Heathbrock Limited

Chester Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on 18 and 27 September 2017. Both visits to the service were unannounced. Chester Lodge care home is a privately owned service providing residential and nursing care for up to 40 people. It is located close to Chester city centre. At the time of our inspection there were 35 people living at the home.

The service had a registered manager. 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.

At the last inspection December 2016, we asked the provider to take action to make improvements in regards to safe care and treatment, capacity and consent and overall governance. These actions had not been completed.

During our visit we found a number of new and repeated breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

People we spoke with said that they felt safe at the home and relatives felt that staff did their outmost to support people and protect them from harm. However, we found that the risks to people's health and safety were not always identified, assessed or managed.

There was a safeguarding concern prior to the inspection in relation to the management and assessment of pressure ulcers. Care plans did not always include accurate information for the prevention and management of pressure ulcers.

A number of people were at risk of malnutrition or dehydration. However, food and fluid charts were not always completed in detail to reflect what people had eaten and drunk over a 24 period and to inform assessment of the person's nutritional status.

Referrals to health professionals were made when concerns regarding people's health were identified, but this was not always done in a timely manner. We found that advice and guidance provided by health professionals was not always implemented to ensure that risks to people's health and wellbeing were minimised

People did not always receive their medication as prescribed as there were delays in administration. Medication was not always stored in a safe and secure way.

Accident and incidents were not effectively monitored. Review of these did not always identify causation,

risk or patterns. Management plans to reduce the occurrence of accidents were not always followed or their effectiveness reviewed.

Some call bells were out of reach and inaccessible. When people were unable to use a call bell, robust plans had been put in place to ensure the person received the attention they needed.

The premises were not clean and we detected unpleasant smells in parts of the building. The management of infection control required improvement .

Staff showed limited understanding of their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Supporting documentation did not reflect how specific decisions for people who may lack capacity had been made in their best interest. Decisions were made by people without any legal delegation to do so. However, staff practice showed that people's consent was considered before care or support was provided.

Staff did not always respect people's opinions and choices in regards to how they wanted their support to be provided. People were not always kept comfortable and were not always treated with dignity and respect. People informed us that the staff were caring and did the best that they could to look after them.

Care plans did not always record people's needs accurately. Records were not personalised to reflect people's individual preferences about how they would like their care and support to be provided.

The quality assurance system in place was not effective and did not monitor the quality and safety of care. The service has now been non-compliant with the regulations since October 2015. Improvements had not been made or sustained.

Staff attended annual training sessions in areas such as moving and handling, first aid and safeguarding adults to update their knowledge and skills. There was adequate fire safety management and evidence to support effective evacuation in the event of a fire.

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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The deployment of staff was not in line with meeting people's needs and people had to wait for support. People received their support in a way that did not promote their safety and wellbeing.

Medication administration required improvement and people were not adequately protected from the risk of harm.

Infection control was poorly managed. The premises and equipment used was not clean.

Call bells were not always in reach for people to use. Accidents and incidents were reviewed but they were not always investigated to identify appropriate actions.

Recruitment procedures were safe

Is the service effective?

Inadequate

The service was not effective.

People's rights and best interests were not fully protected in line with the Mental Capacity Act 2005.

People had access to health professionals. However, advice and guidance was not always sought promptly or followed appropriately. People were not protected from the risk of dehydration and malnutrition. Food and fluid charts were not accurately completed, reviewed or analysed.

People were cared for and supported by staff who had received training and support for their role.

Is the service caring?

Inadequate

The service was not consistently caring.

People's privacy, dignity and confidentiality were not always respected.

People had to wait for their care and were not always kept safe and comfortable.

People were supported by staff who they described as kind, friendly and caring. Family members told us they were free to visit the service whenever they wished.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not consistent in terms of detail. Accurate information regarding people's care needs was not always recorded.

The registered provider had a complaints policy which people were aware of.

Staff promoted activities both inside and outside of the home.

Is the service well-led?

Inadequate

The service was not well led.

The registered manager and registered provider had repeatedly failed to make and sustain the necessary improvements to the service.

The registered provider's quality assurance systems were not effective. Systems did not always identify areas of concern or where improvements and changes were required.

CQC were not notified as required about incidents that had occurred at the service.

Chester Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 18 and 27 September 2017 and both visits were unannounced.

The inspection team comprised two adult social care inspectors, a specialist advisor who is a pharmacist and a specialist advisor who is a registered nurse.

Prior to the inspection we reviewed information held on the service such as statutory notifications, notifications, complaints, compliments and intelligence from other agencies such as the local authority and the clinical commissioning group. Some concerns had been raised from other agencies in regards to the management of medicines, pressure care prevention, and meeting dietary needs.

During the inspection we talked to people using the service, their relatives and friends or other visitors. We also undertook pathway tracking. This captures the experiences of a sample of people who use a service by speaking to them, discussing their support with staff, and reviewing their notes and records.

We interviewed staff and reviewed records relating to staff employment, training and support. We also looked at records relating to the overall management and governance of the service.

Inadequate

Is the service safe?

Our findings

People who used the service and relatives told us that they felt overall the service was safe. Their comments included "The staff would never do anything bad here, they are very kind" and "There is nothing for you to worry about, we are all very safe here". Some people expressed concern about the staffing levels in that "Sometimes I don't know when staff are coming and I feel anxious" and a relative said "I do worry sometimes as to what goes on when I am not here as staff are not always quick to respond but that is not their fault, they are so busy".

At the last inspection in December 2016, we found a breach of Regulation 12 of the Health and Social Care Act 2008 because care and treatment was not provided in a safe way. On this inspection we found that improvements had not been made.

In December 2016 we had concerns about the use of thickening powder that was prescribed to thicken fluids to the correct consistency to reduce the risk of choking where the person had swallowing difficulties. We had continued concern on this inspection.

Staff told us that three people were using this product. Staff did not recognise that this was a prescribed medication and had to be used safely and correctly. We found that not all containers had dispensing labels that gave the name of the person it was prescribed for and directions as to the amount that should be used. The amount of thickener required by each person varies dependent on the consistency required. Not all staff were able to tell us how much product was required in fluid to achieve the right level of consistency for the individual. This meant that people could be put at risk of choking.

There were no records of when fluids had been thickened and to what consistency and there were no detailed care plans to support this. This meant that people were at risk of harm because people may not be getting their fluids at the right consistency and there was a risk they could choke. Tubs of thickening powder were found on bedside tables and on drinks trolleys. This presents a risk if people inadvertently consume the product.

Some people had difficulty with swallowing food and fluids. We looked at their care plans and found no risk assessments in regards to the management of choking in a given situations. Nutrition care plans indicated that staff should ensure that these people should be sat upright before, during and sometimes after receiving food and fluids. However, on both days we observed staff assisting people whilst they were lying down or on their sides. This meant that people were not protected from risk of harm associated with choking.

We found that the management of medicines was not always safe. On the first day of the inspection there was a significant delay in people getting their morning medication and the medicine round' was not completed until 11.45am. The nurse administered to all people on the day as there was no senior carer available to assist the "residential" service users. There registered manager informed us that there had been no time to cover their absence. Some items were not in the medicines trolley and the nurse had to go to the

medicines room on the ground floor to get them.

During the medicines round the nurse was interrupted on a number of occasions with questions from other staff.

We found that some aspects of the administration did not meet with best practice. For example signatures were made on medication administration sheets (MARs) before the person had actually taken the medicine.

We had concerns over the storage of medicines that needed to be kept in a fridge. Upon opening the fridge, we found that there was a frosted up ice box. We asked the registered manager to take urgent action to remedy this and to take steps to install a suitable thermometer which they did.

We found some inhalers stored in the fridge when they did not need to be .There was no indication as to when they had been opened and one was over the 5 months post expiry date. Food stuffs were stored in the medicines fridge : the cooling Ensure bottles etc. should ideally be carried out in the kitchen fridge. There was excessive stock of some medicines and staff were not using the oldest medication first. This was poor practice which could lead to errors occurring.

Prescribed creams were kept in people's bedrooms so that they could be used when personal care was being provided. However, there were no individual risk assessments in place to ensure that this was safe. One person self-administered some of their medication, but we saw that these were left on the table whilst the room was unoccupied. This meant that there was a risk of harm as others had access to medication not prescribed or intended for them.

We found that people's call bells were not always accessible for them, for example we found them on the floor, under beds, or located far away from the person. One person was at risk of falls and their care plan instructed staff to remind them to use the call bell when they needed help. This person was in bed, but their call bell was under the bottom end of the bed out of reach. This person also had a pressure mat to alert staff as to when they got up, but this was under the bed so would not have raised an alarm if the person got out of bed.

Some people had been identified as being unable to use a call-bell, but no risk assessments had been carried out and no safety measures were in place apart from instructions to staff to "check regularly". There was no explanation of what was meant by "regularly" and no evidence of what checks were made and when.

We noticed a number of infection control issues. There was information available for staff as to when but not how to clean equipment used for the delivery of oxygen. However, we found this to be dirty and not clean. On the first morning of the inspection, we saw three catheter bags that were still full from overnight. One was lying flat directly on the carpet.

There was a strong unpleasant odour throughout many areas of the home including some bedrooms. The premises were visibly dirty in some areas with sticky surfaces, debris on the floor, dusty fans and vents. Some areas were in need of repair which made it difficult to ensure that they were clean, for example walls were scuffed, bed rails chipped, and tiles, flooring and door frames were marked and damaged. There was a hole in one of the bathroom ceilings. Gloves and wipes such as those used for personal care were not disposed of correctly and were found in a waste bin, left on a chair, dropped in the corridor and in a sink.

The registered manager used a dependency tool to assess the hours of support required; however this did

not take into account factors such as the layout of the building or the location of those people requiring the most care. Following the inspection the registered provider provided information which showed that the number of staff hours deployed exceeded those they assessed as required to meet the basic needs of people at the service. The registered manager told us that they did not have the right number of staff on the first day of the inspection due to a number of factors outside of her control.

The registered provider undertook a random audit of call bell response times and told us that these had not highlighted any concern. We observed that a number of people were upset at having to wait for their medication, breakfast or personal care. Call bells were not answered in a timely manner and on one occasion we had to ask staff to respond to it as it was over three minutes ringing and was ignored.

A record was kept of accidents and incidents and these were reviewed by the registered manager for themes and trends. We identified that a number of people using the service had sustained unexplained bruising or skin tears. Not all had been further explored to establish how or why these had occurred or whether there were any common factors to take into consideration. One person had a pressure mat to alert staff as they required assistance when mobilising, but records indicated that on a number of occasions they had by-passed the mat and been at risk of harm. No alternatives had been explored.

These were breaches of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 as the registered provider failed to ensure that care and treatment was provided in a safe way.

We raised concern with the manager over the management of people's money. We observed the registered manager give a relative a blank cheque belonging to a person using the service. They did not enquire what the cheque was for, did not complete any paperwork in relation to the cheque or get the person who was requesting it to sign to for it.

Health and safety checks were carried out on the premises and the utilities such as gas, electricity and water. There was a fire risk assessment in place and each person had a personal emergency evacuation plan in case of an emergency. Fire drills and simulated evacuations were carried out. The fire service had attended a "false alarm" in June and had complimented the service on their evacuation strategy at the time.

Comprehensive risk assessments were not in place in regards to people who smoked within the outside space of the service.

Staff had an understanding of safeguarding and what this meant in their day to day work. Staff were confident that if they reported concerns that they would be addressed. We found that staff had reported concerns that they had with the practice of others and that action had been taken by the manager. The registered manager reported to the local authority low level concerns on a monthly basis: these are occurrences where there was a potential for harm or a low impact on a person.

There were systems in place to assure, as far as possible, that only people of suitable character and skill were employed at the service. Following completion of an application form, details were verified by way of references, identity checks and interview. A check was also carried out with the Disclosure and Baring Service (DBS) to ensure that the person did not have criminal convictions or cautions to be considered. Risk assessments were in place to ensure that staff under the age of 18 were supported in line with legal requirements.

Inadequate

Is the service effective?

Our findings

People said they had confidence in the staff to look after them. Comments included "All the staff are great and they help me a lot." and "We are fed well here and I really like the food."

In December 2016, we found a repeated breach of Regulation 11 of the Health and Social Care Act 2008 because the registered provider had failed to act in accordance with the Mental Capacity Act (MCA). On this inspection, improvements had not been made.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Not all of the people who used the service were able to make complex decisions for themselves, such as where to live, the impact of refusing treatment or how to keep themselves safe. There were no 'decision specific' mental capacity assessments in regards to interventions such medication or the use of restrictive equipment or practices. For example, staff had been advised to keep one person in their room until they became more settled. No mental capacity assessment had been undertaken to determine whether the person lacked mental capacity to agree this restriction and their care being provided in this way. Where bed-rails or recliner chairs were in use, there was no MCA or best interest discussion recorded. There was no evidence of other least restrictive options being considered and no best interest decision being concluded.

Care plans relating to cognition were confusing or conflicting. They did not give an accurate view of what decisions a person could or could not make. Generic statements were written such as "Due to a diagnosis of [condition] [name] does not have the capacity to make a complex decision". We also noted that the DoLS assessment, carried out by the service, for the same person indicated that they had the capacity to consent to all care and treatment. Another person was said to be unable to use the call bell as they could not understand risks. However, other parts of their care plan indicated they were "Able to follow instructions if they wish to" and "Can make their own decisions".

Some people had a DoLS approved by the supervisory body and "conditions" had been specified which the service must comply with. There was an action plan in place in regards to these conditions, but there was no information as to how compliance was being achieved.

Some, staff had received training about the MCA and DOLS. We saw that the registered manager was making

arrangements for additional training. Staff were not always clear as to how this related to day to day work. Staff told us that they always did their best to help someone make a decision but were of the belief that families were then 'decision makers' where a person lacked capacity. Records we looked at confirmed this view from staff. Statements in care plans included "Family will make decisions on certain aspects of care", "Mum is next of kin and signs all consent forms". Where this had occurred there was no indication whether they had the legal authority to consent on behalf of the person. The registered manager confirmed that a Lasting Power of Attorney for Health and Welfare was not in place for any people at the service.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had failed to ensure that care and treatment was provided in line with the requirements of the MCA.

Referrals had been made to appropriate health and social care professionals as needed; however outcomes were not always recorded.

Some people were at risk of malnutrition or dehydration. Visiting professionals expressed concern that staff were not always proactive in assessing or managing the risk. Where a person needed to be monitored for food and fluid intake there was no guidance for what the optimum amount would be for that person and no oversight of their daily chart. Records were not always started where there was an identified risk. For example: One person had been noted to have weight loss by staff and the GP. However, food monitoring charts had not been put into place by staff. This meant that when the dietician visited they were not able to assess current diet or risk .We also saw that when the dietician visited another person they had written in the notes that "[name] should have already been on food record charts".

Where records were kept, they were not always fully or accurately completed. This meant that an assessment of a person's intake could not be assured and accurate clinical assessments could not be made. Some records indicated that a person had frequently not had anything to eat and drink after tea time until the next day. This was a period of over 17.5 hours on one occasion. Where intake had been very low there was no evidence that action had been taken to review the person's needs.

The dietician or speech and language team had sometimes made recommendations: foods and fluids were to be fortified; nourishing drinks and snacks were to be given at suppertime, milky coffees were to be encouraged two to three times a day and other extra nourishing snacks. This advice had not been incorporated into the person's dietary care plan and intake records did not reflect what had been offered or consumed. Kitchen staff we spoke with were not fully aware of these requirements. One person's care plan indicated that they should have food cut up into little pieces but we saw it was not. Another person had professional's advice to indicate they required a soft moist diet and no bread. Their care plan stated a soft/puree diet. The stipulation of 'no bread' was not detailed in care plan and not detailed on special dietary requirement list in kitchen.

We saw that some people had been given food and drink but that it had been left out of their reach. Other times we observed that staff had not come back to help them in a timely manner and their meal had gone cold.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had failed to ensure that the nutritional and hydration needs of people were met.

New staff had an induction to the service and an opportunity to work alongside more experienced members

of staff. The Care Certificate is a set of standards that all care staff should adhere to and this training was available to new members of staff as part of the induction process. We spoke with two new staff members who confirmed that they received adequate support and guidance.

Staff told us that they had been given the opportunity to undertake training that was essential to their roles such as moving and handling, health and safety and safeguarding. There was also the opportunity to undertake training around areas of interest such as pressure care and continence care. Records indicated that staff had attended training as required. Staff also confirmed that they had the opportunity to meet to discuss concerns and developmental needs though a supervision and appraisal process.

Inadequate

Is the service caring?

Our findings

People told us that they liked the staff and that they were caring towards them. Comments included "I really like the staff, they do care about everyone", "The staff do their best for me, it's a shame they are as busy as I would like to sit and chat more." and "I am very happy here". Relatives shared this view and felt that staff took an interest in them and their family member. Comments included "It took me a long time to gain trust in the staff but I am confident now that [my relative] has the support they need." and "The staff work hard and are committed to caring for people well".

Our observations indicated that people were not treated with dignity and respect at all times.

On both days of the inspection, people told us they were unhappy at having to wait for care, but were keen to stress that "The staff are not to blame, they were just very busy". Comments made to us included "I don't know when I'll get my breakfast, they come and go" and "I'm dying of hunger in here." and "I have been waiting to get up for well over an hour".

People told us that they were not always offered choice in their day to day routines as it was sometimes dependent on how busy staff were. Not all care plans specifically accounted for a person's choice of when to get up or to go to bed. One person told us they liked to get up before 9.30am but on the day of the inspection they were still in bed at 10.35. We asked staff to let the person know when they may be available to assist but the response was "Everyone wants to get up at the moment". We also observed a person telling the staff they felt better if they got up for their breakfast but this was ignored and breakfast brought to them in bed at around 10.35.

We saw that some people were in bed in the morning but in their day clothes. Due to a poor level of cognition, they were not able to tell us when they had got dressed and records did not confirm this. Care plans did not indicate that people wished to be assisted back to bed in their clothes.

We saw that the majority of people had their bedroom doors open all day. The registered manager told us that people liked to see what was going on and people passing. However, many people were positioned such that they faced away from the door and could not see into the corridor. The care plans for some people indicated that they would like their doors left open at night but none indicated day time preferences. We found that people's privacy and dignity were not maintained as people in bed were seen in various stages of undress, some with parts of body exposed and incontinent products on show.

People were not always kept comfortable in bed. In the morning on the first day of the inspection, some people were in bed in sheets that were dirty or stained and these had still not been changed at the end of the day. We found that people were repositioned in bed but their sheets and blankets were crumpled underneath them. We also found one person in bed with their feet pressed against the hard side of the bed. This meant that adequate checks were not in place and people were at risk of developing pressure ulcers.

Very personal information regarding one person was contained in their care plan. This was a breach of the

person's confidentiality and should have been on a 'need to know' basis only.

In our discussions with staff and through a review of records, we found that people were not always afforded respect in the way they were described. For example, when discussing dietary needs people were referred to as "the purees" or "the softs". Some records suggested that staff did not see the person at the heart of what they did and their behaviours defined them. For example, one daily entry stated "I was told to give [name] a bath despite staff being busy". People were described as "aggressive" and "impatient". This was not respectful or person centred.

These were all a breach of Regulation 10 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 as the registered provider failed to ensure that care and treatment was provided with dignity and respect.

Staff interacted with people in a friendly and caring way and it was obvious that they had a good relationship with some people and their relatives. Relatives told us that they felt welcome at the home and that they could visit at any time. Staff knocked on bedroom doors prior to entering a room and they described how they maintained dignity as far as possible when they carried out personal care and support.

Care plan records were stored securely in a locked office. Care records contained the relevant paperwork for those people who did not want to be resuscitated in the event of their death. This information was placed prominently at the front of the care record so that staff could easily access this information if they needed to.

Staff tried to discuss people's wishes as to how and where they would like their care to be provided in the latter stages of their life. It was acknowledged that sometimes people did not wish to discuss this. We saw that people had care plans in place that considered their end of life wishes.

Requires Improvement

Is the service responsive?

Our findings

People's views varied about the care and support they received. They told us, "They always ask me if I need help" and "Sometimes they seem very short staffed, I get the help I need eventually but it can be a long time." Family members told us, "The staff are very good and I do trust them to look after [My relative] well" and "They do their best, it's a hard job".

In December 2016 we identified a repeated breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) as the registered provider had failed to ensure that accurate and comprehensive records were held in respect of each person. On this inspection we found that improvements had not been achieved.

People did not receive a person centred service or one that was designed individually for them.

Care plans we looked at varied in detail and content. Some of them did not contain enough information to assist staff in delivering care in line with a person's choices. Care plans failed to evidence information regarding everyone's preferences for gender of carer, when to receive care, how to receive care and how they preferred their care and support to be delivered. Some care plans were task orientated in their focus and did not evidence how a person preferred their care or support to be provided. Generalised statements such as "check regularly", "assist with personal care", "Use safe moving and handling techniques" were used.

Some people had behaviours that at times, challenged the service and others. There was little information in care plans to indicate what behaviours were exhibited and staff defined the person by their behaviour such as "aggressive", "anxious", "and impatient". There were no records to identify what behaviours were observed, how they impacted on the person and others, what (if any) were the trigger factors and how best to support the person through this situation. This meant people were at risk of not having their needs met.

Information was sometimes contradictory. A moving and handling risk assessment indicated that a person was independent with transfers and could weight bear with minimal assistance. However, the dependency assessment indicated a score of 2 which meant 'cannot consistently weight bear or are completely unable but can assist'.

The registered manager provided us with guidance notes for staff on the monitoring of some health conditions. However, these were not available for staff within the person's care folder. This meant that staff may not recognise the relevance of this information to an individual and how it may affect the support required. This information was not reflected in people's support plans or risk assessments.

There were no information strategies to support emotional health or describe how low mood presented, signs and triggers. Other people were at risk of a urinary tract infection or constipation but there was no advice for staff as to how to monitor for signs and symptoms and what actions to take for that individual. We found that there was limited information in care plans as to how provide catheter care such as monitoring

fluid input and output, the positioning of the bag to avoid skin damage, it's emptying.

We established from medication records that some people had patches for the control of pain. Staff were not able tell us for what condition the patches had been prescribed.

These were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) as the registered provider had failed to ensure that accurate and comprehensive records were held in respect of each person.

Leading up to the inspection, safeguarding concerns had been raised and substantiated in regards to the assessment, management and monitoring of pressure ulcers. We looked at the records for people who were at high risk of developing a pressure ulcer and found them to be inconsistent. We observed that one person had heel protectors in place but there was no record of this in their care plans to ensure that staff put these in place. Another person had developed pressure ulcers through 'shearing' but there was no evidence of any preventative measures in place to stop this from occurring again. Some people required repositioning to minimise the risk of developing a pressure ulcer. There was limited information as to the pressure relief requirements for a person when they were sitting in a chair.

The service used risk assessment tools in order to assess people's risk of developing a pressure ulcer or malnutrition. We found that these assessments were not always accurate and so there was a risk that the correct action may not be taken.

This was a further breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 as the registered provider failed to ensure that care and treatment was provided in a safe way.

A number of social activities and interactions were provided including reading, listening to music on the radio, watching television and games. Staff encouraged people to be involved in activities. There were also regular trips out into the local community for lunch or to a garden centre. People told us "We are all off out Llandudno soon ". There had been a barbeque prior to the inspection and everyone told us that they had enjoyed it.

Complaints information was displayed in the foyer and people were able to find and access this. This advised people on how to contact the provider directly and gave the contact details and information about the role of the local government ombudsman and CQC. Compliments and complaints were recorded and addressed. We saw that responses had been made where concerns were raised. Complaints and compliments forms were in the entrance area.

Inadequate

Is the service well-led?

Our findings

The service had a manager who was registered with CQC in 2011. People we spoke with all knew who the registered manager was and said that she was "always in and out". People we spoke with said they had no complaints about the service and that it was "in the main, quite good". Relatives said that they had confidence in the manager and the staff.

During the inspection we saw that concerns highlighted at previous CQC inspections since October 2015 had not been fully addressed. The registered provider has continued to fail to meet the requirements of Regulation 11, 12, 14 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Evidence reported in the safe, effective, caring, responsive and well led domains of this report identify issues of continued non-compliance and risks to the health, safety and well-being of the people who use the service. These omissions had not been identified as part of the quality monitoring system within the service nor as part of the registered manager's on going monitoring of the care provided at the service.

People's health was placed at unnecessary risk due to lack of appropriate recording. People were not adequately protected from the risk of dehydration and malnutrition, infection control and falls. These omissions had not been identified as part of the quality monitoring system within the service nor as part of the registered manager's on going monitoring of the care provided at the service.

Records viewed as part of our visit around diet and fluid intake or repositioning were not always completed in full, dated or signed. They were not reviewed to ensure that concerns were highlighted and escalated. This had not been identified as part of the auditing process.

A service development plan had been put in place with an emphasis on falls prevention, mental capacity and the use of thickeners; however these remained areas of concern from this inspection. There were no systems in place for the registered provider to carry out a review of the overall quality and safety of the service. One of the Directors informed us that they were at the service daily and so did not see the need to do this. However, they had commissioned a review external consultants in December and July 2017.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as there was not robust governance in place.

Prior to the inspection, we reviewed the statutory notifications that the registered provider had submitted to the CQC. Notifications enable CQC to monitor any events that affect the health, safety and welfare of people who use the service and decide if we need to take any action. These had been received as required.

Staff confirmed that team meetings had taken place and these were used to share information regarding any changes that occurred at the service. Minutes were available for us to review. We saw from minutes that jugs were to have colour coded tops to assist staff remember who required thickened fluids but these were not in use at the time of the inspection. The registered manager had also held a team building day to

improve communication and morale of staff. Staff were complimentary about this and felt that it was positive. Meetings were also held with clinical staff as a forum to discuss areas of concern and new practices.

There were meetings held with people who used the service and relatives. These were well attended and people were given the opportunity to discuss their opinions on the service. A survey was carried out in March 2017 for staff, people who used the service and their relatives. Issues that arose from people using the service were around doors being closed quietly, the lack of showering facilities and the variety of food. An action plan was put in place to address the majority of issues.

The registered provider had introduced a comprehensive set of policies and procedures for the service. The registered manager informed us that they were reviewed and adapted to reflect the service and records confirmed this. Policies were made available to as folders were made available in the office for ease of access. Specific policies were discussed via the team meeting for
Staff awareness and use at the service. There was a service user guide in place. This included general information about the home including staffing levels, type of care provided and contact details of the manager.

The service supports people that are under 65 but this is not reflected in the "service user bands" registered for the service with CQC. We noted that from our records that discussions about this matter had been on going with the registered provider since 2016 they had still not undertaken the required steps to rectify this.

The last CQC rating was displayed on the registered provider's website in line with the regulations. However, the rating at the service was not conspicuous as it was in black and white and on a notice board with lots of other information. To ensure they are conspicuous, we expect posters will be printed in colour and at a minimum size of A4.