried. We observed that some people required staff to help them with their meal and saw that this was provided in a pleasant, patient way.

We spoke with the chef and kitchen assistant and found them to have a good knowledge of people's dietary needs and likes and dislikes. The chef also explained how they blended bread into the homemade soup so that people got extra nutrition. They told us they often made alternative dishes that were not on the menu to suit the individual.

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. We found this legislation was not properly followed.

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 Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the 'Deprivation of Liberty Safeguards' (DoLS). We checked that 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. We found this legislation was also not properly followed.

We viewed the care records of three people with dementia type conditions and/or complex needs. We saw that people's consent had not always been obtained by following the correct legal procedures. For example, several people at the home shared their bedroom with another person. There was no evidence that people's consent to this sharing arrangement had been sought and obtained. There was no evidence that any consideration had been given to the person's wishes about this arrangement or any evidence that people had been matched appropriately with a suitable sharer.

One person who lived with complex mental health needs shared a bedroom with another person whose capacity was in question. There was no evidence that either person's capacity to consent to sharing a bedroom had been assessed and no evidence that either person had consented. There was no evidence that any consideration of the risks associated with this sharing arrangement had been explored despite both people being extremely vulnerable to potential abuse. Records showed that two safeguarding incidents had occurred recently wherein one person had placed the other person at risk. Despite this, no review of this sharing arrangement had been undertaken to assess and determine whether this sharing arrangement was in both people's best interests.

Two people whose care files we looked at had beds rails on their bed. Bed rails are used to prevent people accidentally falling, slipping, sliding or rolling out of bed but they require formal consent for use, as they are considered a form or restraint. Where people's capacity to consent to bed rails is in question, the mental capacity act must be followed. We saw that neither person's capacity to consent to the use of bed rails had been undertaken. The manager confirmed this. They were also unable to produce any evidence to show that a bed rail risk assessment had been completed prior to their installation. This meant there was no evidence that the bed rails installed were in the person's best interests. It also meant there was a risk that the decision to install the bed rails was unlawful.

This was a breach of Regulation 11 of the Health and Social Care Act. This was because the provider failed to have suitable arrangements in place to obtain and act in accordance with people's consent in relation to their care and treatment.

We saw that where the manager had concerns over people's capacity to keep themselves safe outside of the home without staff support, they had followed the correct legal processes to apply for and obtain a deprivation of liberty safeguard. This suggested that the manager was aware of the mental capacity act and had taken some positive steps towards ensuring compliance. Further implementation of the mental capacity act was however required.

Relatives we spoke with told us that staff kept in touch with them about their loved one. Relatives' comments included "Yes they do (keep in touch). They are very good"; "Yes I come every day, so I get to know any updates" and "Any problems they ring me. I come in every day". Relatives told us staff made them feel welcome when they visited.

Requires Improvement

Is the service caring?

Our findings

At our last visit to the home in June 2016, we had concerns with the culture of the service and the practices employed by staff that did not always ensured people were treated with dignity and respect. Some of the language used by staff to describe people's needs was inappropriate and the support provided to people at mealtimes, was not always dignified. This was a breach of Regulation 10 of the Health and Social Care Act. At this inspection some improvement had been made but the way in which staff referred to people and described their needs continued to disrespectful. This meant there was a continued breach of Regulation 10 of the Health and Social Act.

People we spoke with told us that staff were kind to them. One person said "Nurses are good, staff are lovely". Another person told us "Yes (they are kind) but staff are very busy" and a third person said "They help me choose my clothes, paint my nails, put my make up on, they do everything for me".

During our inspection we observed that the language and manner in which some staff referred to people was not very respectful or considerate. For example, people who required support to eat their meals were referred to by staff as "feeders". People who were able to mobilise were called "walkers". This type of language depersonalised people and did not show that staff were sensitive to people's feelings about being described openly in this way.

We heard staff discuss people's needs in front of other people who lived at the home, as if the person was 'not there'. This did not show that staff respected people's right to have their needs kept confidential or that they considered the person they cared for as a 'person' as opposed to a task.

For example, one staff member was heard to say "I'm going for an apron to feed now. Then I'll toilet him". This was said in front of the person and their peers. Another staff member was also heard to say "Drink it all, it will help you go the toilet" to a person in the communal dining room.

We heard a person who was being cared for in bed crying out for water. We went to find help for this person. When we approached a staff member to ask for some water, we found their response to be dismissive. They replied "They will bring it back up anyway". When we checked on the person 15 minutes after water had been provided, we saw that they were fast asleep. This indicated that person simply required a drink of water to secure their immediate comfort. Despite this, the person needs had not been responded to in a timely manner.

When we looked at people's care files we found some people's care plans lacked sufficient information about their preferences for how they would like to be cared for at the end of their life. This meant that people could not be assured they would receive end of life care in line with their wishes. When we checked staff training records we also saw that only nursing staff had received end of life training. This meant there was a risk that care staff would not know who to support people appropriately at the end of their life.

We looked to see what information people had available to them about the service. We found that there

was no brochure or service user guide available for people to refer to in respect of the home.

These examples demonstrate a breach of 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people using the service were not always treated with dignity and respect at all times.

We saw that people's bedrooms were personalised to them. People had family photographs and the keepsakes that were important to them close at hand. In some of the rooms, we saw that the person's photographs had been fixed to the footboard of the bed so that the person could look at them when they were in bed. This showed that the service ensured that people had the things that were important to them close by.

Inadequate

Is the service responsive?

Our findings

The care plans we looked at contained limited information about people's preferences and wishes in relation to their care. This aspect of care planning required improvement to ensure that staff had information on what people liked and disliked with regards to their care. However, people we spoke with told us that staff knew them well.

People's comments included "Very well, yes"; "Yes, brilliant"; "Yes they do know me" and "Staff made an effort to get to know me. They know how I like my coffee and they ask if not sure". Relatives we spoke with also told us they felt staff knew people well. One relative said "Yes they know him and care for him well" and another relative told us "Yes, they know him so well".

People's feedback about how well staff responded to their needs or requests for help were mixed. Two people were satisfied with the way staff responded to them, their comments included "They do their best at looking after me" and "Staff are good". Other people we spoke with told us staff were kind but did not always provide support in a timely or responsive manner.

One person said "I've been asking all morning for a shower. They are too busy. I waited till 4.40pm. I told them no, not now". The other person told us "I've been left until 2pm the next day with same pad on from the night before. I'm able to speak up others can't. I was told dementia patients take priority".

All of the people we spoke with told us staff were very busy. Some of the people we spoke with indicated that this sometimes impacted on their ability to choose how and when they received their support. For example, when we asked if people could choose what time to get up or go to bed, one person said "Yes, but staff are busy" and another person said "I don't choose I have to wait". I hate it. I missed a hospital appointment because they didn't get me ready in time. Communication is not good". A third person told us "The rules and regulations are stupid. I don't like being told I can't do this or that".

People's feedback did not demonstrate that the service was responsive to people's needs and preferences or designed to ensure these needs and preferences were met.

People's care plans did not contain sufficient detail about the person's needs and risks. This made it difficult to understand what people's needs were and track the care that they had been given. Information was split between computerised and paper based records which did not always correspond with each other or reflect the person's needs or care. This meant it was difficult to tell if people were in receipt of the care and treatment they needed.

For example, one person's eating and drinking care plan stated the person was overweight and required a calorie controlled diet but other records showed that the person had lost a substantial amount of weight over the last six months and was at risk of malnutrition. Food and drink charts were in place to monitor this person's intake due to concerns over their nutritional health. It was obvious the person's care plan was inaccurate and not reflective of the care they person actually required.

One person's daily records indicated that they had been given supportive equipment to wear to alleviate symptoms of a physical impairment. We checked the person's care plan for information about this. We found no adequate information in relation to why this equipment was needed, how the equipment should be fitted and maintained and how long it should be used for, at any given time. This meant there was a risk that staff would not know what this equipment was for or how to ensure if was fitted correctly to prevent further harm.

Several people's care plans stated that the person lived with dementia or a dementia type condition. Despite this, their care plans did not contain adequate guidance on the type of dementia the person lived with and how this impacted on their day to day lives. Guidance provided to staff with regards to the provision of person centred care was very limited. For example, one person's care plan simply advised staff to refer to the Alzheimer Society website for further information about the person's condition and care.

Another person's dementia care plan stated that trips out of the home were observed to have a positive impact on the person's mood. We asked the manager how they had ensured that trips out were arranged as part of the person's care, they told us that the person's family took them out but no trips out had been arranged by the home as part of a plan of care. Records showed this person was distressed and agitated for significant periods of time.

These incidences were a breach of Regulation 9 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to ensure that people's care and treatment was appropriate, met their needs and reflected their preferences.

The provider employed an activities co-ordinator to provide activities for people who lived at the home. We found the activities organiser was very enthusiastic about their role. They showed us the activity planner they had in place. The planner showed what activities were available for people to participate in over a two week period. On the first day of the inspection, people enjoyed participating in a session of bingo.

We asked people who lived at the home and their relatives about the activities provided. One person said "I don't take part I choose not to, but there are plenty of activities". Another said that "Sometimes" there were activities on. Comments from people's relatives included "Always something on" activity wise and "Yes it's very good, something always on". People's feedback showed that their social and recreational needs were considered by the service.

Records showed that other healthcare and social professionals were involved in people's care. For example we saw that GP's, tissue viability services, speech and language therapy, dieticians, optician and chiropody services supported people's well-being as and when needed. During our visit we spoke with a healthcare professional who told us that staff had made a referral through the person's GP to ensure the person got the support they needed. People we spoke with told us that staff got the doctor quickly if they became unwell. This meant people had access to medical advice as and when needed.

The majority of people we spoke with told us they had no complaints about the service. The home's complaints procedure was displayed in the entrance area of the home. The policy displayed advised people to contact the home owner in writing if they had a complaint but failed to give the home owner's name or address for people to do so. We spoke with the manager about this and on the second day of our inspection, this had been addressed.

We looked at complaint records. We saw that there was a system in place for formal written complaints. We reviewed two written complaints and found that the manager had responded to both complaints

appropriately. However, there was no effective system in place to document the receipt and response to any verbal complaints received about the service.

One person told us that they had made a complaint to the manager about their care but had not received a formal response. We spoke with the manager about this. They confirmed the person had made a verbal complaint. They told us they had responded to the person verbally. We asked to see the record in relation to the complaint but the manager told us they had not documented the complaint or the action taken as it had been a verbal. This aspect of service delivery required improvement to ensure all of people's concerns about the service were properly recorded and monitored by both the manager and the provider.

Inadequate

Is the service well-led?

Our findings

At our last visit in June 2016, we identified that the service did not have adequate governance arrangements in place to ensure that the service was well-led. This was a breach of Regulation 17 of the Health and Social Care Act. At this inspection, we found that the provider had failed to take the necessary action to address this and the service continued to be poorly led. This meant there was a continued breach of Regulation 17 of the Health and Social Care Act.

At the last inspection, the service was rated overall requires improvement. Since the last inspection, the home had a new registered manager. The current manager had been in post for approximately eight months at the time of our inspection. They explained that they had started to address some of the issues we identified at the last inspection but that it was a work in progress. They told us that the first few months of their employment had been consumed by "Fire-fighting" a number of immediate issues such as staff training, staff supervision and premises related improvements. When we looked at the manager's records we could see evidence of this.

At this inspection concerns were identified again with the accuracy and completeness of people's care records. Since the manager had commenced in employment, they had implemented a new computer based care planning system for staff to use but not all of people's information had been transferred over to the new system. This meant information in respect of people's care was stored different places, which made it confusing and difficult for staff to follow. In addition, some people did not have the care plans in place to match their needs or care plans which actually reflected the care they required. This did not demonstrate that the provider had taken immediate and effective action after the last inspection to ensure there was a complete, accurate and contemporaneous record of care for each person who lived at the home.

We asked the manager if they audited people's care records to ensure they provided accurate and up to date. They told us they did not audit the records maintained in relation to people's care. This meant there were no quality assurance systems in place to ensure that people had adequate care plans and risks assessments. It also meant that the issues we identified with the assessment of people needs and the planning of their care had not been picked up and addressed.

We found there were no adequate systems in place to ensure staffing levels were sufficient and during our visit we observed the number of staff on duty was not always sufficient to meet people's needs.

There were no adequate systems in place to identify and respond to incidents of a safeguarding nature. There was no analysis of safeguarding events to enable trends in the type of safeguarding incidents to be picked up and addressed. Records showed that the governance arrangements in place for safeguarding incidents failed to be effective in mitigating risks to people's safety.

There was limited evidence that accident and incident information was used to enable staff to learn from and prevent accidents and incidents from re-occurring. For example, the provider did not analyse the time, location, staff present and type of accident and incident to see if there were any patterns or trends in the

accidents and incidents occurring so that preventative action could be taken.

Medication audits were ineffective in identifying and resolving the issues we identified during our inspection with regards to the safe management of medication. For instance, governance arrangements had not identified that people's medication was not always administered as prescribed, that some people did not have their own supply of prescribed thickening medication or that staff were not following best practice in how people's medication records were maintained.

We saw that the manager undertook a daily check of the premises. Records showed they also noted general observations of day to day staff practices whilst doing this. A monthly bedroom check was also undertaken to ensure people's bedrooms were safe and clean. Records showed that the manager had identified and acted upon a number of improvements. We found however, that the manager's checks failed to identify a number of the safety and environmental concerns we identified during our visit. For example, people's unsafe bed rails, the lack of accessible call bells and aspects of poor cleanliness.

We saw that a satisfaction survey had been carried out with staff in March 2017 and that staff had given positive feedback about working for the provider. An action plan of improvements had been developed as a result of this survey which had been reviewed again in August 2017 by the manager.

We looked at the arrangements in place to seek the views of the people who lived at the home, on the quality of the service provided. The manager told us that a satisfaction survey had been carried out in 2016 but they were unable to produce any records of this or any evidence of the action taken. This meant there was no evidence that people's views had been sought and used to drive improvements to the service.

This evidence demonstrates that the provider did not have effective systems in place to assess, monitor and improve the quality and safety of the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that regular staff meetings had taken place since the manager had commenced in employment. There had also been a resident and relatives meeting in January 2017. During our visit, staff were pleasant and co-operative and the manager did their best to assist us with the inspection.

Staff we spoke with gave positive feedback about the manager and the way they approached the staff team. They told us the manager had asked them to work together as a team to improve things for the people who lived at the home.

At the end of our visit, we discussed our concerns with the manager and they acknowledged that significant improvements were required to the service overall. They accepted the concerns we raised and said that they were already aware of the majority of issues brought to their attention. They told us that they had plans in place to improve the service and these had been discussed with the provider.