Key Healthcare (St Helens) Limited

Grace Court Care Centre

Inspection report

Prescot Road
St Helens
Merseyside
WA10 3UU

Website: www.keyhealthcare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on the 1 and 6 December 2016.

This was the first inspection of the service since its registration in April 2016.

Grace Court is situated in a residential area close to St Helens town centre. The service can accommodate up to 30 people who require accommodation with nursing and personal care needs. All accommodation is situated on the ground floor of the building. One area of the building is designed to support 20 people and the other area to support 10 people. A dining room is situated between both areas and can be accessed by all people who use the service. At the time of our inspection 27 people were using the service.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe effective infection control procedures were not always followed. Soiled linen was dragged through communal areas in laundry bags and two face masks belonging in place for one person was stored on a dusty floor.

Equipment in use was not always safe. On two occasions we saw that people were using wheelchairs to access the community without the appropriate foot rests in place which put both people at risk of potential harm.

Care plans were not in place to identify the needs of people in relation to eating their meal or the time in which they ate their meals. We found that one person's agreed food menu had not been provided. Failure to plan for people's needs and wishes in relation to their dietary needs could put individuals' at risk of not receiving the diet of their choice.

Under the Mental Capacity Act 2005 (MCA) in relation to Deprivation of Liberty Safeguards (DoLs) we found that appropriate applications had been made to the supervisory body on behalf of people. However, we found that the principles of the MCA were not always followed in relation to best interest decisions made on behalf of people unable to make the decision for themselves. Records available failed to demonstrate that best interest decisions had been appropriately recorded.

Records relating to people's care planning and care delivery required improvement. We found that people's needs in relation to receiving meals and their medication whilst in bed were not always planned for. Records

also failed to demonstrate in detail the care and support people had received or been offered. Failure to maintain robust care planning documents and records puts people at risk of not receiving the care and support they require.

Auditing systems in place to monitor the service on a day to day basis were not effective. The systems had failed to identify areas for improvement in relation to people's care planning, record keeping, safety of specialist equipment and responses to complaints made about the service. Regular robust audits throughout the service failed to ensure that areas of improvement were addressed quickly to improve the service that people received.

The laundry processes and management of people's personal effects were not always effective. People and their family members raised concerns that laundry was not always returned to the right person and personal items, for example, hearing aids and foot wear were often lost within the service.

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

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Procedures were in place to protect people from harm. Safeguarding procedures were available at the service. Staff demonstrated a good awareness of situations that they needed to report under the local authority safeguarding procedures.

Emergency procedures were in place. Each person had personal emergency evacuation plan (PEEP) that detailed what support individual's required in the event of them having to be evacuated from the service in an emergency.

Staff recruitment procedures were in place. The process involved obtaining references and carrying out checks to help ensure that only staff suitable to work with vulnerable people were employed.

When supporting people staff did so in a polite and respectful manner. Staff offered comfort to people when they became anxious or disorientated by holding their hands and hugging them when invited to do so..

People were relaxed and comfortable amongst staff and it was evident that positive relationships had been formed between them.

People told us that staff were kind and looked after them well. Family members told us that staff were always welcoming.

Prior to a person moving into the service an assessment of their needs took place and was carried out by a senior member of staff. The purpose of the assessment was to ensure that the service had the facilities and provision to meet the person's individual needs.

People were registered with a local GP to service. In addition a community psycho-geriatrician visited the service on a regular basis to support people with their changing health needs.

People's medicines were stored and recorded which helped ensure that people received their medicines safely. However, we did see one situation when a prescribed cream was stored inappropriately which was moved when brought to the attention of staff.

Accidents and incidents that occurred were recorded. The registered provider had a system in place to monitor all incidents and take action to minimise the risk of reoccurrence.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Equipment used by people was not always safely managed.

Good infection control practices were not always in place.

People told us they felt safe using the service.

People felt safe using the service.

Is the service effective?

Requires Improvement

The service was not always effective.

People's dietary needs were not always planned for.

Best interest decisions made on behalf of people under the Mental Capacity Act 2005 were not always recorded appropriately.

Staff had completed training in relation to their role.

People had access to a light, airy, pleasantly furnished environment.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy was not always respected.

People's laundry was not always returned directly to them.

People felt that staff were caring and respectful towards them.

People's personal confidential information was stored appropriately.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care was not always recorded.

A complaints procedure was in place.

People were happy that staff knew of the care they required.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager in post.

Appropriate records were not maintained within the service.

Auditing systems in place failed to identify areas of improvement required within the service.

Grace Court Care Centre

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 1 and 6 December 2016 and was unannounced.

The inspection was carried out by an adult social care inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service prior to our inspection. This included notifications we had received from the registered provider which they are legally obliged to send us following significant events and incidents which occur at the service.

During the inspection we spoke with nine people and spent time with a further nine people during mealtimes. Not everyone who used the service was able to tell us about their experiences so we spent time observing the care people received to help us to understand their experiences. In addition we spoke with 11 family members and seven staff members, including the head of care, a nurse, the cook and the registered provider.

We reviewed the registered providers policies and procedures, care planning documents in use for three people and the recruitment files of five staff members. In addition, we reviewed records relating to the management of the service. These records related to medicines, the delivery of care and support, staff training and the quality monitoring systems in use.

Before our inspection we contacted the local authority who commissions the service and the local authority safeguarding unit to obtain up to date information which they held about the service.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe at the service. Their comments included "Yes I feel very safe. All the young ladies [Staff] look after me very well. When I need someone to help me there is always someone about" and "I have all these people around me. I am never on my own. Thumbs up I am safe with them [Staff]".

People were not always protected from the risk of infection. We saw that bags containing soiled laundry were dragged along the floors through the building to the laundry for washing. We raised this with the registered provider who demonstrated that specific trolleys had been purchased to safely transport soiled laundry bags through the building. However, these trolleys were not in use.

In one person's bedroom we saw that oxygen face masks used by the person were on the floor which was dusty. This inappropriate storage of masks could not guarantee that they were clean and ready for use when needed. We brought this to the attention of senior staff who addressed the issue.

Prescribed medicines for people were not always stored appropriately. We saw that creams prescribed for one person were stored in a drawer that contained food products. This storage practice failed to ensure that appropriate infection control practices were in place because prescribed cream to use of a person's body should not be stored with food products. Prescribed creams for people should be stored appropriately in a locked storage facility.

People's safety was not always promoted when using equipment. We saw on two occasions staff transporting people out of the building in wheelchairs which had no foot rests on. Failure to have access to appropriate foot rest when using a wheelchair puts people at risk from injury, and may also impact on their posture whilst in the sitting position. This was brought to the attention of the registered provider who addressed the issue immediately.

Equipment was not always replaced in a timely manner to support people's health and safety. A pressure relieving mattress needed by one person had failed to operate and had been removed. The mattress had been replaced by an alternative specialist mattress that was of a different type to the one that had failed to operate. Records failed to demonstrate what level the mattress should have be set at to ensure that it was appropriate for the person's comfort. Staff were not able to confirm that the new mattress setting was equivalent to the previous mattress. On this occasion the person had not experienced any harm. No action had been taken to address the problem with the person's own mattress for a period of four days. When this was brought to the attention of senior staff they were unaware of the issue with the mattress and there were no records available to demonstrate that the mattress had been changed or needed repair.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had failed to demonstrate that they had done everything reasonably practicable to provide safe care and treatment.

The registered provider utilised a 'staffing tool' to calculate the number of staff needed on a daily basis to

support the needs of people who used the service. Staff told us that there had been recent changes to how staff were deployed around the service. They told us that they had been moved to support people that they were not always familiar with their needs. On the first day of the inspection we saw that staff were extremely busy supporting the needs of certain people. Visiting family members raised concerns in relation to a lack of staff in communal areas to support and supervise people. Family members told us that they felt this situation was worse at weekends. They described people as "Panicky" and people being supported with their meals were left on occasions as staff were needed to support others. Family members described mealtimes in communal areas and at mealtimes as "Chaotic and unorganised" because of the lack of staff. One commented that the lack of continuity of staff confused their relative. Another family member told us that they had raised their views about staffing at the last 'residents' meeting and they had been told that things would improve. During one mealtime we saw staff asking each other who had eaten and who had not. Staff commented that the changes to the deployment of staff had resulted in them working with people whose needs they didn't know. During the second day of the inspection we found the service to be more calm and organised.

Safeguarding policies and procedures which were available within the service gave guidance and information as to what actions needed to be taken in the event of an incident of abuse or suspected abuse. Staff told us that they had completed safeguarding training and records confirmed that 85% of staff had completed this training. Staff knew what action they needed to take if they thought a person had experienced or was at risk from harm or abuse. A safeguarding log had been developed to record all incidents of concern relating to protecting people from harm. We found that not all of concerns raised with the local authority had been reported to the Care Quality Commission (CQC). Staff explained that it appeared that concerns raised over a weekend had not been reported to the CQC. This meant that we did not have access to all of the information required to help us decide if we needed to take further action to in response to safeguarding concerns. This was brought to the attention of the registered provider who made a commitment to address this.

There was a dedicated lockable room with locked cupboards, fridge and trolleys for the safe storage of people's medicines. Policies, procedures and professional guidance were available and accessible to staff about the safe administration of medicines. Controlled drugs (CD's) were stored securely and appropriate records were maintained. Controlled drugs are medicines prescribed for people that require stricter control to prevent them being misused or causing harm. The nurse on duty explained safe systems which were in place for the ordering, storing and disposal of medication.

Each person had a medication administration record (MAR) that detailed their prescribed medication and the times they needed it administering. MARs also contained the name, photograph and GP contact details and were seen to be completed appropriately. Where a person had been prescribed medicines to be administered on an 'as and when required basis' (PRN) a PRN care plan was devised. This care plan recorded information by way of signs and indicators to look for as to when the medicine should be administered.

Risks to individuals' had been assessed and formed part of people's care plans. At the time of this inspection work was taking place to commence a review of all care planning documents including the risk assessment processes in place. For example, in relation to people's skin and moving and handling needs. A system was in place to monitor any falls people experienced. Clear guidance was available to staff as to how to record when a person had a fall and how and when to seek advice from the community falls prevention service.

Personal emergency evacuation procedures (PEEPS) were in place for people who used the service. These documents contained important information as to what support a person needed in the event of needing to

be evacuated from the service in an emergency. A 'grab bag' was also available to staff on duty for use in an emergency. This bag contained equipment and information, for example, the contingency plan and fire risk assessments that would be needed in the event of having to evacuate the service quickly.

Accidents and incidents experienced by people were recorded. In addition, a monthly report was completed to consider all accidents, incidents and dangerous occurrences. The reports had been completed and contained detailed information in relation to the causes and outcomes of accidents and incidents and the times in which the situations occurred. Once these reports were completed they were analysed by the registered provider to identify any trends of incidents that could be avoided.

Staff recruitment procedures were in place. An application form had been completed and written references had been applied for and received. In addition, a Disclosure and Barring Service (DBS) had been carried out. Carrying out these checks minimised the risk of people being employed who are not suitable to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

People and their family members told us that they thought staff were trained to be able to meet their needs or their family member's needs. One family member told us "I have seen them [Staff] chasing their tail but they all seem to know what they are doing".

People's dietary preferences were not always met. A specific menu for a person had been planned and agreed with the involvement of a family member, however, the meals on the menu had not been made available to the person. In addition, people's care planning documents failed to demonstrate what actual support a person needed to eat their meal. For example, we were told by a family member that their relative required support to grasp their food and guidance to take the food to their mouth to maintain their independence when eating. There was no information recorded in relation to these specific needs of the person.

No plans or records were in place as to how and when people had their meals whilst they were in bed. This meant that people getting up later and going to bed early could be at risk of not having their breakfast or supper. One family member explained that on one occasion their relative had stayed in bed until 2.30pm. Staff were unable to say if they had had their breakfast and lunch whilst in bed. During discussion staff recognised the need for clear care planning in relation to people receiving their meals to ensure that people had a balanced diet available to them throughout the day.

Lounge areas had dining facilities for people to have their meals. In addition, a larger dining room was available. People told us that they were able to eat their meals in their rooms if they wished. Dining tables were set with cutlery however, there were no condiments available to give people the opportunity to season their food. During one mealtime we asked for some salt but none could be located. Seven family members raised concerns about the quality and quantity of the food served. They told us that deserts were often dry and cream or custard was not always available when asked for. At the time of the inspection the menus were in the process of being changed.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had failed to plan effective care and treatment for people.

Small kitchen areas were available around the service for staff to prepare drinks and snacks for people. Throughout the inspection we saw that people were offered hot and cold drinks on a regular basis.

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 make particular decisions, any made on their behalf must be done in their best interests and as least restrictive as possible. Best interest decisions made on behalf of people were not recorded appropriately. Staff confirmed that there was no formal process in place for the recording of decisions made in people's best interests under the Mental Capacity Act 2005 (MCA). When a decision had been recorded it failed to

demonstrate that the people's rights were being maintained in line with the principles of the Mental Capacity Act 2005. For example, one decision with regards to the administration of covert medication was recorded in a letter of authorisation from a doctor. The letter failed to demonstrate that the principles of the MCA had been considered.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had failed to demonstrate that effective systems were in place to apply the principles of the Mental Capacity Act 2005.

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. The authorisation procedures for this in care homes are called Deprivation of Liberty Safeguards (DoLS). We saw that application for DoLS had been authorised on behalf of a number of people who used the service.

People were registered with a local GP service and when required people had been referred to specialist health care professionals. For example, for eating and drinking assessments and the management of falls. In addition, a community psycho-geriatrician visited the service on a regular basis. The psycho-geriatrician told us that they were in the process of carrying out health reviews with people who used the service.

Staff told us that they had received training for their role. Records demonstrated that the majority of staff had received training which included health and safety, safeguarding people, dementia, first aid, food hygiene and the Mental Capacity Act. No staff were recorded as having received training in infection control. Staff informed us that this was in the process of being arranged. The majority of staff delivering care and support to people had completed the care certificate. The care certificate is a nationally recognised set of standards that care staff are expected to meet within their practice.

Staff told us that they felt supported by senior staff, describing them as approachable. Records showed that all staff had received a 'supervision' letter in October 2016 highlighting areas relating to the service. Staff said that they had not had the opportunity to have a formal supervision for their role, however they felt they could approach the management team for any advice they needed. Supervision gives staff the opportunity to sit with their supervisor and discuss their role and identify and development needs. The head of care was in the process of devising a schedule of supervisions for all staff.

The building was light and airy with wide corridors to aid people's visibility and movements. Furnishings in communal lounges were bright to support the orientation of people living with dementia. All bedrooms were located on the ground floor. One family member told us that they liked the layout of the building and felt that the accessibility helped with the needs of their relative.

Requires Improvement

Is the service caring?

Our findings

People and their family members told us that the care was good and that staff were committed and dedicated. People's comments included "All the staff are lovely", "No problems with the staff they look after me all the time", "All I can do is praise them for their help. They are all so very kind and gentle" and "They look after me well".

Family members comments included "Staff are brilliant. All the staff chat with people when they have the time. They do the best they can. I like the home very much it just needs to be better organised and staffed", "The staff are welcoming and kind, they sit and talk to [Name] when they can. He really likes rugby, they always make sure it's on the TV for him" and "No problem with the staff, they are very caring. The problem is there is no continuity of care. Staff change over all the time".

Several visiting family members raised concerns about the laundry procedures at the service. They told us that on many occasions people's clothing went missing along with other personal items. For example, one family member told us that they had purchased six pairs of slippers for their relative within a period of eight months as they were constantly being lost. Another family member told us that their relative had been wearing another person's shoes as only one of their shoes could be found. People not having access to their own clothing and personal effects could impact on individuals' self-respect and create unnecessary anxiety.

People's privacy and dignity was not always respected. For example, two senior members of staff were seen to enter a person's bedroom without knocking and they removed pieces of equipment without explaining what they were doing. On another occasion, during a mealtime we observed staff, visitors and a visiting health care professional using the main dining room as a walk through from the car park at the rear of the building whilst people were eating their meals.

Family members raised concerns that when people were spending time in their bedrooms with the doors open they could be seen by people passing. This compromised people's privacy. This was brought to the attention of the registered provider who confirmed that window blinds had been ordered to promote people's privacy.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had failed to ensure that people's privacy was maintained.

Family members told us that they felt they were not always informed as quickly as they would have liked of their relatives changing needs. For example, one family member said that their relative had been taken to hospital at 3am in the morning; however, they were only informed the following morning at 9am. The family member said that if they had been informed earlier they would have gone straight to the hospital to be with their relative who was alone.

Staff treated people with politeness and respect when supporting them with their care. Staff responded to people who indicated that they wanted comforting by holding their hands and hugging them. Staff calmed

people who were anxious or disorientated by reassuring them. People were relaxed and comfortable amongst staff and it was evident that positive relationships had been formed between them.

Family members told us that they had built up positive relationships with the staff. They told us that they were always made to feel welcome when visiting and were always offered refreshments during their visits.

People's confidential and personal information was stored appropriately. Care planning documents were stored in an office that was locked when staff were not present. Computers in use were password protected to ensure that information was only accessible to authorised staff.

Requires Improvement

Is the service responsive?

Our findings

People told us that the staff knew what care they needed. However people said they were not aware that they had a care plan.

Prior to a person moving into the service an assessment of their needs took place and was carried out by a senior member of staff. The purpose of the assessment was to ensure that the service had the facilities and provision to meet the person's individual needs. If a person's needs changed whilst using the service a further assessment took place to ensure that Grace Court could continue to provide the appropriate care and support the person required. We observed a senior member of staff liaising with a local hospital to arrange a re-assessment of a person's needs. The person had been in hospital for some time and senior staff explained that in order to ensure that the service could continue to meet the person's changing needs, a further assessment needed to take place. We found that the people's needs identified in the assessment process were not always planned for.

Each person had a file that contained their personal information and care planning documents. However, the care planning documents in place failed to fully demonstrate people's needs and what care they required to keep them safe. Care planning documents were not person centred and failed to fully identify specific needs of individuals' and how these needs were to be met. For example, they failed to identify the support required for a person who required support to eat their meals. Even though the person was able to hold food and chew, their care plans failed to identify what support the person needed with co-ordination to eat.

People's care plans failed to demonstrate what support was required and had been planned when a person was in bed and required a meal or their medication. In addition, there were no specific plans in place in relation to people needs as to when and how they had their personal care needs met. For example, oral care, bathing and showering. The lack of detailed care planning for people could result in a person not receiving the care and support they required.

Care planning documents failed to effectively demonstrate what actions staff needed to take in the event of a person needing medical support or who and when family members needed to be contacted. Family members told us that they felt the general organisation around the service could be improved. They said that although they felt listened to, communication within the service was poor. For example, two family members raised concerns regarding how people's medical needs were communicated and responded to by staff. One family member said that on one occasion they had had to insist that staff contacted a Dr as their relative was unwell.

No activities to promote and maintain people physical and psychological wellbeing were taking place. Staff sat and spoke with people at different times throughout the day however, people told us that they were bored and had no stimulation. One person told us "No magazines, nothing to do I just sit here and drink my water. It's very boring". Staff told us that an activities coordinator had recently been employed and would be commencing their employment once all of the recruitment checks had been completed. The newly

recruited staff member would be responsible for planning and arranging meaningful activities for people to participate in.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had failed to plan effective care and treatment for people.

Staff were seen to be responsive to people's needs. For example, one person had become unwell and staff were seen to respond quickly in calling for medical support. whilst waiting for the support to arrive staff offered reassurance to both the person and their family member. Another person told a member of staff that they were cold and staff immediately suggested to the person that they went together to get a cardigan.

A complaints policy and procedure was in place and clearly displayed in the foyer of the building. A complaints register had been created to record all complaints made regarding the service and outcomes. People and their family members knew who to speak to if they were not happy or wished to make a complaint. However, a number of family members said that they felt that their complaints were not always fully listened to and that they did not always receive a formal response. No records were available to demonstrate that complaints about the service had been actioned in line with the registered provider's procedures. The current system failed to demonstrate that people had received a response to their concerns.

Inadequate

Is the service well-led?

Our findings

There was no registered manager in post. Two managers had been employed at the service since its opening in April 2016. The registered provider was in the process of recruiting a new manager for the service. Interim arrangements had been made in which a manager from another service was overseeing the overall management of Grace Court until the appointment of a new manager.

The quality of some of the records was poor. Records were unsigned and undated and were difficult to interpret because acronyms were used without any codes. For example, record entries included "[Name] Bld done for FBC yesterday", "[Name] back on ABX for UTI" and "[Name] haematoma (RT) leg walked into weighing scales. [Staff] ? diuretics as legs swelling again". Failure to maintain detailed up to date records could result in a person not receiving the care and support they need.

Systems were in place to record what care and support people required, had been offered and received. However the systems were not effective because records of care delivered to people throughout the night were brief and failed to fully demonstrate what care and support a person had received. Checks carried out every two hours during the night were recorded using a tick box format. However they failed to demonstrate the actual care given such as what checks had taken place and the care given to people in relation to their continence needs. Records relating to what personal care had been offered and delivered during the day were not always maintained. For example, records in people's care planning documents failed to show when a person had been offered or received a shower or bath, had their oral health needs met or their hair washed. Staff stated that a further set of records detailing this information was maintained, however they were unable to locate these records. Failure to maintain accurate and up to date records puts people at risk of not receiving safe and effective care.

A system was in place which required staff to keep a daily record of people's dietary and fluid intake, personal care needs and any visitor's people had received. However, these records were not always completed. For example, no records had been completed for one person who had been discharged from hospital several days prior to this inspection. This meant that there was indication of what care had been provided to the person. Records for other people indicated that their care needs had been met; however they failed to detail the actual care which had taken place.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had failed to maintain appropriate records for the care and treatment delivered to people.

The registered provider's current systems in place for monitoring the service on a day to day basis had not always been effective as they failed to identify areas of improvement needed to ensure that people received the safe care and treatment they required. The monitoring systems had failed to identify that not all notifications of safeguarding incidents had been sent to the Care Quality Commission. In addition, the systems in place had failed to identify that best interest decisions made on behalf of people had not been appropriately recorded to demonstrate that the decisions were made within the principles of the Mental

Capacity Act 2005.

The monitoring systems in place had failed to identify and address inappropriate infection prevention practices as soiled laundry being transported across the floors within the service. In addition, breathing masks used by a person were not stored appropriately for safe use as they had been placed on a dusty floor.

There were no effective systems in place to ensure that specialist equipment in use by people was being monitored to ensure that it remained safe to use.

There was no effective system or monitoring in place to ensure that the deployment of staff on duty was suitable to ensure that people received the care and support they required in a timely manner and to meet the changing needs of people.

No effective systems were in place to monitor the responses to complaints made about the service. Family members who had raised concerns did not always receive a response and action had not been taken to resolve their complaints.

There were no effective systems in place for the monitoring of people's care records. Personal care delivered to people was not consistently recorded. In addition records failed to contain sufficient details of the care and support people were offered and received.

Meetings with senior staff, people who use the service and their family members had taken place. The purpose of these meetings was to gain people's views and suggestions for improvements to the service and to give them updates on changes within the service. Family members said that they had raised their concerns at the meetings in relation to the quality and quantity of foods served. In addition, others said that they had raised concerns about the lack of stimulation available to people, and the number of staff on duty to meet people's needs. One family member told us that they had suggested that a quiet area be developed in one part of the service to allow people and their visitors to sit in private. Family members told us that no action was taken in response to their suggestions. This information was shared with the registered provider who made a commitment to make improvements to how the service listens to people and their family members.

The registered provider had commissioned the services of an outside organisation to carry out periodic audits of the service delivered at Grace Court. The audit reports were based on the regulated activities. In the event of an area requiring improvement the report recorded what action was required. The most recent audit was dated October 2016 and had highlighted several areas of improvement required within the service. We found that these suggested actions had not been addressed. For example, the audit identified that a clear complaints process and outcomes should be logged along with audits to ensure responses are carried out in line with the complaints policy.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had failed to ensure that effective systems were in place to regularly assess, monitor and improve the quality of service that people received.

A number of effective systems were in place to regularly monitor the health and safety of the environment. A handy person was employed to carry out regular checks on the fire detection system, the grounds and the nurse call system. Records demonstrated that these checks were carried out on a regular basis.

Staff meeting had taken place. The minutes to these meetings were detailed and contained clear guidance

to staff in relation to procedures within the service. For example, the minutes of one staff meeting for senior staff clearly gave direction and guidance on the safe management of medicines, and respecting data protection and confidentiality.

The registered provider recognised that improvements were needed and additional support from outside of the service to implement more robust systems to ensure that people's needs were planned for at all times. On the second day of our inspection we spoke with the registered provider who demonstrated a commitment to ensuring that improvements would be made 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 10 HSCA RA Regulations 2014 Dignity and respect This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had failed to ensure that people's privacy was maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had failed to demonstrate that effective systems were in place to apply the principles of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had failed to demonstrate that they had done everything reasonably practicable to plan and provide safe care and treatment.

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

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had failed to ensure that effective systems were in place to regularly assess, monitor and improve the quality of service that people received; and to ensure that appropriate records were maintained.