Knotty Ash Residential Care Home Ltd

# Knotty Ash Residential Home

## Inspection report

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11 January 2019
14 January 2019

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| 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

This inspection took place on 10, 11 and 14 January 2019. The first day was unannounced; the provider knew we were returning on the other days.

Knotty Ash is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service provides support to up to 35 people and there were 32 people living in the home on the day of the inspection, many of whom were living with dementia.

The service did not have a registered manager in post at the time of the inspection. 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. The registered manager had left the service in November 2018. A new manager had been recruited and started in post a few days before this inspection.

At the last inspection in June 2018, the registered provider was found to be in breach of Regulations 11, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because consent was not always gained in line with the Mental Capacity Act 2005, people's records were not always accurate or up to date, the environment was not always safely maintained and systems in place to monitor the quality and safety of the service were not effective. We asked the provider to complete an action plan to show what they would do to improve the key questions of safe and well-led to at least good. During this inspection, we looked to see if they had made the necessary improvements. On this inspection we found some small improvements had been made regarding the Mental Capacity Act 2005, but the provider remained in breach of some legal requirements.

At the last inspection the provider was in breach of regulations as the systems in place to monitor the quality and safety of the service were not effective. We found during this inspection, that they were still not effective. Quality assurance processes were not in place to review all areas of the service and those that had been completed did not always reflect what actions had been taken to address the issues. If more robust quality assurance processes had been in place and were being monitored closely, then the serious issues that were found during the inspection would have been identified earlier by the registered manager or the provider and dealt with.

The management team completed various quality audits including care plans, medicines, cleaning and health and safety. However, these audits had not proved effective at identifying issues and were not reviewed to ensure issues had been resolved.

Medicines were not always managed safely within the home, as they were not booked in and counted accurately, there were no guidelines in place for staff to administer medicines that were prescribed 'as

needed', and there were no times recorded for the administration of medicines that needed to be given at specific times.

There was no clear system in place to oversee accidents and incidents. Although a log was maintained, no information was analysed to establish potential themes or trends. This meant it would be difficult for lessons to be learnt or for actions to be taken to prevent recurrence of some incidents.

Small improvements had been made in relation to the homes compliance with the Mental Capacity Act 2005 (MCA). We saw a care file which had appropriate mental capacity assessments completed, and evidence of best interest decisions being made. However, we found that staff had not been trained in MCA, and had limited knowledge of how this related to peoples care. We have made a recommendation about staff training on the Mental Capacity Act 2005.

Some peoples care records lacked detail. We saw some care files that contained detailed information, including peoples likes, dislikes and preferences regarding personal care and food. However, some care files contained very limited information. and had limited personal details in there. A lack of personal information makes it harder for staff to tailor care to suit that persons preferences and needs. We spoke to the manager and director about this and we were told that care files were currently being updated to make them more person centred.

People told us that staff treated them in a caring way and respected their privacy and supported them to maintain their dignity.

People told us they felt safe with the care provided by staff. Staff we spoke with understood their responsibility in relation to protecting people from the risk of harm. Staff told us they had received training that had helped them to understand and support people.

The home appeared clean and well maintained during the inspection. Staff had access to personal protective equipment such as gloves and aprons and bathrooms contained paper towels and liquid hand soap to help prevent the spread of infection.

Activities were available and we saw people joining in and enjoying singing and dancing during the inspection. We also observed lots of warm and caring interactions between staff and people who lived at the home throughout the inspection.

Our observations throughout the day showed that people were treated with dignity and respect. People received comfort when needed. Staff used their knowledge of people to engage them and help build positive relationships.

Policies set out that when a safeguarding incident occurred management needed to take appropriate action by referring to the relevant safeguarding agency. However, we found an incident had not been reported to us, as legally required.

Safe staff recruitment procedures were in place to protect people from receiving personal care from unsuitable staff.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that

providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

The provider was in breach of the regulations surrounding safe care and treatment and good governance. You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

People's medicines were not managed in a safe way.

Health and safety checks had not been completed or reviewed regularly.

Accidents and incidents were not thoroughly reviewed to mitigate future risks.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Care plans lacked a person-centred approach in relation to nutrition and hydration needs.

People were supported by staff who felt supported and received regular supervisions.

Staff were not knowledgeable about the Mental Capacity Act 2005 and did not always apply the principles of the act.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

Some people had their choices restricted. The restrictions were in place due to lack of equipment and safety concerns. However, the impact on the restriction for these people had not been considered, and it was unclear that other options to resolve the problems had been explored.

Peoples privacy and dignity was respected.

Although care plans lacked detail regarding peoples likes and dislikes, staff were able to support people in a way that matched their preferences, as they had built good relationships with people.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Peoples care records lacked detail.

People were not always involved in their care plans.

There were activities available for people to enjoy.

## Is the service well-led?

**Inadequate**

The service was not well led.

There was a lack of robust systems in place to monitor and assess the quality of service being delivered and drive improvement.

There was a lack of leadership to ensure that an appropriate standard of care and support was provided to people.

The provider had not deployed appropriate strategies to address previous breaches of regulation to drive continuous improvement.

# Knotty Ash Residential 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 provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was a comprehensive inspection which took place on 10, 11 and 14 January 2019 and was unannounced. The inspection team included an adult social care inspector, inspection manager 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. In this instance, care of people living with dementia.

Before the inspection we reviewed information relating to the service including notifications sent to us by the provider. A notification is information about important events which the provider is required to tell us about by law. We contacted the local authority quality assurance team, to ask their views about the quality of the service provided.

During the inspection we spoke to the registered provider, the home manager, deputy manager, the assistant support officer, activities coordinator, and five members of care staff on duty. We were also able to speak with four visiting relatives and five people living in the home.

We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We spent time looking at records, including four people's care records, one staff file and other records relating to the management of the service, such as policies and procedures, medication records, training records and audit documentation.

Inadequate

# Is the service safe?

## Our findings

At the last inspection in June 2016, we found that the provider was in breach of Regulation 12 and the safe domain was rated as requires improvement. This was because medicines were not always managed safely, environmental risks were not well managed, and risks to people were not accurately assessed or well managed. During this inspection we checked to see if improvements had been made. We found that although some concerns regarding risks to people had been improved, we saw there were still concerns with regards to medications and the environment.

We found medicines were not always managed safely. We looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), for people living in the home. We found that no times were recorded when medicines were administered. One person was prescribed medicine that was required to be administered at the same time each day. It was difficult to tell if this had happened. We spoke with a senior carer who was responsible for administering medicines during the inspection and we were told that the times people received medicines varied. This meant this person was not always receiving their medicine as prescribed.

People in the home were prescribed 'as required' medicines. There were no guidelines for staff to follow to ensure these medicines were prescribed to people in line with GP recommendations as to when they needed them. One person was prescribed 'as required' medicine and we found this had been given to this person twice a day every day for the last few months. We spoke to a senior carer who could not tell us exactly when this medicine should be given. This meant this person was at risk of receiving this medicine when they did not need it.

We looked at MAR charts during the inspection and found gaps in the recording of medicines that had been administered. We were unable to confirm if these medicines had been given. We did see evidence that the deputy manager had sent information to staff via email, reminding them to complete medicine records immediately when administering medicines.

Some people in the home were prescribed medicated patches. Some of these patches required replacement patches to be placed on the skin in a different area of the body for 3-4 weeks after removal. We found there were body maps available with the MAR charts so staff could see where the patch had been placed previously. However, these body maps were not always completed and we found numerous ones were blank. This meant the home were not following the manufacturers guidance for site rotation. This also meant the person was at risk of increased absorption of the medication.

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

Systems were in place to help ensure the building and equipment was safe and well maintained. For example, external contacts were in place to check the gas, electrics and lifting equipment. We viewed the certificates for these and they were in date.

However, we found that there were issues with some of the fire safety checks within the home. We were told fire safety checks were carried out monthly. We found that these checks had not been completed in June, July, August and November 2018. When we spoke with the director she reported there had been issues with maintenance due to the position being vacant at times. There was no plan put in place when the maintenance position was vacant to ensure these checks still took place.

The provider had also arranged for an external fire safety assessment in July 2018. We found there were urgent actions that needed to be addressed, for example weekly fire alarm testing and fire marshals to be in place. We found no evidence of weekly fire alarm testing, and when we spoke with staff we were told "I've worked here quite a while and never heard it". We spoke to the director about this and she informed us that the fire alarm was tested weekly, but we saw no record of this.

When we asked staff who the fire marshals for the home were staff told us they did not know. When we spoke to the director she told us she was a fire marshal. We discussed this being inadequate provision for the home, especially as she did not work weekends or night time. We were told it had been hard to get staff on training, but we saw no evidence that training had been planned for staff.

We reviewed people's emergency evacuation plans (PEEPs) within their care files. We found these were not always easily available to see. Some PEEPs were contained as a separate sheet and others were included as part of an initial assessment. One person's PEEP detailed how to evacuate them in an emergency, and included the use of an evacuation chair if this person was located on the upper level of the building. When we spoke with staff they reported they had not been trained to use any equipment. We spoke with the director regarding this and she confirmed staff had received training in lifting and handling which included the use of equipment.

There were people in the home who needed the use of a hoist. When we asked staff how they would evacuate these people they reported they did not know. They said they would have to leave them in their room in that situation as they were unsure of the full evacuation procedure. We had seen one person's PEEP required the use of slide sheets. When we asked staff what they would do to evacuate this person they were unsure and reported they would not know how to use these and were unsure they would be physically able to.

We also saw records of water temperature checks. According to the home these should have been carried out monthly. We saw that in the last six months, three water temperature checks had been completed. In September 2018 a check had been completed and one of the rooms had a bathroom tap temperature of 48 degrees Celsius. The temperature should not exceed 44 degrees Celsius according to health and safety guidelines. There was a space on the temperature recording form for a manager's signature after review but this was blank and there was no evidence that this had been looked into. We looked at the water temperature record for January 2019 and it showed that the same room was showing a bathroom tap temperature of 47 degrees Celsius. This meant there had been a continued risk of scalding for the person in this room. We spoke with the director who knew the temperature should not exceed 44 degrees Celsius, but was not aware that the temperature had exceeded guidelines over that period of time.

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

People's care plans contained risk assessments in areas such as mobility, nutrition, falls and skin integrity. We found there had been some improvements with the risk assessments since the last inspection. For instance, care files now contained detailed information for risks such as seizures. There was clear information for staff that identified symptoms that may show a seizure was imminent and also detailed

guidance on how to manage the situation should it arise.

However, we found one person was at risk of pressure sores. The risk plan stated they should be re-positioned every 2-3 hours. We could not find any record of repositioning for this person. We spoke with staff, who could tell us who needed re-positioning and that this had been completed as per the care plan. We spoke with the manager of the home about this. We were shown a new repositioning chart which was being implemented immediately to ensure this person's care was accurately recorded. However, this form was not adequate and did not detail the information needed. The manager told us she would be updating the form straight away.

Most people we spoke with who lived at the home told us they felt safe. Comments we received included "I feel safe, there's always someone around," "I like living here, the staff are lovely. They do everything you want them to."

However, one relative we spoke with did not feel the home was always safe. We were told "I don't think it's always safe, I've found medicines on the floor in the past and nobody seems to answer the phone of a night." One other relative we spoke with also felt there were not enough staff in the night time. Staff we spoke with also raised that they did not feel there were always enough staff. They told us they had discussed this with the management team. We spoke with the director and the manager about this and we were told there were weekly discussions to identify the numbers of staff needed based on the needs of the people living in the home. These discussions were not recorded anywhere, but we saw rotas which reflected the staffing levels we had been told were needed for that period. During the inspection we found no issues with the staffing levels and we saw that staff responded quickly when people needed help and calls bells were answered in a timely way.

The provider had safeguarding and whistleblowing policies in place. Staff received training in safeguarding and demonstrated a good understanding of the types of abuse and how they should respond. We found that appropriate safeguarding referrals had been made to ensure they were investigated and acted upon.

We could see that accidents, incidents and safeguarding events were recorded, and that appropriate action had been taken in response to each situation. However, the audit trail of this was not clearly recorded. There was no clear system in place to oversee accidents and incidents. Although a log was maintained, no information was analysed to establish potential themes or trends. This meant it would be difficult for lessons to be learnt or for actions to be taken to prevent recurrence of some incidents. This issue was raised during the last inspection and had not been acted upon. We raised this with the manager, and by the end of the inspection we were shown a new auditing tool that was being implemented immediately.

We looked at how staff were recruited within the home and saw that adequate checks had been completed. This included photographic identification, appropriate references and Disclosure and Barring Service (DBS) checks. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff.

The home appeared clean and tidy during the inspection. Staff had access to personal protective equipment such as gloves and aprons and bathrooms contained paper towels and liquid hand soap to help prevent the spread of infection.

During our last inspection we were told new carpets were being fitted. On this inspection we could see this still hadn't happened. We were told the home were replacing the floor and this was going to be happening

very soon. We saw there were gaps in the carpet along the corridor. This posed a risk to people in the home of tripping over the carpet. We checked the carpet and it was secure to the floor in most places. We asked the manager to ensure this was part of the home daily checks to monitor the risk of accidents if the carpet got any worse before it was replaced.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). During this inspection, we checked to ensure the provider was working within the principles of the MCA.

At the last inspection in June 2018, we found that the home was not working in line with the principles of the MCA and was in breach of regulation. During this inspection we found there had been some improvements. We saw evidence that people were assessed for capacity for specific decisions and these were clearly detailed in the assessment. A capacity assessment form was in place and we saw this had been appropriately completed in line with the MCA. However, we saw that the issues with capacity assessments found at the last inspection had not been updated. The manager told us they would be reviewing capacity at least every 6 months, and when these people were reviewed they would complete the assessment in line with their new procedure.

We found that since the last inspection managers had completed MCA training. There was evidence that the learning from this training was being used to improve compliance with the MCA. However, staff had not received training in the MCA. When we spoke with staff regarding MCA and DOLs, they were not clear what this meant in relation to care. Staff were aware there were people in the home subject to DOLs, and knew this meant there were restrictions to their liberty. Staff told us it meant "people cannot go out on their own". Staff seemed unaware there could be conditions on a DOLs and that each MCA and DOLs is decision specific, and DOLs is not just related to not being allowed out. Staff we spoke to said they would like more training in the MCA. We recommend that the service seek support and training for staff, about the Mental Capacity Act 2005.

We looked at systems in place to ensure staff were supported in their role. Staff told us they felt well supported and received regular supervision. Supervision sessions between staff and their manager give the opportunity for both parties to discuss performance, issues or concerns along with developmental needs. Records showed that most staff had also taken part in an annual appraisal of their role.

We saw that when staff started in their role an induction was completed to ensure they had the knowledge required to support people safely and effectively. We also saw that staff worked "shadow shifts" where they worked alongside the existing staff to enable them to get to know the people who lived in the home and how they liked to be cared for.

The service liaised with other healthcare professionals to ensure people's needs were met. Records showed that advice was sought from people's GP, mental health team, speech and language therapist and social

workers.

The care plans we looked at did not have clear information about people's dietary needs or about their known allergies, likes and dislikes. For example, one persons record said "support [this person] with adequate food and fluids. Offer them foods they like." There was no information in the file to identify what this person liked. There was also no information for what adequate food and drink was for this person. This meant people were not always supported to receive individual care and support with eating and drinking. We did see some care plans that contained more detail and enabled staff to support people in a way that they preferred. One care plan stated "[The person] needs regular fluids. They enjoy cups of tea with 2 sugars, or a glass of milk at night."

Menu's showed that a variety of healthy meals were on offer and that alternatives were also available. They catered for people's individual needs and at the time of the inspection were providing soft and liquidised meals. Snacks and drinks were also available throughout the day. We observed people being offered tea and biscuits late afternoon.

The building met the needs of the people living in the home. The corridors were wide, well-lit and had handrails that were a contrasting colour to the walls. This made them easy to see and people could use them for support when required. People had numbers on their bedroom doors. At the last inspection, we were told the home was in the process of designing new pictures with people for their doors. At this inspection we found only a few people had a picture outside their door. The use of pictures helps people identify their rooms more easily. We discussed this with the director and manager, and we were assured all pictures would be available for people's use.

Requires Improvement

# Is the service caring?

## Our findings

People were supported with compassion, dignity and respect. Staff were able to clearly describe how they protected people's privacy and dignity. This included knocking on people's doors and ensuring personal care was provided in private. People told us that their care workers spoke with them in a respectful manner and always sought their consent before providing personal care and other support. One person told us "they respect my dignity and privacy and they will knock and wait before entering my room." One relative told us "Staff respect [the persons] dignity and privacy. They knock on [the persons] door before entering."

People were happy with the care and support they received from staff. Comments included "Staff are lovely, kind and gentle," "Staff are caring, they support me to be as independent as possible," "Staff are very good." The relatives we spoke with were also happy about the care that their relatives received. Their comments included "Staff are a bundle of fun," "The staff are quite good, they know the people well."

Some concerns were raised by relatives relating to people's ability to be independent and to have their choices respected. We were aware of one person who liked to spend time in their room but due to the location of their room this was not always possible. We also were made aware of a person who could not have their choices respected in relation to their personal care as the service provision was not flexible to meet their needs. We could not see that other options had been explored to support people.

We observed caring interactions between staff and people who used the service. For example, one person was displaying signs of anxiety and we saw a staff member gently reassure them until their mood changed and they became less anxious. We also saw staff singing and dancing with people using the service whilst sat in the lounge.

Care records we reviewed lacked evidence of people's involvement. Care plans and reviews were not signed to record the participation or agreement of people and their relatives. Information recorded about people's life histories was inconsistent as these had been completed for some people but not for others. Life histories can be a valuable source of information to assist staff in building caring relationships with people.

Staff took time to listen to people and supported them to express themselves according to their abilities to communicate. Staff knew people well and we saw they shared jokes with people and enjoyed each other's company. For example, staff made eye contact when they spoke with people, to check people understood their words. People were confident to seek support when they wanted it, which showed they trusted staff.

Some staff had completed Equality and Diversity training, and there was evidence within care plans that peoples individual beliefs, including cultural or religious traditions, were taken into account. We saw one person who had visits from the local church to support with their religious needs.

Equipment was in use within the home to help maximise people's independence. This included the use of walking frames, and wheelchairs. Some care plans included prompts to remind staff to encourage people to do as much for themselves as they could. This enabled people to continue to be as independent as possible,

whilst helping to ensure that they remained safe. One relative told us "[The person] used to love cleaning the house, so the staff let her help with dusting in the home". During the inspection we also saw people moving freely and safely as much as they could around the home.

Requires Improvement

# Is the service responsive?

## Our findings

There was no one within the home who was receiving end of life care at the time of the inspection, however some staff had completed this training meaning they would be able to appropriately support someone when needed. We did also see evidence that care files included information regarding people's future wishes; where they would like to be cared for and their end of life care preferences.

The service was meeting the Accessible Information Standard (AIS). AIS was introduced by the government in 2016 to ensure that people with disability or sensory loss are provided with information in a format that they can understand. Where people required support to communicate this was documented in their care plan. One care plan we viewed for a person stated "[The person] needs support with all their communication needs; can understand things when speaking in a slow voice". The director told us that information such as complaints process, service user guide and quality assurance surveys were available in larger print to use if needed. Although we saw evidence that information was available in different formats when requested, we didn't see this being used widely in the home. We discussed this with the manager who said they will address this.

The care files we looked at showed plans were in place in areas such as nutritional needs, personal care, continence, mobility, medical history, communication, social, cognition and skin integrity. At the last inspection, we found there were concerns with care plans not reflecting peoples current needs and no care plans for specific health conditions, such a seizures. During this inspection we found care plans were in place for managing health conditions, for instance seizures. These plans also informed staff how to respond in that situation.

However, care plans we looked at, showed limited involvement from the person or their relatives. Some people told us they had not been involved in their care plan, comments included, "Neither me or my family have been involved with my care plan." And "Nobody has ever spoken to me about my care plan." Some care files had evidence of discussions with the person regarding care, others did not.

Some care plans also lacked personal detail. One person's cognition and mental health care plan stated "[The person] can be low in mood, and is unable to express themselves verbally. Staff to monitor facial expressions." There was no information in the file that indicated what this persons facial expressions may be when feeling low in mood.

We saw evidence that care plans were reviewed regularly. Care files were also audited but this was irregular and inconsistent. Some files contained out of date information. For instance, one person's care file we saw stated that no 'do not attempt resuscitation order' (DNAR) was in place, but we saw a copy of the DNAR order in the file. When information in care files is not kept up to date, it puts people at risk of not receiving care and support in line with their current needs and wishes. We raised this with the manager who informed us they had been working through auditing files and ensuring information was correct and in order. The manager agreed to address this immediately.

The home employed an activities coordinator and there was a timetable of activities available. During the inspection we saw people actively taking part in singing and dancing sessions in the lounge. People were singing along, clapping and appeared to be enjoying themselves. When care staff were available they also joined in and danced with people. People we spoke to told us they would prefer more variety and choice with activities. One person told us "There's not much going on, I didn't like a lot of the activities, don't mind the bingo". Relatives told us they thought more could be done, one comment was "I wish they took them out more."

The service had a robust complaints policy which was displayed for people to see. There were also meetings held with people and their relatives where complaints could be raised. People told us they knew how to make a complaint and that their complaints were taken seriously and resolved to their satisfaction. One person said, "If I wasn't happy I'd speak with the manager. I've never needed to but I know how to". We saw that complaints had been responded to appropriately.

Inadequate

# Is the service well-led?

## Our findings

There was no registered manager in post. The registered manager had left the home in November 2018. A new manager had started a few days before the inspection, and the intention is she will become the registered manager for the home. In the time that there has been no manager, the director, deputy manager and assistant support officer were responsible for managing the home.

At the last inspection in June 2018, we found that the provider was in breach of regulations regarding good governance and the well-led domain was rated as inadequate. This was because the systems in place to monitor the quality and safety of the service were not effective. This regulation was also not being met at an inspection visit we completed in March 2017. During this inspection we looked to see if improvements had been made and found that these systems were still not effective and the provider was still in breach of the regulation.

Following the last inspection, the provider submitted an action plan to inform us of what they would do to improve the service based on the concerns identified. We reviewed the action plan as part of this inspection and found that some actions had been completed, for instance some of the care plans had been re-written with more detail. However, a lot of the actions regarding oversight of the home had not been completed. Medicines audits, care plan audits and falls audits had not happened as detailed in the action plan.

We looked at how the provider maintained oversight of the quality of the service. We were told that the director met with the registered manager (deputy manager once the registered manager left) weekly to discuss areas of the home. We saw evidence of these weekly meetings occurring for a period of two months, but they did not appear to be a weekly occurrence. We saw that these meetings discussed things such as accidents/incidents, medicines audits, staffing and safeguarding referrals. However, these meetings did not prove effective, as we could see things discussed at the meeting had not happened. For instance, one meeting recorded that a weekly medicines audit had been taking place, but this had not happened.

We saw that there were some audits in place completed for areas such as kitchens, cleaning, care plans, medicines, MAR charts and health and safety. However, these audits were inadequate and infrequent. The director told us medicines were audited weekly, which was also an action on the action plan completed by the service because of a breach of regulation at the last inspection. We found medicines had only been audited twice since the last inspection in June 2018. When we raised this with the director she told us the previous registered manager had told her that the audits were complete. There had not been any checks by the director to see if this was the case. The audits did not appear to be effective as neither of the medication audits highlighted the issues we found on the inspection.

The deputy manager and new manager of the home informed us they were implementing a new medicines auditing system. MAR charts and medicines will be audited on alternating weeks, meaning both will be audited twice a month. We were also told a new action log will be added as part of the audits.

At the last inspection we found that quality assurance processes were not in place to review all areas of the

service, in particular accidents/incidents. At this inspection we looked at how accidents and incidents were reviewed and found that there was still no effective audit in place to look for patterns and trends, only a list of the incidences. The records were also disorganised, with some accident forms kept in the accident file, and others kept elsewhere. At the end of the inspection we were shown a new audit tool that had been created that day to monitor accidents. This tool had been completed for the month of December, and clearly showed there had been an issue with a two sensor mats not working during two separate falls. Having the audit in place enabled managers to see this and check on the mats to ensure they were working. We were told this tool was being implemented immediately.

We were told monthly fire safety checks were meant to occur. We found that these checks had not happened in June, July, August and November 2018. When we spoke with the director she reported there had been issues with maintenance due to the position being vacant at times. There was no plan put in place when the maintenance position was vacant to ensure these checks still took place.

We also found that when audits identified areas that required improvement, there was not always evidence to show what actions would be taken. For instance, a fire safety assessment completed in July 2018, highlighted some urgent actions that were needed including having an appropriate number of fire marshals and weekly fire alarm testing and fire safety checks. The action plan created from this stated these issues were "to be actioned" with no information on who was responsible and when they would be completed. There was also no evidence of review of any improvement action plans.

If more robust quality assurance processes had been in place and were being monitored closely, then the serious issues that were found during the inspection would have been identified earlier by the registered manager or the provider and dealt with. This meant that the systems in place to monitor the quality and safety of the service remained inadequate, and the breach had not been met.

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

There were policies and procedures in place to help ensure staff were effectively supported to understand and perform well in their roles. These were regularly reviewed and up to date at the time of this inspection. Staff told us they had access to these at all times.

The service demonstrated a good partnership with other agencies with effective communication between all parties. We saw evidence of meetings with social services and health care professionals. We also saw evidence of appropriate referrals to other professionals in order to support people with their needs, for example we saw people referred to dieticians when they were seen to be losing weight.

Staff told us the changes in the management team had been difficult as "different managers work in different ways." There was positive feedback regarding the new manager and staff felt she was supportive and had already implemented some improvements to their practice. Staff felt comfortable raising concerns to the senior carers and the deputy manager, but told us that in the short time there had been no registered manager, they had not felt comfortable raising issues with the director. This was because they felt nothing was done when they raised something. Staff also felt communication could be better within the service, especially when changes were implemented. We discussed this with the director, who told us she had previously arranged for communication training to help with this.

The home manager had only been in post for a few days before the inspection, but throughout our discussions during the inspection it was clear she had plans in place to address some of the issues we

identified and improve the quality of 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 | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Health and safety checks were inadequate and did not ensure the premises were always safe.<br><br>Medicines were not always managed safely within the home. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems and processes to monitor the quality and safety of the service were inadequate.<br><br>Failings from previous inspections have not been acted on. |