Amore Elderly Care Limited

Atkinson Court Care Home

Inspection report

Ings Road
Cross Green
Leeds
West Yorkshire
LS9 9EJ

Tel: 01133918800
Website: www.priorygroup.com

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection of Atkinson Court Care Home commenced on 6 and 7 September 2017 and was unannounced.

The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with the Care Quality Commission (CQC) about the incident indicated potential concerns about the management of risks. This inspection examined those risks.

Atkinson Court Care Home is a purpose built care home for older people requiring general or specialist dementia nursing care. The home is located in a residential area of Leeds and is easily accessible. Atkinson Court Care Home provides a modern environment with 75 single en-suite bedrooms with shower facilities arranged over three floors. The home has 24 'intermediate care beds' for people discharged from hospital who need more support before returning home.

At the time of our inspection, there was a registered manager in post. A registered manager is a person who has registered with the CQC 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.

Our last inspection of the service took place on 3 and 8 November 2016 when we rated the service 'Requires Improvement'. We found two breaches of the legal requirements in relation to staffing levels and reporting notifiable events. During this inspection we found improvements had been made and the service was now compliant with these regulations.

During this inspection, we found the provider had failed to establish and operate effective governance systems. Audits undertaken in relation to people's care plans failed to assess the quality of information provided to staff or drive improvements as required. Care plan evaluations were not always completed when required and were not an effective tool to identify shortfalls.

Internal 'inspections' carried out by the provider failed to highlight issues identified during our inspection and had not ensured compliance with Regulations 9, 10, 12, 13 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always receive safe care and treatment because known risks were not appropriately mitigated or planned for. Staff did not have access to relevant guidance to ensure care was delivered safely or consistently.

Staff, who had not completed relevant training, used physical interventions to deliver care and support to

the people who used the service. The use of physical interventions had not been appropriately planned or reviewed.

People's care plans did not always reflect their current level of need. We found people's care plans did not always include relevant information to ensure staff could deliver person-centred care.

We found the principles of the Mental Capacity Act 2005 were followed within the service. However, appropriate records had not been created following best interest meetings which meant it was not always clear care and support was delivered in people's best interests.

People were not always treated with dignity and respect by staff; we witnessed a member of staff talking to people in an inappropriate and uncaring way.

People were supported by suitable numbers of staff who had been recruited safely. Records showed staff had completed a range of training and received appropriate levels of one to one support as well as annual appraisals.

People received care and treatment from a range of healthcare professionals. People were supported to eat a balanced diet of their choosing. However, we found limited options for people who were vegetarian.

People were supported to make decisions in their daily lives. People we spoke with told us staff were kind and supported them to undertake activities.

People who used the service, their families or appointed representatives were involved in the initial and on-going planning of their care. The provider's complaints policy was displayed within the service which, helped to ensure it was accessible to people.

Staff told us the registered manager was supportive and approachable. The registered manager was aware of and fulfilled their regulatory duties to report notifiable events that occurred within the service.

The provider was reactive to the concerns we identified during and after the inspection had taken place. We have taken this in to account when assessing and making judgements about the on-going level of risk at the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People were not protected from abuse and avoidable harm. Staff used physical interventions to carry out care without relevant training.

Known risks were not managed and appropriate guidance was not provided to ensure staff delivered care safely and consistently.

Medicines were not managed safely. There were issues with storage, overstocking, recording, covert administration and self-administration of medicines.

People were supported by suitable numbers of staff who had been recruited safely.

Is the service effective?

Requires Improvement

The service was not always effective. Best interest meetings and decisions were not always recorded appropriately so it was unclear if people received the least restrictive support to meet their needs.

Some staff carried out care interventions that they had not been trained to complete safely.

Staff had completed a range of training and received regular supervisions and annual appraisals.

People were supported to eat and drink sufficiently to maintain their health and wellbeing. However, we found options for people who were vegetarian were limited.

People who used the service were supported by a range of healthcare professionals.

Is the service caring?

Requires Improvement

The service was not always caring. During the inspection we heard a member of staff speaking to people inappropriately and treating them in an undignified way.

Despite our observations, people told us staff were kind and attentive to their needs.

Private and sensitive information was stored appropriately.

Is the service responsive?

Requires Improvement

The service was not always responsive. People did not always receive personalised care that met their individual needs.

People's needs were not planned for and the service was not responsive to their changing needs.

The provider had a complaints policy in place at the time of the inspection which was displayed within the service.

Is the service well-led?

Inadequate

The service was not well-led. The quality assurance systems in place were inadequate and not operated effectively. They did not drive necessary improvements across the service.

Internal processes were not always followed when incidents occurred which meant senior management were not aware of them.

The service had a registered manager who fulfilled their regulatory duties to report notifiable incidents as required.

Atkinson 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 was planned to check whether the registered provider was 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 commenced on 6 and 7 September 2017 and was unannounced. The inspection team consisted of two adult social care inspectors and two experts-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we contacted the local authority commissioning and safeguarding teams to gain their views on the service. We reviewed our systems for any notifications that had been sent in as these evidenced how the provider managed incidents and accidents that affected the welfare of people who used the service. We also looked at the action plans sent to us by the provider following our last inspection.

During the inspection, we spoke with 18 people who used the service and nine of their relatives. We also spoke with the registered manager, 16 members of staff including care, domestic, kitchen and administrative staff as well as two visiting healthcare professionals.

We used the Short Observational Framework Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed staff interacting with people who used the service and the level of support provided to people throughout the day.

We looked at 12 people's care plans along with the associated risk assessments and medication administration records (MARs). We also reviewed how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make informed decisions themselves or when they were deprived of their liberty, actions were taken in their best interest.

We also checked a selection of documentation relating to the management and running of the service. This included training records, recruitment information for six members of staff, complaints information, a number of the provider's policies, completed questionnaires and quality assurance systems.

We completed a tour of the entire premises to check general maintenance as well as the cleanliness and infection prevention and control practices.

Inadequate

Is the service safe?

Our findings

Staff we spoke with described the different types of abuse that may occur and knew how to recognise the signs or symptoms that could indicate someone was suffering from abuse. However, a member of staff we spoke with told us a person who used the service had informed them they had experienced abusive practices during a night shift. The member of staff said, "When [Name of the person who used the service] made the allegations, I told the nurse on shift, they were from an agency. I don't know what they did about it." When we asked the person if they had reported the allegation to the registered manager they said that they had not. We asked the registered manager if they were aware of the allegation and they told us they had not been made aware of it, subsequently the local authority safeguarding team had not been notified and no investigation had taken place. We asked the registered manager to inform the local authority safeguarding team and establish who was to investigate the allegations.

Staff told us, and records indicated that a small number of people who were living with dementia would become aggressive and agitated during personal care. One person's skin integrity care plan stated they could be 'quite aggressive and hits out' and advised 'staff should use distraction techniques', but contained no further information about what distraction techniques were known to reduce the person's agitation. Another person's care plan advised staff to use 'Non Abusive Psychological and Physical Interventions' (NAPPI) techniques, but included no further descriptions as to what the techniques were. Training records showed only 16 staff had completed this training and when we looked at incident and daily records it was clear staff who had not completed the training had used physical interventions.

Staff told us they used low-level physical interventions to deliver the care and support to people when they were resistive. A member of staff said, "I haven't done any training [in relation to using physical interventions safely], we just hold people's hands and stop them from hitting out." Another member of staff told us, "No I haven't had the training, but if they need personal care I still give it, we just stop them from stopping us really." Daily records showed that one care intervention was carried out by five members of staff; other records stated people were aggressive and resistive during care, but due to the level of recording it was unclear if physical interventions were used.

The use of planned physical interventions must only occur when a marked threshold has passed and alternative strategies have been unsuccessful. It must only been carried out by trained staff who are following an appropriate care plan, which ensures it is the least restrictive intervention required to meet the person's needs.

The above information demonstrated a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the end of this report.

Following the inspection, we received updated copies of people's care plans which included detailed guidance for staff to follow when physical interventions were required to deliver essential care. The care plans stated that all interventions would be nurse led and undertaken by staff who had completed relevant

training and included guidance on alternative strategies that would be attempted prior to any physical interventions being used. We were also provided with confirmation that all staff would complete training so they understood how to undertake physical interventions safely.

We reviewed risk management within the service and found appropriate action had not always been taken to mitigate known risks as required. For example, a person's 'physical aggression' care plan stated '[name of the person] will rise and start banging doors, tipping furniture, throw objects about, flood their room'. The care plan failed to include any known triggers or provide appropriate guidance for staff on how to support the person when they displayed the described behaviours. Accident and incident records showed the person had been aggressive towards other people who used the service, but there was no care plan in place to show this had been planned for and there was no available guidance for staff to follow.

A person's 'mental health' care plan stated they 'can be verbally and physically aggressive' and 'if [name of the person] enters a resident's room who will assault them, two staff will have to remove them quickly, this will mean holding their arms and hands and taking them out of the room'. The care plan provided no information regarding what techniques or strategies staff should use when the person was verbally or physically aggressive and contained no triggers for their behaviours.

Records showed one person had suffered from four falls in one weekend. The person had a falls risk assessment in place, but there was no evidence to show that it had be reviewed or updated after the high number of incidents over two days. There was no evidence to support any action being taken to prevent further falls occurring.

Two people were involved in a sexualised incident for which care plans had been developed to ensure further incidents were minimised. The care plans stated the people should not be left in a room together without a staff presence. Despite this, during the inspection there were two occasions were the people were together unattended.

A person was discharged to the service with pressures ulcers. Records of an internal multi-disciplinary meeting showed that it had been agreed that if the ulcers did not show signs of improvement, a specialist tissue viability nurses would be contacted for their support. Although no improvements had been recorded, and there were indicators that further deterioration had occurred, a referral to a tissue viability nurse had not been made. This meant appropriate action had not been taken to mitigate this known risk.

The above information contributed to the breach of Regulation 12 (2) (a) (b) (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the end of this report.

We reviewed the management of medicines within the service and found there to be issues with storage, overstocking, recording, covert administration and self-administration.

During our observations, we noted the medicines fridge on the intermediate care ward was not locked. We saw medicines were left in offices which were not locked and people who used the service had access to. We found discontinued medicines were still present in the trolley and fridge on the ground floor. Medicines that may be required by a person such as an inhaler were stored within a locked trolley thereby causing a possible delay in administration.

There was an issue of overstocking within the home, especially on the first floor. The medicines cabinet in particular was over full with some people having several months' supply of their medicines and thickening

products. There was no clear segregation of the medicines in the cabinet on the first floor with one person's medicine being stored in five different places. Stock rotation to ensure that the oldest products were used first was not consistent.

Stickers to ensure that once medicines were opened they were used within the required period of time were not always being used. There were issues with the recording of the administration of pain control patches. Several of the records did not include both the application and removal date. A relative we spoke with told us that on a number of occasions, old patches had not been removed before the new one was applied.

Covert administration of medicines was not always agreed in an appropriate best interest forum and had not had input from a pharmacist. Agency staff were unaware of the people who should have their medicines administered covertly. People on the intermediate care unit were not supported to self-medicate, which would be expected to facilitate their rehabilitation and support them to eventually return home. There were inconsistencies with storage as some patients had their medicines within their rooms whilst others received them from a trolley. Some people preferred to have their medicines dispensed into a pot and decide themselves when to administer them. The signature on the MAR chart was not an accurate record of actual administration.

The above information contributed to the breach of Regulation 12 (2) (g) (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the end of this report.

Despite our findings, people told us, "I get the drugs that I need and the nurse gets different types for me, because as I have trouble swallowing" and "They bring me my medicines every day. I have dry itchy skin on my shoulder and they put cream on it day and night."

At our last inspection of the service in November 2016, we identified issues with staffing levels. Staff were not always deployed in suitable numbers to meet the needs of the people who used the service. We issued a warning notice for this breach.

During this inspection, we found the provider had taken appropriate action and ensured people were supported by appropriate numbers of staff. We saw dependency assessments had been completed for each person who used the service, which identified the amount of support people needed across a range of daily tasks. The assessments where then used to calculate the amount of staff required to meet people's needs. A person who used the service told us, "There are people around you all the time. When I press my buzzer, I don't have to wait long. The longest I have ever had to wait has been five minutes." A relative we spoke with said, "There are always nursing staff available. I have been visiting for two years, they don't know when I am coming and there is always a lot of staff on."

The registered manager told us, "We do have to use a lot of agency staff, but today for example, we don't have one member of agency and as you have seen we are recruiting." They also said, "At no time in the last three months have we been short of staff, we have always made sure every shift is covered." We saw evidence to confirm this.

We saw evidence to confirm staff were recruited safely. The six staff files we saw included references and a Disclosure and Barring Service (DBS) check. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. These checks help employers make safer recruiting decisions and help to minimise the risk of unsuitable people from working with people at risk.

We found the environment to be clean and free from odours. Checks were carried out on equipment to ensure it remained safe and in good working order.

Requires Improvement

Is the service effective?

Our findings

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Records showed that either DoLS were in place as required or applications had been made and were awaiting authorisation.

We found records that showed best interest meetings had taken place. However, there was no evidence of the conversations that were held or the decisions that were made. For example, we saw a form completed for one person that stated, 'to assist and support [name of the person] for all care and nursing interventions'. Due to the lack of appropriate records, it was not clear how it had been established that the decision, 'for [name of the person] to be assisted with all care interventions' was the least restrictive way to deliver the care they required. A care plan was subsequently created that stated two or three people should deliver care interventions and if the person resisted care then physical interventions should be used.

The need for a person to receive their medicines covertly was also recorded on a best interest form. Records showed the meeting was attended by a family member, the person's GP and psychiatrist, nursing staff from the service and a pharmacist. The record showed that the pharmacist had not agreed for medicines to be administered covertly and was 'concerned'. There were no records of the discussions held, the concerns raised by the pharmacist or the action taken to alleviate those concerns. The form stated that the person should 'receive their medication covertly'. Subsequently a care plan was created that stated the person should have their medicines given covertly in a branded sugary drink, there was no record to support that the pharmacist had been contacted to ascertain if the drink would have any effects on the medication.

Following the inspection, we received copies of updated documents which clearly described the decisions that needed to be made in each person's best interest, the people who attended the meetings, the discussions held, the rationale that showed why the proposed action was the least restrictive and an updated care plan.

When reviewing people's care records it was clear that they were supported by a range of healthcare professionals. We saw advice and guidance from GP's, community mental health teams, psychiatrists, physiotherapists and pharmacists.

We reviewed staff training records and found staff had completed training in a range of subjects. This included moving and handling, safeguarding vulnerable adults, infection prevention and control, cyber security and IT security, food safety, fire safety and first aid.

As highlighted in the safe section of this report, staff completed care interventions that they had not been trained to undertake safely. We also had concerns that only 10 staff had completed training with regards to supporting people who were living with dementia even though the service had a dedicated dementia unit.

People who used the service praised the staff team. One person said, "I don't know what training staff get, but I feel confident when they care for me. I like it here; I don't want to be anywhere else." A relative we spoke with told us, "The staff are excellent. My sister has a catheter, they are always checking it. She has a special mask she has to wear at night which they never forget to put on. There are always going to be issues, but on the whole I think they are very good."

We reviewed staff files and saw evidence that supervisions and appraisals took place. Staff told us they felt supported in their roles, one person said, "We get a lot more support than we used to. We have unit managers and shift leaders so there is always someone you can talk to."

People were supported to eat a diet of their choosing. We saw that options were provided at each meal and further alternatives could be provided if requested. A person raised concerns about the vegetarian choices available, which we raised with the cook. Records showed the person had been given limited options and were provided with vegetarian sausages as a main meal on both days of our inspection. The cook provided reassurance that they would speak to the person to establish their preferences. We informed the registered manager of the issues who confirmed action would be taken.

During our meal time observations, we saw people were supported as required. Staff knew people's individual levels of independence and ensured they were enabled. For example, we saw some people had their food cut up for them, but following that were left to eat independently. Other people were given plate guards and some people were supported to eat by staff. The interactions were appropriate and staff were attentive.

We saw evidence that when concerns with people's dietary intake were identified relevant professionals were involved with their care. Food and fluid charts were completed when required.

Requires Improvement

Is the service caring?

Our findings

People who used the service were not always treated with dignity and respect. During our observations, we saw a person being brought into the lounge on the dementia unit. The person used a wheelchair and was visibly upset; they appeared to be crying. The member of staff who brought the person into the room informed another member of staff that the person had been supported with personal care and that was the reason they were upset. The language used and the tone were inappropriate. The member of staff left the room and returned with a drink for the person, they then spoke to them in a condescending way and showed a lack of empathy towards their feelings.

Later in the inspection a person needed to be supported to be repositioned in their specialist wheelchair. Staff needed to use a slide sheet so the person was taken to their room. During this episode of care, the same member of staff was heard using a raised voice and aggravated tone. A senior member of staff intervened to prevent further distress being caused to the person who used the service.

The above information demonstrated a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the end of this report.

Following each incident we reported what we had witnessed and heard to the registered manager, and, after the second incident had occurred, they took action to address our concerns.

People's needs were not always met in a caring way. For example, the main lounge on the dementia unit did not have a television, which meant stimulation for people at certain times of the day was minimal. A member of staff told us, "A resident broke it [the television] a while ago and we haven't replaced it yet. I think that's quite bad because it means they just sit there, we could have put an old movie on or a musical or something just to pass the time."

Despite the incidents above, we witnessed caring and positive interactions between people who used the service and staff. Staff were observed using their knowledge of people's individual preferences and interests to reassure them and redirect them when required. They were kind and considerate; using appropriate physical contact such as hand holding to calm people when they were distressed.

A person who used the service said, "Staff come and sit with me to comfort me, not that I need it. They try to make you feel at home." A relative we spoke with commented, "It's homely here, everyone mucks in and looks after one another and the staff are very friendly." Another relative said, "I visited 24 homes before I found this one, I think it's very good."

People were supported to make decisions in their lives; we heard staff offering people choices. This included where they wanted to spend their time, if they wanted to participate in activities and what food to eat. People received the support they required when more complex decisions about their care and support needed to be made. Advocacy information was displayed within the service and records showed people had

accessed this service.

Staff had completed cyber security and IT security training to ensure they understood their responsibilities to keep private and sensitive information stored securely. A member of staff said, "I wouldn't tell anyone about what people do here, it's no one's business. We keep things confidential; I wouldn't want someone to discuss my private life." Another person said, "We keep all the files in the locked offices on the units and we all understand about confidentially."

Requires Improvement

Is the service responsive?

Our findings

People who used the service, their relatives or appointed representatives were involved in the initial and on-going planning of their care when possible. We saw evidence that initial assessments were completed before people moved in to the service. The assessment captured information regarding people's needs and levels of independence and was used to create a number of care plans.

People did not always receive responsive or personalised care because their care plans failed to accurately reflect their needs or include their preferences. People's care plans lacked information about their personal abilities and levels of independence. For example, a person's 'personal care and hygiene' care plan stated 'a full wash should be carried out twice daily'. There was no information regarding the person's abilities to complete any areas of care independently such as washing their own hands or face, cleaning their teeth or brushing their hair. This meant staff would not be aware of how to meet their individual needs in a person-centred way.

We reviewed the incident records, which showed a person had been involved in an incident with another person who used the service. Staff told us the person displayed behaviours that challenged the service and others so we asked to see their care plans. Some of the records were not present in the person's file. An external healthcare professional confirmed they had seen the care plans the day before, but they were not available at the time of the inspection. This meant staff did not have information they required to ensure the person's needs were met safely, effectively and in line with their preferences.

When we cross referenced people's care plans with the incident records and saw they were not always updated after incidents occurred. We also found evidence that showed people's care plans were not updated when their mobility had deteriorated. This meant staff may not be aware of their current levels of need.

Staff told us a person displayed behaviours that challenged the service and regularly walked around the unit which heightened the possibility of incidents occurring. They also said medicines prescribed to be taken only when needed, were used to reduce their agitation and distress. A behaviour management care plan had not been created and no guidance was available for staff to follow.

We found a best interest decision was in place for a person to wear a particular item of clothing that would prevent them from taking their clothes off in public areas. However, there was no care plan in place for staff to refer to if the person did remove their clothing. Subsequently, there was no information about possible triggers for this behaviour or strategies of how staff could prevent it from occurring.

Four people's care plans contained blank life story documents, which would provide staff with information about their lives before they moved into the service and enable them to develop meaningful relationships with people. A relative we spoke with told us, "I don't know what their care plans say, but I do think the permanent staff knows their needs. The issue we have is with the agency staff. They don't know them; they don't what they like and they just can't deliver the same level of care in my opinion."

During our observations we saw a member of staff using their knowledge of people's interests to engage them, which enabled care and support to be delivered. The staff member said, "You have to know the things they respond to, what brings them out of their shells." We asked them if other staff had the same knowledge and if the information was recorded in people's care. They said, "I had a meeting with [name of unit manager] last week about this we are going to start making a list for staff to use." However, at the time of the inspection this had not been completed which meant valuable information that would enable person centred care to be provided to people was not available to staff.

The registered manager told us, "I acknowledge some of our care records do not include certain information and may have contributed to some of the incidents. I have relied on the staff to do things and in some cases it hasn't happened." They also said, "We recruited a unit manager who was very experienced, but we soon realised they did not have the skills and expertise we needed, there were issues with the care plans [the unit manager developed] and we have been playing catch up."

The above information contributed to the breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the end of this report.

Following the inspection we were sent copies of updated care plans which contained relevant information about people's needs. They contained detailed guidance for staff to follow which would enable them to deliver person-centred care in line with their preferences. The group director of performance and regulation told us, "We will review all of the care plans so we can be confident they contain the right level of information not just the ones highlighted by the inspection process."

During the inspection, we saw people engaging in different activities either on a one to one level or in groups. One person said, "I like to talk to people and I love getting visitors." Another person said, "I like singing, we do karaoke here you know." A relative told us, "My sister is able to go out whenever she wants, she gets involved in all the activities, and she loves them." Another relative said, "They take her out shopping or to a café. They are doing weekend activities which we think is important."

The provider had a complaints policy which was displayed at the entrance to the service. We saw that when complaints were received, they were investigated and responded to in line with the provider's policy. A visiting relative we spoke with said, "We had an issue about cleanliness not that long ago. We spoke with the manager and they sorted it out immediately. Another relative said, "The manager has an open door policy, if I have a problem I would raise it with them." A person who used the service said, "I don't have any complaints."

Inadequate

Is the service well-led?

Our findings

The service was not well-led. The provider failed to ensure effective governance systems were operated to assess monitor and improve the service or mitigate risks. The group director of performance and regulation told us, "We are working on governance across our elderly care services. We realised our oversight could improve and we are currently on a journey with lots of our services."

The provider conducted internal inspections of the service; a full inspection was completed in July 2017 and a 'safe' inspection in August 2017. The internal inspections had failed to drive required improvements across the service and ensure compliance as required. The inspection carried out in July highlighted a high number of medicine errors and stated action would be taken to rectify the issues. However, the inspection carried out in August stated there had been a further eight medication errors between 1 and 17 August 2017 alone. This showed us the governance systems were not effective in mitigating known risks or driving necessary improvements.

The care plan auditing tool was used to check whether specific documents were in place, it was not used to assess the quality of information or ensure that it remained accurate. The audits we saw highlighted, amongst other things; care plans were not being updated as required, that specific documents were not in place, consent had not been obtained and risk assessments were not always in place as required. We reviewed audits from May, June, August and September 2017. The audits highlighted similar concerns and failings to have appropriate documentation in place, but were not effective in preventing any future reoccurrences.

The care plan audits stated care plans were to be re-written annually and evaluated monthly. We found evidence that this did not occur. For example, one person's medication care plan was evaluated on 28 June 2016, February 2017, twice in March 2017 and not again until July 2017. This meant it was evaluated five times from a required 14. A healthcare professional we spoke with said, "I am not sure what the auditing is like, but the care planning is not good, they are not person-centred and just don't have the level of detail they need. I would have thought the audits would show that."

The systems and processes used by the provider failed to highlight that people's care plans instructed staff to carry out physical interventions which they had not completed training to do so safely. They also failed to identify staff were carrying out physical interventions that they had not been trained to carry out. Daily records showed five members of staff had been involved in an episode of care for one person. Due to the inadequacy of the provider's systems and processes this had not been highlighted.

The provider had not developed effective systems and processed to assess the quality of care records or to ensure they were updated as required. When we cross referenced the accident and incident records with people's care plans we found they were not updated following specific incidents. This meant staff did not have relevant information about people's behaviours or appropriate instructions to mitigate known risks.

The systems and processes implemented by the provider were not always followed as required. The

provider's incident management, reporting and investigation policy stated 'Priory Group aims to provide the best possible and safest care and treatment to all service users; however there are times when incidents will happen. The aim of this policy is to ensure that incidents are effectively managed, reported and investigated.' However, the group director of performance and regulation informed us the provider's Situation, Background, Assessment, Recommendation (SBAR) process had not been followed after a recent incident. This meant senior management, including the director of risk and safety and the divisional quality director were not informed of the incidents as required, which could have prevented appropriate action being taken

The registered manager told us, "We have safety, quality and compliance meetings every week. Any issues or specific incidents that have occurred will be discussed there and the agreed actions will be recorded." However, we reviewed the safety, quality and compliance meeting records for August and September 2017 and found no reference to a specific incident that had occurred.

We found that the principles of the Mental Capacity Act 2005 were followed within the service. However, best interest paperwork did not include evidence of the discussions that had taken place. This meant it was not clear if the care and support delivered following the meeting was in the person's best interest or agreed as the least resistive way to meet their needs.

We reviewed the daily records for people that staff said were resistive to care. On numerous occasions records stated care had been delivered, but people were aggressive, had hit out at staff or were resistant to the delivery care. From the records, it was unclear if staff had used physical interventions to deliver care or how the support was provided. Therefore, the provider failed to ensure that contemporaneous records were kept in relation to the care and support delivered to people who used the service.

The above information contributed to the breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response and will report on any action once it is completed.

The registered manager told us that they conducted daily 'walk rounds' to check people's general presentation, staffing levels and infection prevention and control. They said, "Some things you can't audit so I go round and check things are done to a standard I am happy with." They also said, "The RMN [registered mental health nurse] was supposed to audit the care records, but they have not been at work for some time."

At our last inspection of the service, we found the provider had failed to complete statutory notifications as required. During this inspection, we reviewed the accident and incident reports held at the service with the information we had received. We established that the Commission had been notified of specific events as required. The registered manager said, "I make sure everything gets reported."

We saw staff, people who used the service and relative's meetings were held regularly. This helped to ensure people had a suitable forum to provide feedback about the service. Meeting minutes included issues raised and the action taken by the service, for example, improvements to the laundry and the availability of fresh fruit on the units.

People who used the service were asked to complete questionnaires so their feedback could be captured. The completed documents we saw covered a range of subjects including, if they were happy living at the service, if the felt safe, if the staff were caring, the activities and the meals provided.

Staff told us the registered manager was approachable and supportive. Their comments included, "[Name of the registered manager] is really good, they listen to our feedback and genuinely care about all the residents" and "The manager is supportive, I think they are good."

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 9 HSCA RA Regulations 2014 Person-centred care Care plans did not always reflect people's current needs. Care plans lacked adequate information regarding people's needs and preferences.

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 People who used the service were not always treated with dignity and respect.

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 People did not receive safe care and treatment. Action had not been taken to effectively mitigate known risks and appropriate guidance had not been developed to ensure staff knew how to deliver care safely and consistently.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not safeguarded from abuse and improper treatment. Appropriate systems were not in place regarding the use of physical interventions.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had failed to ensure systems and processes were established and operated to assess, monitor and improve the service or mitigate risks.

The enforcement action we took:

We issued a warning notice in respect of this regulation.