Helmreal Limited

Court Nursing Home

Inspection report

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Date of inspection visit:
27 April 2017
28 April 2017

Date of publication:
13 June 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this inspection on 26 and 27 April 2016. The inspection was unannounced.

Court Nursing Home is located in Rock Ferry, Wirral and offers accommodation with nursing care for adults living with nursing and mental health needs. Accommodation is in single or shared bedrooms and some of the bedrooms have en-suite toilet facilities. There are 15 single and eight shared bedrooms. At the time of the inspection, 27 people lived at the home.

On the day of our visit, there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager had been in post approximately 18 months at the time of our visit.

During this visit, we found breaches in relation to Regulations 9, 11, 12, 16, 17 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to the management of risk, the implementation of the mental capacity act, poor care planning and recording keeping, lack of an adequate complaints procedure, poor recruitment practice with regards to staff and ineffective quality monitoring systems. You can see what action we told the provider to take at the back of the full version of this report.

We looked at the care files belonging to five people who lived at the home. We found that people's care plans did not cover all of their needs and risks and lacked clear information about the management of risks. Information about people's care was unclear and where professional advice had been given, care plans had not always been updated to reflect this. This did not demonstrate that people's health and welfare risks were monitored and managed safely.

We found that dementia care and person centred care planning was poor. Care plans lacked adequate information about people's preferences and did not provide staff with person centred guidance on how best to support them when they became upset or displayed behaviours that challenged. Information relating to people's like and dislikes, end of life wishes and support to remain independent was limited and did not show that people's needs were properly assessed so that personalised care could be provided.

The home was clean, free from offensive odours and well maintained. Equipment was properly serviced and maintained. The risk of Legionella had been assessed but the water checks undertaken did not show that the risk of Legionella was managed safely. We also found that some of the hot water temperatures dispensed from taps in the home's communal bathrooms were too hot and presented a scalding risk. There was no evidence any action had been taken to address this.

The provider's fire evacuation procedure was unclear and information in place to assist staff and emergency

services personnel in the event of a fire or other emergency evacuation was inadequate. This meant staff and emergency personnel lacked vital information to protect people from harm during an emergency situation.

Where people's capacity to consent to decisions about their care was in question, the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguard legislation (DoLS) had not always been followed. People's capacity to consent had not always been assessed to ensure legal consent was obtained. We saw people had access to independent mental health advice and support as and when required to help them understand and participate in decisions about their liberty which showed the beginnings of good practice.

People we spoke with said the food at the home was good and they got enough to eat and drink. We found however that some people had special dietary requirements which were not always met in accordance with dietary advice or in a way that mitigated risks of malnutrition. Staff lacked sufficient knowledge of people's nutritional needs. There was no evidence that the people who were at risk of malnutrition, had their dietary intake monitored in any meaningful way to ensure their nutrition and hydration needs were met.

People who lived at the home, relatives and visitors we spoke with during our visit spoke positively about the home and the staff. They told us staff were kind and caring and that all staff including the manager and provider were approachable and easy to talk to. None of the people we spoke with had any complaints or concerns about the service and no formal complaints had been recorded by the manager. The provider's complaints procedure required improvement. It lacked sufficient information on which organisations people could contact should they wish to make a complaint about the service. It was not readily accessible to people who lived at the home, as the procedure was displayed in an area that people could not voluntarily access.

We observed that staff treated people kindly and spoke to them with respect. It was obvious that people felt comfortable and relaxed in the company of staff. The atmosphere at the home was warm, homely and caring and we saw lots of positive interactions between people who lived at the home and staff to demonstrate that they had positive relationships with each other.

Staff we spoke with told us they felt supported to do their job and records confirmed this. Some staff training had expired which meant that the knowledge of some staff may be out of date.

A satisfaction questionnaire had been devised but had not been circulated to enough people, to enable the provider to be confident of the overall quality and safety of the service. No resident and relatives meeting took place and there were no other formal systems in place to enable people's feedback on the service.

We looked at the quality assurance systems used by the manager and provider to monitor the quality and safety of the service. We found improvements were required. This was because the systems in place failed to effectively identify and address the areas of concerns we found during our visit. For example, poor risk management, a lack of person centred care planning, inadequate emergency arrangements, poor staff recruitment practices and poor record keeping. As the systems in place failed to identify the areas were improvements were required no action to address these had been taken. This demonstrated that the governance systems in place were ineffective and that the management of the service required improvement.

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.

Information in relation to people's risks and their management was contradictory and unclear. This placed people at risk of inappropriate and unsafe care.

Fire and emergency procedures were unsafe and put people at risk of harm.

The premises and the equipment in use were safe but the systems in place to monitor and mitigate the risk of Legionella were not always followed.

Staff were not always recruited safely to enable the provider to be sure staff were safe to work at the home.

Medication administration was safe.

Is the service effective?

Requires Improvement

The service was not always effective.

People's capacity was not assessed and care was not planned in accordance with the Mental Capacity Act 2005 if their ability to make an informed decision was in question.

People said they were well looked after by staff.

People told us the food was good and they got enough to eat and drink but we found that people's special dietary needs were not always known by staff or monitored effectively to ensure their dietary needs were met.

Staff were trained and supported in their job role but some staff training was out of date. Staff worked well as a team and the manager was approachable.

Is the service caring?

Good

The service was caring.

People we spoke with were happy with the staff that supported them. They told us the staff were kind and caring.

We observed staff to be warm, caring and compassionate in their approach. Interactions between people and staff were warm and friendly.

People had access to independent advocacy services to help them understand and be involved some aspects of decision making.

Information in respect of people's ability to be independent and their end of life care required development.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Person centred care planning was poor and people's care and treatment records were not always accurate, complete or up to date.

People's healthcare needs were met by a range of health and social care professionals and the service ensured people received the support and equipment they needed.

Some activities were provided on the day of our visit, but the views of people and relatives, on the activities provided, was mixed.

People we spoke with had no complaints and no complaints had been recorded since 2015.

The provider's complaints policy was not readily accessible to people who lived at the home and lacked sufficient information on how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were systems in place to aid good governance but these were not effective. They had not picked up issues we identified during our inspection.

There were very limited opportunities for people to provide feedback on the quality and safety of the service.

A positive and inclusive culture was observed at the home. Staff

worked well together as a team and the atmosphere was positive.

Court Nursing 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 inspection took place on 26 and 27 April 2017. The inspection was unannounced. The inspection was carried out by an adult social care inspector, a specialist advisor in medication management 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 service.

Prior to our visit we looked at any information we had received about the home and we contacted the Local Authority and another healthcare professional for feedback. On the day of the inspection we spoke with three people who lived at the home, four relatives, a visitor to the home and a visiting healthcare professional. We also spoke with two care staff, a nurse, the administrator, the registered manager and the provider.

We looked at the home's communal areas and visited a sample of people's individual bedrooms. We reviewed a range of records including five care records, medication records, staff personnel and training records, policies and procedures and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt safe at the home and all of the relatives we spoke with said they felt their loved ones were safe. One relative told us "Staff are marvellous – they (the person) are more than safe". Another relative said "They (the person) can't talk or speak but I feel they are safe and that they know their needs".

We looked at five people's care files. We saw that some of the risks with regards to people's care were assessed. For example, risks in relation to malnutrition, pressure sores, moving and handling and falls were all assessed but other risks were not.

For example, risks associated with people's medical or nursing needs were not properly identified or assessed. For example, one person lived with epilepsy but this medical condition had not been properly risk assessed. Epilepsy affects people differently yet staff had limited information on how this person's condition presented, the potential warning signs or triggers and had limited guidance on how to support this person when a seizure occurred. This meant there was a risk staff would not recognise when an epileptic incident was likely or the action to taken when an incident occurred.

Some of people who lived at the home lived with mental health needs. This sometimes meant that they experienced episodes of distress or displayed behaviours that challenged. Despite this, people's behavioural risks were not risk assessed to enable safe and appropriate support to be planned.

We found the information about people's risks contradictory and confusing and when their needs had changed, risk management plans were not always updated. This placed people at risk of receiving inappropriate and unsafe care.

For example, one person was at high risk of developing pressure sores. We saw that their risk management advice given to staff advised them to assist the person to a standing position at regular periods to alleviate pressure on their skin. This guidance was unsafe as the person was now immobile and unable to weight bear. Information in relation to the location and status of this person's pressure sores was also incorrect.

We looked at the daily records relating to the care people had received. People's records demonstrated that people did not always receive the support they needed to keep them safe. We found that where professional advice had been sought and advice given, this advice had not always been followed.

For example, two people had been referred to and received professional advice from a dietician in relation to their nutritional risks. We saw their risk management plans had not been properly updated with the professional advice given which meant staff did not have clear and appropriate guidance on how to manage their nutritional risks. We also saw that staff lacked sufficient information on what dietary intake was sufficient for these people to maintain a healthy weight. This made it difficult for staff to know if people have enough to eat and drink to maintain their physical health.

Staff recorded people's dietary intake on a food and drink chart but there was no evidence these charts were monitored in anyway by nursing staff or the manager to enable them to be assured that the person's nutritional risks were safely managed in accordance with any professional advice given. We checked a sample of the food and fluid intake charts for these people. Records showed that people had not always received the fluids and diet they required, as recommended by their dietician. This did not demonstrate that people's risk of malnutrition was mitigated.

We looked at the emergency evacuation arrangements in place to ensure people were protected from harm in the event of an emergency situation such as a fire. We found the arrangements to be inadequate. The provider's fire evacuation procedure was not clear and when asked, staff did not demonstrate that they knew what action to take in the event of a fire to keep people safe. We asked to see evidence that staff had practised what to do in the event of an emergency evacuation. The registered manager told us that fire drills were undertaken by the health and safety officer but they were unable to provide any records to evidence this.

People who lived at the home did not have adequate personal emergency evacuation plans (PEEPs). PEEPs provide emergency service personnel with information about a person's needs and risks during an emergency situation such as a fire. This information assists staff and emergency service personnel to quickly identify those most at risk and the best method by which to secure their safe evacuation. People's PEEPs information failed to provide this information.

We checked the arrangements in place for the management of Legionella infection. Legionella bacteria naturally occur in soil or water environments and can cause a pneumonia type infection. We saw there was a legionella risk assessment in place which advised the provider to undertake a regular temperature check of the home's water system to ensure that water was stored and circulated at temperatures sufficient to control the risk of Legionella.

We found evidence that some of these checks but not all were undertaken. Records showed that the temperature at which water was stored and circulated was not sufficiently hot to manage and mitigate the risk and there was no evidence any action had been taken to address this. This meant that the provider had not done all that was reasonably practicable to mitigate the risk of Legionella from developing.

There were records of regular checks on the temperature of the water dispensed from the taps in the home's communal bathrooms. We saw that some of the temperatures recorded were unsafe and presented a scalding risk. We spoke to the provider about this. They told us that the health and safety officer undertook these checks and had not reported any issues to them. The acknowledged that the records in place showed that some of the water temperatures were unsafe and said they would ensure these water temperatures were adjusted without delay.

These examples are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there was no suitable system in place to ensure that identified risks in relation to people's care were adequately and safely managed.

External contractors were employed to test and maintain the home's electrical, moving and handling equipment, fire alarm, bath hoists and the passenger lift to ensure they were safe and suitable for purpose. On the day of the inspection, the home's gas safety certificate was not in place but the gas system had just been inspected and they were awaiting the certificate. The provider contacted the gas engineer and after the inspection we received confirmation that although the system required remedial work which was in progress, it was safe to use.

We looked at the recruitment records of five staff members. Four of these staff had been recruited in the last twelve months. We found safe recruitment practices had not been followed. Previous employer references sought by the provider had not been verified. Previous employer references had been returned on the home's (Court Nursing Home) letterhead and there was no name or address of the previous employer on the reference request itself. There was no other evidence to show that the source of the reference had been checked. We asked the home's administrator and the provider about this and they acknowledged that they had not checked the identity of the referee. This meant there was no evidence that the references provided were from an appropriate and reliable source.

We also saw that some staff references did not correspond with the previous employment history stated by the staff member on their job application form and some staff members only had personal references on their file prior to appointment. This meant the provider could not be sure that the staff member's previous work conduct was satisfactory.

We saw that most, but not all of the staff members whose files we looked at, had a criminal conviction check renewed on employment with the provider. We found that one staff member's check was over five years old and had not been renewed prior to their employment at the home. This meant there was a risk it was out of date.

These incidences were a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not taken reasonable steps to ensure that staff were safe and suitable to work at the home.

Medication was kept securely and at safe temperatures. Medication was dispensed in the majority via monitored dosage blister packs. We checked a sample of people's medication administration charts (MAR) and found that stock levels balanced with what medicines had been administered. Record keeping in respect of the ordering, booking and management of medication were well maintained, organised and clearly showed that medication was managed appropriately.

We observed one instance were a person's medication was used 'off licence'. Off licence use means that the way the medication was administered was not in accordance with the prescriber's instructions. There was no evidence that any pharmacy advice had been sought in relation to this. After the inspection, we received an email from the manager confirming that they had now sought pharmacist advice and it had been confirmed by the pharmacist that the person's medication was safe to administer in this way.

The provider had a policy in place for identifying and reporting potential safeguarding incidents. Staff spoken with had an understanding of safeguarding and how to protect people from the risk of abuse. We found that not all of the safeguarding incidents that had occurred had been reported to the Care Quality Commission appropriately. We spoke to the manager about this as it is a legal requirement.

The accident and incident records we looked at showed that that staff acted promptly and appropriately when an accident and incident occurred to ensure people received the support they required. Accident and incident records were completed appropriately and monitored by the manager.

Staffing levels at the home were adequate to meet people's needs. People were assisted promptly and pleasantly by staff and people received supported when they required it.

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 so that they can 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. 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.

Some people who lived at the home had dementia or complex mental health needs which may have impacted on their ability to make informed decisions. We found their care files lacked any adequate information about these needs and the support the person required to make informed decisions.

For example, we looked at five care files and only one person's care file contained any evidence that an assessment of their capacity to make a specific decision had been assessed. The other four people's files lacked any evidence that their ability to make decisions about their care had been assessed. There was no evidence of any best interest decision making and no evidence that everything practicable had been done to support the person to make their own decisions about the care they wanted to receive. This included decisions to deprive them of their liberty (DoLS). This meant that the principles of the MCA and the DoLS legislation had not been followed and people's human right to consent to their care had not been respected.

We spoke with the manager about this. They told us that four out of the five people whose care files we looked at, had a DoLs in place prior to them coming into post. They acknowledged however that there were other aspects of decision making in relation to people's care which also had not been formally assessed.

During our visit, we saw that most people's bedrooms were locked and that they spent most of their day in communal lounge or dining room on the ground floor. This meant that once people were taken to the communal lounge, they had no choice about returning to their room later in the day if they wanted to. No-one we spoke with raised any concerns with regards to this but it did mean that people's liberty of movement within the building was restricted. We found a lack of information in people's files about the rationale behind this and how the decision to restrict people's movement within the building had been assessed and agreed upon.

These examples were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to have ensure people's legal right to consent to their care was assessed and legally obtained.

We saw that people's care files contained evidence that people had access to appropriate mental health advocacy support and during our visit, we spoke with a visiting independent mental health advocate (IMCA) who supported people at the home. They told us they visited the home regularly to represent and help people express their views when a decision about a deprivation of liberty was made by the Local Authority. The IMCA told us that since the manager had come into post, approximately 18 months ago referrals to the IMCA service had been made appropriately to ensure people had access to the support they needed. They told us that communication with the IMCA service had significantly improved since the current manager had come into post and that they "Got things done". This showed the beginnings of good practice with regards to MCA which now needed further development.

We looked at five staff files. Staff files showed that staff members had an appraisal and received regular supervision by the manager. This showed there were systems in place to ensure staff members were supported to do their job.

We looked at staff training records. We saw staff had access to regular training opportunities. Training was provided in a range of health and social care topics such as safeguarding, moving and handling, health and safety, basic life support, mental capacity, falls and managing behaviours that challenged. We found that the training of some staff had expired. For example, moving and handling training and infection control had expired for eight staff and safeguarding and mental capacity training for ten staff. This meant there was a risk that staff knowledge may be out of date.

All but one of the people and relatives we spoke with told us there was always plenty to eat and drink between meals. Everyone told us the food was very good. One person said "The food is spot on, we get a choice and it's always hot. We get plenty to drink through the day".

People were able to choose where they ate their meals and we saw that people ate in the communal lounge, conservatory or dining room. People's meals were served pleasantly by staff but we saw that the table settings were sparse. There were no tablecloths, napkins or place settings to make the environment in which people ate their meals appealing. Shortly after lunch, we saw that one person was given biscuits that were placed directly on the table without a plate. This was not very hygienic. We also saw that some staff wore latex gloves when serving food or supporting people with their meal which did not look very nice. The environment in which people were served their meals required improvement. A pleasant environment during mealtimes has been shown to stimulate people's appetites and make mealtimes an enjoyable experience.

The atmosphere at lunch was pleasant. Staff chatted to people socially as they served their meals and were attentive to their needs throughout the lunchtime period. On the day of our visit, the main meal was chicken hot pot but we saw some people had asked for an alternative and that this has been catered for. For example, we saw that one person had asked for and was given cheesy mash potatoes, two people had sandwiches and one person had asked for and been given pancakes. We over heard a staff member ask a person who was struggling to eat their meal whether they would prefer something else to eat. The person asked for a bowl of soup and this was responded to appropriately. The staff member offered them a variety of different soups as well as asking them if they preferred to have their soup served in a bowl or mug. This showed that people had a choice of what to eat and drink whilst they lived at the home.

We found that information about people's nutritional needs was at times unclear. Where professional advice in respect of people's nutritional well-being had been recommended, care plans had not always been updated consistently to reflect this advice. There was also limited information about people's preferences with regards to what they liked to eat and drink. There was a file containing information in the

kitchen relating to people's special dietary needs but not all of this information was up to date. This aspect of service delivery required improvement to ensure people received the diet they needed and preferred in order to maintain a healthy weight.

It was clear from our conversations with staff that they the people they were caring for and had built good relationships with them. During our visit we observed many positive interactions between staff and the people who lived there which confirmed this. Staff spoken with on the day of our visit had a basic understanding of the day to day care needs of the people they looked after. For example, they knew which people required repositioning to prevent pressure sores, those who required a mobility aid to mobilise and which people needed their dietary intake recorded.

We found however that when we asked staff about people's special dietary needs, they were unsure about what there were. Staff were unsure what an adequate dietary intake was for each person and the dietary supplements they required. This aspect of service delivery required improvement so that those people who required assistance to maintain a healthy weight were supported effectively.

Good

Is the service caring?

Our findings

We saw that staff supported people through the day in a kind and compassionate manner. They were patient when people became agitated and distressed and re-directed their attention appropriately to diffuse their upset. For example, one person became intermittently distressed throughout the day and walked about continuously. We saw that staff encouraged the person to sit down and have a cup of tea at regular intervals and used positive touch to reassure the person. It was obvious from our observations that staff had good relationships with the people they cared for and clear that people were relaxed and content in their company.

We spoke with three people who lived at the home. They told us staff were kind and treated them well. One person said "The staff are very good, I have no complaints at all. They treat me very well and they always knock before coming into my room". Another person told us "The staff know me well and always have time to sit and chat. Even the Governor (the provider) comes to chat to me."

Relatives spoke highly about staff and told us they were kind and caring. Their comments included "The staff are caring and very positive at all times"; "They are wonderful, they do more than care" and "The staff are brilliant and very pleasant."

We saw that people were supported to maintain relationships with their friends and family. People's relatives and visitors visited throughout the day and received a warm welcome. The relatives and visitors we spoke with told us they were always made to feel welcome and that they were able to visit at any time without restriction. One relative said "I am always made welcome and offered a drink".

We saw that staff tended to people's personal hygiene needs in a discrete and respectful manner which protected their right to privacy and dignity. Staff told us that they encouraged people to into the communal lounge on the ground floor during the day and we saw that the majority of people spent most of their day in communal areas. People who lived at the home who smoked had the use of a dedicated smoking room as and when required with the support of staff.

People's care files contained evidence that they had access to advocacy support. Advocacy services provide support and representation for people who require support to make their views and wishes known. People also had access to independent mental health advocacy services (IMCA) when they did not have close family or friends to support them to make specific decisions about their care. IMCAs act as the person's representative and help them to participate in specific decisions made on their behalf. The facilitation of advocacy support for people who lived at the home was good practice. It showed that staff cared that people's views and wishes were listened to and acted upon where possible.

We found that people's care plans contained limited information about what they could do independently and how staff could promote their independence. This type of information is important as it encourages staff to promote people's ability to maintain important life skills and some control over their day to day life. We also noted that information in relation to people's wishes in relation to their end of life care was limited.

This meant there was a risk that the staff would not know what people's wishes were should their health decline.

Requires Improvement

Is the service responsive?

Our findings

We saw that people's needs were assessed and the support they received at the home was planned. People's care plans covered the support people required in a range of areas. For example, areas covered included personal care, mobility, skin integrity, falls, nutrition, continence, communication and cognition. Information about people's needs and the care they required was however unclear and at times contradictory. This meant people at risk of not receiving the care and treatment they needed and preferred because care records were not accurately maintained.

We saw that people's care plans were focussed on the support tasks to be provided rather than a personalised approach to support. They contained limited information about people's preferences, and wishes in relation to their care. Some of the information in people's needs and risks had been reviewed but other information had not. We also saw that where people's needs or the care had changed, their care plan information had not always been updated to reflect this. This meant staff did not have clear and accurate information about the person centred care people required.

Dementia care planning and the person centred planning for people's mental health needs was poor. Where people had emotional needs or behaviours that challenged, there was no evidence they had been assessed and explored so that person centred support could be planned. For example, there was a lack of information in people's care files about the frequency, intensity or triggers to their behaviours and staff had no guidance on how best to support the person when these behaviours were displayed.

For example, one person was described as prone to occasional physical aggression and episodes of distress. There was no evidence that the cause of the person's distress had been explored and no guidance was given to staff on how to alleviate the person's distress when they became upset.

Some people's care files contained observation records relating to their behaviour at specific times for example, when they experienced a change in their behaviour or a specific incident had occurred. This monitoring was only completed for a short period of time and there was no evidence that the information was used in any meaningful way to inform future risk management or the delivery of personalised care.

These incidences were a breach of Regulation 9. This was because the provider had not done all that was reasonably practicable to assess and design care that ensured people's need and preferences were met.

We spoke with the manager about the lack of personalised information in people's care files. They told us they were in the process of introducing a new care plan. They showed us an example of a care plan they had just developed. We saw that it contained greater details about people's needs and preferences.

We saw that the service was responsive when people required support from other healthcare professionals. For example, district nurses, dieticians, tissue viability services and GPs. Records showed that people were supported to attend routine health appointments to maintain their wellbeing such as dental, chiropody and optical appointments.

Where people had been assessed as requiring specialist equipment to maintain their well-being this had been provided. For example, pressure relieving mattresses, mobility aids and adaptive seating. One person required a specialist chair to help them sit in a safe position. Records showed that staff at the home had organised for an assessment of the person's needs to be undertaken by an occupational therapist specifically for this purpose. This showed that the service was responsive when people needed additional support to maintain their health and wellbeing.

On the days we visited we saw that people enjoyed an activity session which involved potting plants in the garden, a sing a long, a team based quiz and bingo. The staff team joined in and encouraged people to participate. A small prize was awarded to the winning team and we saw that people enjoyed these activities.

When we asked people who lived at the home about the activities on offer they told us that no activities were provided. One person told us" I do not go out and there are no activities going on". A second person reiterated this and a third person told us "They take me to the pub for a drink when there is enough staff. There's not much going on otherwise".

Relatives we spoke with said that there were some activities available but their views on them varied. One relative said "They put music on and get them singing along. They had a singer on St George's day. I have seen the residents playing bingo but my husband can't take part." Another told us "Last Sunday afternoon there was a singer and they are going to take them to the pictures. They have done some planting with them and they have their own name on their pot to water".

People and the relatives we spoke with told us that the manager and the provider were approachable and easy to talk to. One person told us "I have no worries about being in the home. I have never had to talk to anyone to complain or anything". Another person said "The Owner is great to talk to, as are all the staff. The home is great to live in" and a relative we spoke with said they had "No worries or concerns, they (the person) seem happy and well looked after. I would speak to the staff if I had concerns."

Information about how to make a complaint was displayed on the noticeboard in the entrance area of the home. People who lived at the home did not have easy access to this area. This meant that information about how to make a complaint was not readily available to them.

We looked at the home's complaints procedure. We saw that it gave people clear timescales for the handling and response to their complaint and the telephone number of both the manager and the provider for people to contact should they wish to complain. The policy however lacked important information about which external organisations people could contact should they remain dissatisfied with the outcome of their complaint by the provider. For example, the procedure advised people to contact the local authority contract monitoring in the event of a complaint. This was incorrect. The Local Authority has its own complaints department for the handling of people's complaints about their care. The number for the contract monitoring team was also incorrect.

The procedure also advised people to contact the Care Quality Commission but failed to make it clear that The Commission have no legal powers to investigate people's individual complaints. This legal duty lies with the Local Authority. No reference to or contact details for the Local Government Ombudsman were provided either. The Local Government Ombudsman investigates complaints about adult social care services provided by local authorities. It is a free, independent and impartial service.

This meant people did not have clear or accessible information on how to make a complaint. This was a

breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

We checked to see what arrangements were in place to monitor the quality and safety of the service provided. We saw that the provider had a range of regular audits for this purpose but some of these were ineffective.

The manager undertook audits relating to the delivery of care. For example safeguarding audits, accident and incident reviews and medication audits. We looked at a sample of these audits and saw that appropriate action had been taken to address any immediate concerns. On looking at the provider's safeguarding records we found that incidents of a safeguarding nature had not always been reported appropriately to the Care Quality Commission. This is a legal requirement of the provider's registration to provide regulated care.

The provider and the previous health and safety officer (who had just left their employment with the provider prior to our visit) were responsible for audits associated with health and safety, the environment, the home's equipment, fire safety, legionella and care records. We found that the majority of these audits were ineffective in identifying the areas of concern we had found during our visit.

For instance, there was no adequate system in place to ensure care files contained accurate, complete and contemporaneous information about people's needs, care and preferences. The provider told us that they checked that people had the relevant documentation in their file. For example, they checked that people had a care plan and risk assessment but confirmed that they did not check what the documentation said to ensure that the information and guidance given to staff about people's needs and care was accurate and clear. This meant that the inconsistencies and inadequacy of the information in people's care files had not been picked up and addressed. This placed people at risk of receiving unsafe and inappropriate care.

Documentation completed by clinical staff in respect of people's pressure area care and wound management was also poor and it was difficult to determine in some instances whether the care provided was in accordance with professional advice. Clinical staff, as a condition of their professional registration with the Nursing and Midwifery Council, have a duty to ensure their clinical notes, are clear and accurate. We did not find this to always be the case and the way in which the provider's currently audited for care records had again not picked this up.

The health and safety, environmental audits and fire safety arrangements in place failed to recognise that the home's fire procedure was unclear and potentially unsafe. They failed to identify that personal emergency evacuation plans were inadequate in mitigating risks to people's safety during an emergency situation. They also failed to identify that the actions specified by the provider's Legionella risk assessments were not always followed appropriately and that some hot water temperatures in communal bathrooms posed a scalding risk. This showed that the systems in place were not effective in protecting people from potential harm.

During our visit, we identified that the provider did not have robust systems in place to check that staff were

recruited safely. There were shortfalls in the gathering of information about the character of some staff members, their previous work conduct and suitability to work at the home.

People's satisfaction with the service was checked using a satisfaction questionnaire but the circulation of this questionnaire was limited. At the time of our visit, only five surveys had been completed in 2016, three by people who used the service and two by visiting health care professional. This was not a representative sample of the views of the people who lived at the home or their relatives.

We asked the manager and provider if any resident and relative meetings took place to gain people's views and involve them in the running of the service. They told us that at the present time no resident or relatives meetings were organised.

We asked them whether there were any other mechanisms for seeking people's opinions about the care they received. The provider told us they had an open door policy. They said that if anyone wanted to discuss an aspect of their care their door was always open but acknowledged there were no current systems in place to seek and gather feedback on the overall quality and safety of the service. This meant that there was no effective system in place to enable the provider to gather, analyse, learn from and improve the service based on people's feedback.

These examples demonstrated that there were no effective systems in place to assess, monitor and improve the quality and safety of the service so that risks to people's health, safety and welfare were mitigated. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the day of our visit, the culture of the home was open and inclusive. Staff worked well together and were observed to have warm, supportive relations with the people they cared for. Staff we spoke with felt supported in the workplace and said the home was well run. Everyone we spoke with including two visiting healthcare professionals were positive about the service. This demonstrated that there were aspects of the service that were well-led.

At the end of our visit, we discussed some of the concerns we had identified with the manager and provider. Shortly after our visit, we received an email from the manager to inform us that they had started work on the required improvements immediately after our visit.

The manager told us the fire procedure had been reviewed, people's personal emergency and evacuation plans were in the process of being developed and that a new health and safety officer had been appointed. This showed that the manager and provider had responded proactively to the issues we had identified.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's needs, preferences and wishes were not properly assessed or included in their plan of care. Regulation 9(1),(2) and (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People's capacity and ability to consent to their care had not been assessed in accordance with the MCA and DoLS. Regulation 11(1),(2),(3) and (4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider's complaints procedure did not provide clear information on how people could make a complaint and was not readily available. Regulation 16(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	governance The provider did not have effective systems in place to assess, monitor and mitigate risks relating to the health, safety and welfare of people who lived at the home. Regulation 17(1), (2)(a) and (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not have effective recruitment procedures in place which ensured that persons employed were safe and suitable to work at the home. Regulation 19 (1) and (2)