Phoenix Healthcare Limited

# Warren Lodge Care Centre

## Inspection report

Warren Lodge
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## Ratings

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

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

# Summary of findings

## Overall summary

About the service
Warren Lodge Care Centre is a care home without nursing. People in care homes receive accommodation and personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The service supports people requiring care for reasons of age or frailty, some of whom are living with dementia. The service is registered to accommodate up to 55 people. During the inspection there were 21 people living at the service and one person was in hospital. The service is divided into two units known as the Main House and the Courtyard. The Courtyard is designed specifically to meet the needs of people living with dementia.

People's experience of using this service
The registered person did not ensure systems were in place to oversee the service and ensure compliance with the fundamental standards were always effective in identifying when the fundamental standards were not met.

Recruitment processes were in place however they were not as robust as they should be, to ensure as far as possible, that people were protected from staff being employed who were not suitable.

The management of medicine was not always safe. People with specific condition did not always receive their prescribed medicine safely and on time. Storage and handling of medicine was not always managed appropriately.

People were able to access healthcare professionals such as their GP. However, people did not always have their healthcare needs identified and addressed in a consistent or timely way.

The service did not always assess risks to the health and wellbeing of people who use the service and staff. Where risks were identified action was not always taken to reduce the risks where possible. Staff recognised and responded to changes in risks to people better however, a timely response and appropriate action was taken inconsistently.

The registered person did not always ensure they maintained clear and consistent records when people had injuries and the Duty of Candour was not applied.

We made a recommendation to explore relevant guidance on how to ensure environments used by people with dementia were more dementia friendly.

We have made a recommendation about seeking guidance from a reputable source to ensure the principles of the Accessible Information Standard were met.

There had been significant management changes since the last inspection. This also affected the service management. The new interim manager and new nominated individual had to review and establish systems and processes to ensure they could review, assess and monitor the quality of care in a consistent way.

The provider was taking steps proactively as part of the quality assurance process to ensure people were protected against the risks of receiving unsafe and inappropriate care and treatment. There was progress in making various improvements but not sufficient at the time of the inspection for us to judge this would be sustained.

The service had improved communication and worked better with other health and social care professionals to provide effective care for people.

There was an activity programme and some people were involved in activities. The manager took action to ensure all people had opportunities for social engagement and meaningful activities according to their interests to avoid isolation. However, improvement was needed to ensure activities were more personalised.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People felt safe living at the service. Relatives felt their family members were kept safe.

Staff understood their responsibilities to raise concerns and report incidents or allegations of abuse. They felt confident issues would be addressed appropriately.

We observed kind and friendly interactions between staff and people. People and relatives made positive comments about the staff and the care they provided.

People told us staff were available when they needed them, and staff knew how they liked things done most of the time. The manager reviewed and improved staffing numbers to ensure enough qualified and knowledgeable staff were available to meet people's needs at all times.

The manager had planned and booked training to ensure staff had appropriate knowledge to support people. Staff said they felt supported to do their job and could ask for help when needed.

There were contingency plans in place to respond to emergencies. The premises and equipment were clean and well maintained. The dedicated staff team followed procedures and practices to control the spread of infection and keep the service clean.

People had sufficient to eat and drink to meet their nutrition and hydration needs. Hot and cold drinks and snacks were available between meals.

People confirmed staff respected their privacy and dignity. The manager was working with the staff team to ensure caring and kind support was consistent.

People and their families were involved in the planning of their care. They encouraged feedback from people and families, which they used to make improvements to the service.

The manager held residents and relatives' meetings as well as staff meetings to ensure consistency in action to be taken. The staff team had handovers and daily meetings to discuss matters relating to the service and

people's care.

Staff felt the management was open with them and communicated what was happening at the service and with the people living there. People and relatives felt the service was managed better and that they could approach management and staff with any concerns.

Rating at last inspection
At the last inspection the service was rated Inadequate overall and placed into Special measures (Report was published 22 November 2018).

Why we inspected
This was a planned comprehensive follow-up inspection based on the rating at the last inspection.

Enforcement
We found breaches of six regulations relating to mitigating risks, staff recruitment, assessing and responding to people's needs, Duty of Candour, submitting notifications and the provider's system to ensure compliance with the fundamental standards. The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We have asked the provider to send us a report that says what action they are going to take. We will check that the action is taken. We will continue to monitor all information we receive about this service. We will carry out a comprehensive inspection within six months of the publication of this report in line with our methodology for services rated as inadequate if we have not proposed to cancel provider's registration.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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

We always ask the following five questions of services.

**Is the service safe?**

The service was not safe.

Details are in our Safe findings below.

**Inadequate**

**Is the service effective?**

The service was not always effective.

Details are in our Effective findings below.

**Requires Improvement**

**Is the service caring?**

The service was not always caring.

Details are in our Caring findings below.

**Requires Improvement**

**Is the service responsive?**

The service was not always responsive

Details are in our Responsive findings below.

**Requires Improvement**

**Is the service well-led?**

The service was not well-led.

Details are in our Well-Led findings below.

**Inadequate**

# Warren Lodge Care Centre

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out over three days by three inspectors, a specialist advisor and an expert by experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of care service. For example, in this inspection, caring for people with dementia.

Service and service type
Warren Lodge Care Centre is a care home without nursing. The service supports people requiring care for reasons of age or frailty, some of whom are living with dementia. The service is divided into two units known as the Main House and the Courtyard. The Courtyard is designed specifically to meet the needs of people living with dementia.

The service did not have a manager registered with the Care Quality Commission. However, the new manager had applied to become registered and there was a registration process underway at the time of the inspection. The provider is legally responsible for how the service is run and for the quality and safety of the care provided. During our inspection we were assisted by the interim manager and the nominated individual. We will refer to the interim manager as 'the manager' throughout the main body of the report.

Notice of inspection
This was an unannounced inspection. This meant the service was not aware we were coming.

What we did
Prior to the inspection we looked at all the information we had collected about the service including previous inspection reports and notifications the registered person had sent us. A notification is information about important events which the service is required to tell us about by law.

We also reviewed the information the provider sent us as part of their improvement plan after the last inspection.

During the inspection we spoke with nine people who use the service and four relatives. In addition, we spoke with the manager, the nominated individual and 19 members of the staff team.
We observed lunch in both dining rooms, planned activities and interactions between staff and people living at the service. We carried out a tour of the premises.

We looked at records relating to the management of the service for example:
Audits and quality assurance reports
Medicine management
Nine people's care records and associated records
Records of accidents, incidents and analysis
Falls analyses
Compliments and complaints
Eight staff recruitment files
Staff support, supervision and appraisal information
Maintenance records

Following the inspection, we asked the provider for some further information which we received. This included follow up information on recent survey and analysis, meeting minutes, further recruitment and training information, further audits and policies relating to the running of the service.

Inadequate

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm
Inadequate: People were not always safe and were at risk of avoidable harm. Some regulations were not met.

Using medicines safely

●At the last inspection, we found people's medicine management was not always safe. At this inspection we found issues again with the management of the medicine.

●Two people needed time specific medicine due to their condition, but this was not noted in their care plan, medicine profile or medicine administration record (MAR) sheet. The records did not include any reference that these two people had a specific condition requiring medicine to be given at the same time every day. This meant that people were at risk of not having their meds on time. We noted this to the manager and on the third day of inspection, the GP sent new prescriptions to both people indicating specific times to administer medicine.

●On the first day we were informed one person was receiving antibiotics for an infection. The next dose was due at 14:00 but the staff wanted to administer the dose 45 minutes earlier. They explained the GP had given instructions the antibiotics could be administered one hour earlier or later. However, there was no note on the person's file to indicate this was the case. After we pointed this out, the staff waited until 14:00 to administer the medicine.

●We reviewed the specialised drugs cabinet and the records kept. The records tallied however we noted to the staff helping us that the checks were not regular. We also informed the manager. Part of the daily medicine audit kept in the medicine administration record folder was to check the stock daily. We noted daily entries were written as "N/A", (not applicable) meaning the required daily check had not been carried out. There was no explanation as to why not.

●We found a loose tray of paracetamol on the shelf in the medicine room. We also found expired medicine, for example, there was an open bottle of an oral solution that was out of date. As per instructions on the bottle, this should have been disposed of after 90 days. However, it was still in the cabinet. Again, this was not picked up during the daily audit and checks of the specialised drugs cabinet.

●We found not all people had plans in place for 'as required' (PRN) medicine. PRN medicine care plans that were in place, were not updated since August 2018. Once we noted this to the manager and the nominated individual, we saw they put some new PRN medicine care plans in place. However, all these plans lacked information specific to the person, any side effects to observe for, or when and how to administer.

●When people had to receive specialised drugs, the provider's policy stated this had to be done and signed for by two staff. We saw in the MAR sheets this was not done consistently.

●We found medicine information did not tally with the information in the care plans. Some people had allergies, but it was not documented on their medicine profile.

This was a repeat breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not ensure care and treatment was provided in a safe way. They did not ensure the proper and safe management of medicines.

●We observed staff were polite and patient when administering medicine. The medicine trolley was left locked at all times when staff had to go away from it. When medicine was administered, the staff signed the MAR sheet afterwards.
●The training records confirmed staff had received training in handling medicines.

Assessing risk, safety monitoring and management (to people)
●At the last inspection, we found the registered person did not always ensure risks to people's health and wellbeing were identified and managed in a timely way. People were not safe and were at risk of avoidable harm.
●At this inspection, we found some measures were in place to ensure risks to people were identified and appropriate actions taken to mitigate the risks. However, these measures were not always followed and actions to mitigate risks were not always taken, effective or appropriate. For example, one person needed their condition monitored in a specific way and certain times of the day. The care plan also indicated clear guidance when to call 999 number. We looked at daily notes and saw that the monitoring of the condition was recorded inconsistently. Some days it was not checked at all. One day the person had to have support from emergency services however staff called 111 rather 999 as per the care plan. Eventually paramedics were sent, and the person needed oxygen and also, they were diagnosed with an infection.
●We spoke about the monitoring record with the manager and the nominated individual as staff did not record they have checked the person and their condition clearly and consistently. It was not clear what these recordings meant. We asked for an explanation, but the manager was not able to explain what the records meant at that time.
●On the third day of the inspection, the manager informed us they had spoken to the doctor about this person, following the guidance and the level of needs for this person.
●Looking at the daily notes, there was a change made by GP to the trigger for calling 999. However, the information in the care plan did not reflect this change. After the inspection, the recording of monitoring checks in the daily notes was improved stating if the person was laying or sitting but not consistent. Failure to establish clear guidance and follow instructions as per the care plan put the person at risk and the staff could not ensure the person received safe care.
●We reviewed another person's care records as they were in hospital. We had concerns relating to their care before the admission as they were found unresponsive in their chair in the dining room. The person was seen by the GP and reported as a suspected urine infection. The GP requested a urine sample however this was only provided six days later, and the antibiotics started seven days later. This was the day the person went to hospital. The level of care and support provided did not ensure safe care and timely treatment that may have prevented the hospital admission.
●At the last inspection we found information in care plans for people who were at risk of, or who already had, pressure ulcer damage was not always written clearly to indicate exactly how to care for their skin condition.
●At this inspection we found there was only one person being seen by the community nurses for support with a dressing. On the day of the inspection there was no dressing on the person's wound and it appeared to be healing. However, it was unclear from the care notes of the community nurses whether the person had been discharged and they had decided that the dressing could be left off to aid the healing process. The community nurses' diary showed the visits were made. It was not clear if the nurses came back to see the person as the page for that day was blank and we were not able find further information. The staff on duty were not able to tell us if the community nurses had visited on this day.
●We reviewed the care records for this person and found some inconsistencies. For example, the person was assessed to be at high risk of pressure damage. Some of the care plans such as skin integrity, mobility and continence did not accurately reflect information regarding equipment to be used. The setting of the mattress to be used was not recorded within the care plan. The staff did not record equipment checks

consistently. Thus, they could not be sure the mattress was working properly and not damaged. As the detailed information was an important part of the support with skin integrity, failure to keep accurate and consistent records could result in inconsistent care delivery and increase the risk of harm.

This was a repeat breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person did not ensure risks relating to the safety and welfare of people using the service were consistently assessed, recorded and managed.

●We could not judge if the skin care was improved overall. Due to the lack of an effective system in place before, the manager implemented the nurses' meetings weekly and a tracking system to follow the progress. The manager felt this would help ensure people needing any help were supported in a timely manner.

Learning lessons when things go wrong

●At the last inspection we found, the incidents and accidents were not monitored consistently to gather necessary information to mitigate the risks, identify themes and trends, and put safety and prevention measures in place.

●The manager told us they had recently introduced new monthly audits. The first of these was undertaken on 1 March 2019 and covered the month of February 2019. We looked at all accidents and incidents for the month of February 2019 and in total there were 11. Staff had recorded when the accident/incident/near miss had taken place. However, the forms did not always clearly evidence what the findings were or investigate the root cause.

●We reviewed the monthly audit for February 2019 that looked at different details about each incident to help identify trends, patterns and themes. These included times of incident and whether it was a person requiring residential, nursing or dementia support. However, the audit only accounts for six incidents for the month of February despite the fact that 11 took place.

●We spoke with the manager about this and he advised they had not accounted for incidents where there was no injury. This meant, for example, where a person had had a number of falls but did not sustain an injury they were not reviewing these as part of their audit process. It was not recognised the frequency of the falls should be looked into and find out the pattern or reason why it happened to prevent a fall that may cause an injury.

●The final page of the audit asked for "patterns identified, during and following audit" and "comments and feedback" but the information was limited. There was no action plan as part of the audit and it did not highlight areas for improvement or action needed to be taken to mitigate risk to individuals.

●The manager told us they were still looking at how to ensure the audit was effective. We looked at the audit dated the 20 March 2019. This was completed by the care manager for the period of 1 March 2019 to 20 March 2019. It highlighted there were six incidents/accidents for this time period however we found seven forms. We also identified one incident had not been included. This was regarding a person presenting with behaviours that challenge towards a staff member. We asked the manager why this incident was not included, and they said because it was towards a staff member.

●We noted to the manager it was unclear what parameters were looked at as part of the audit. Patterns and themes identified as part of this audit were for example, "The pattern that is identified is that most of the falls have happened when residents are on their own and therefore incidents are unwitnessed". This did not look at individual risks and patterns. It did not highlight any action as a result to prevent recurrence.

●The provider completed a "Quality Review and Clinical Governance Meeting". As part of this meeting accident and incidents were discussed. We looked at the minutes of a meeting which took place on 12 March 2019. This stated for the period of 18 February 2019 to 24 February 2019 there had been no accident or incidents where harm occurred. However, when we looked at accidents and incidents where harm occurred during this period, we found there were in fact incidents which resulted in harm. For example, one

person sustained a skin tear on 21 February 2019. We looked at the section of the minutes highlighting accidents and incidents where no harm had occurred. The minutes stated there had been three incidents and four falls for the period of 25 February to 12 March 2019. This did not match the numbers in the accident and incidents folder for this period. In addition, under the header "trends/patterns/analysis", it only said "Individual cases". This did not evidence trends, patterns or analysis. Under the header "details" and "target date" these were blank.

●We also looked at incident and accidents since the last inspection. The previous nominated individual sent an action plan indicating there was a daily analysis taking place including of the root cause so that preventative action could be identified. The recordings were inconsistent, often lacking detail of the investigation or root cause analysis. The incident forms were not always signed off to indicate the manager at that time had reviewed it.

●We looked at the folders with information about lessons learned from incident or accidents happened. It was an improvement since the last inspection and it was good to see the manager involved the staff to reflect and learn from them. However, the system overall in place did not highlight areas for improvement or action needed to be taken to mitigate the risks to individuals.

This was a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person did not ensure care and treatment was provided in a safe way. They did not consistently assess the risk to health and safety of service users or mitigate such risks.

Recruitment and selection

●At the last inspection, we found discrepancies with the recruitment information required by the regulations. We listed all discrepancies to the management team, so they could rectify them. However, we did not receive any further information.

●At this inspection, we looked to see if safe recruitment procedures were used to ensure people were supported by staff who were of good character, suitable for their role and had appropriate experience. The action plan sent after the last inspection indicated a full audit had taken place to ensure all recruitment information complied with this regulation.

●We found some discrepancies again with employment histories, evidence of conduct and work permits. We noted this to the management team. We also found two staff were employed when their conduct from previous employment had been of concern. They did not declare this during the application and interview processes. We asked to see any supporting evidence to show this had been explored and discussed with these members of the staff and the management team at that time. The provider confirmed to us after the inspection they were not able to provide further evidence regarding this. They said the lessons had been learned from this to ensure safe recruitment process is followed in the future. This meant though the recruitment process had not been followed appropriately and put people using the service at risk of being supported by unsuitable staff.

This was a repeat breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not followed their established recruitment procedures or obtained the information required by the regulations to ensure the suitability of all staff employed.

Assessing risk, safety monitoring and management (premises)

●At the last inspection we found the registered person did not ensure there was an oversight from the management of maintenance required in the building. Where actions were identified to be completed, it was not done in a timely manner to make the service a safe place to provide care and support to people.

●At this inspection we found the monitoring and maintenance of the environment and equipment had improved. Staff monitored other general environmental risks, such as water temperatures, fire exits and slip

and trip hazards as they went about their work. The manager had an action plan in place working through it to ensure safety in the service such as fire and prevention of legionella.
●Business contingency and emergency planning was in place to ensure people were supported in unplanned events and equipment was available to help staff.

We are satisfied that the service has achieved compliance with Regulation 12 (2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person ensured the premises used by the service provider were safe to use for their intended purpose where people received care.

Staffing
●At the last inspection we found staff were not always deployed in a way that kept people safe or supported appropriately. The deployment of staff did not always ensure people were supported to meet their complex needs such as being confused or distressed.
●During this inspection, we found the staff organisation was better. We observed where people needed support, it was provided in a timely manner. There was an extra staff member appointed to ensure people received support during lunchtime.
●Overall, there were enough staff to support people's needs and the manager regularly reviewed the numbers needed. Most of the staff felt there were enough staff to do their jobs safely. A few staff noted more staff on the floor would be good, so they would not need to rush at times, and people would get better attention. The manager was always helpful ensuring the service operated at safe staffing levels.
●We observed care staff answered call bells promptly on our visit. People and relatives felt staff were available when needed. We saw staff responded to people's request for support during the day. One relative said, "Now yes, staff are available. Since [manager] came in, it is almost a different home."

We are satisfied that the service has achieved compliance with Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person improved and ensured there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to ensure they can meet people's care and treatment needs.

Systems and processes to safeguard people from the risk of abuse
●At the last inspection we found the provider did not ensure they followed their established systems and processes to safeguard people and respond appropriately and in timely manner when allegations of abuse came to light.
●During this inspection we found the provider improved their approach and response to the safeguarding concerns raised.
●At the time of our last inspection, we also found only 19 staff members' safeguarding training was up-to-date. As part of their role, staff must receive suitable and relevant safeguarding training.
●During this inspection, we found all the staff members were up to date with their training. Staff knew how to deal with and report any issues relating to people's safety.
●People told us they felt safe living in the service and they knew who to ask for help if they felt unsafe. Relatives said they felt their family members were safe with the staff.

We are satisfied that the service has achieved compliance with Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person ensured the provider's systems and processes to protect people from abuse and improper treatment were operated effectively.

Preventing and controlling infection
●Appropriate measures were in place regarding infection control. We saw dedicated staff ensured the

service was kept clean, tidy and odour free. Staff followed a cleaning schedule and used appropriate personal protective equipment to help protect people from the risks relating to cross infection.

●Staff were trained in infection control and followed the provider's policies and procedures. The manager or the senior staff carried out audits to ensure standards of cleanliness were good.

Requires Improvement

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence
Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations were not met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
●At the last inspection we found people's care plans did not always have guidelines to ensure staff supported them appropriately including personal care, emotional and behavioural support and consent. Where people may show behaviour that challenged, the staff did not have enough detailed guidance on how to minimise the risk without restricting people or their independence.
●At this inspection we found the care plans were kept under review and amended when changes occurred or if new information came to light. However, this was not done consistently as we found information that did not match people's current needs and support.
●For example, we observed staff helping one person take their medicine. The staff member was telling the person what each medicine was for. This was in the lounge with five other residents and we shared our concerns over the confidentiality of this process with the manager. They explained the person liked their medicine to be taken in a certain way and at specific time of the day. We noted to the manager this was not part of the care plan. They said they had discussed this last week with staff in order to make changes to the care plan.
●We spoke to one person who said they would like to lay down after having their medicine. It was documented in the care notes for this person on 2 January 2019, they were suffering from postural hypotension and experiencing a drop in the blood pressure causing dizziness on standing. The GP noted this mainly occurred in the morning, but it did happen throughout the day. Postural hypotension is a side effect of some medications prescribed for the treatment of certain condition that the person had. The GP reviewed the person on 17 January 2019 and noted the person's wellbeing had improved. However, information on the person's wishes to lay down and risk of feeling dizzy when standing from a lying position was not included in the care plans for maintaining a safe environment and medication.
●Another person had a catheter in place and the continence care plan contained good detail of the responsibilities of the staff team. The care plan informed the staff the person was prone to infections and taking preventative antibiotics. The care plan stated the person should be encouraged to drink plenty and report any concerns regarding the catheter to the senior staff or to the management. However, the care plan did not include guidance for the staff on the importance of keeping the catheter site clean. Neither did it include information on the risks and potential problems associated with having a catheter in situ, for example bladder spasms, stomach cramps, or leakage that could be a sign that the catheter is blocked; or what to do if blood and or debris was seen in the bag or within the tube.
●Some of the people had positive behaviour support (PBS) plans in place. One person who was known to present behaviour which challenges did not have a PBS plan in place. The emotional support care plan for this person stated they may become anxious and stressed during personal care with details of how they present. However, the care plan did not clearly state how the staff should support the person during personal care to ensure their safety. The emotional support care plan for another person contained good

detail on how they liked to be supported when feeling low in mood.
●At the last inspection we found the staff did not understand when they were using restraining practices to support people with personal care. At this inspection, we reviewed the personal care plans again. It was improved and provided information on how to support people with this activity. The staff identified some triggers such as not to use certain words and to use a gentle approach when it was time for their personal care. However, one care plan overall stated very clearly the person was uncomfortable when certain members of the staff team would support them. The care plan and best interest meeting minutes indicated there was an underlying historic reason that could cause distress or anxiety to the person. As part of the best interest decision making meeting, the decision makers have to take into account any present and past views, wishes, and feelings of the person. We raised our concerns as we felt this was not fully considered and the instructions for personal care were too contradictory. Having certain members of staff team providing care presented a risk of causing more distress to the person rather than ensuring it was prevented.

This was a repeat breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not ensure people's care and treatment was appropriate and met their needs. The registered person did not ensure it was designed with service users' views and with a competent professionals balancing risks and benefits of particular treatment.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
●At the last inspection we found people were not always referred to health professionals in a timely way. People's changing needs were not always monitored appropriately to ensure their health needs were responded to promptly. People did not always have appropriate care plans to help them and staff look after their specific conditions.
●At this inspection we found people had access to health and social care professionals including a GP, dietitian, occupational therapist, community nurses, and the community mental health team. A GP visited the service and reviewed people's health regularly. However, some records were unclear around how people's hydration was to be managed.
●We looked at three people who were on 'fluid watch' at the time of inspection. It was unclear from the care records and nutritional care plans how fluid targets were being calculated. There was also no upper limit for fluids being recorded. The three people had a daily target of 1000mls however, it was not clear how this target had been decided. We were informed it would be the GP who decided this. However, after contacting the GP the manager informed us that it was not the case and should have been decided by the dietitian. The service worked with a nutritionist who provided some information on fluids. This included a tick chart for recording the number of drinks taken during a day and a chart depicting the different colours of urine and equating this to the various stages of hydration. We noted it was important to ensure that fluid targets were individual, accurate and identify an upper and lower limit. During the inspection, we observed staff regularly offering a variety of drinks and encouraging people to drink.
●During our inspection we observed one person displayed behaviour that may challenge on a number of occasions. The staff at that time responded well and provided reassurance to the person. However, the daily notes were not consistently recorded. Some language used presented a concern such as the staff hugged the person while the other two staff provided personal care. We asked the manager about this and he explained the person consented to the hug and it was actually a cuddle. Although it may work as an effective approach to personal care, this was not part of the personal care plan to support the person. From the daily notes it was clear this person did not like this aspect of their support.

Staff support: induction, training, skills and experience
●At the last inspection we found staff did not have the training they needed to meet people's needs and

ensure their safety in the service. The management did not always have an overview of staff performance and development needs.
●At this inspection we found the training records were improved and staff were being regularly reminded to ensure they were up to date with their training.
●Community professionals supporting the service also provided sessions around the Mental Capacity Act (MCA) and pressure area care. Management of challenging behaviour was a theme that ran through all the sessions provided.
●We reviewed support and supervisions for staff. This is a meeting between staff and their line manager to discuss staff's practice, development needs and any other areas of support. The manager had a matrix compiled to record the sessions completed.
●The manager told us they had not started to complete annual appraisals as they were working on establishing a good supervisions process so that staff understood the aim of it.
●Staff felt they were supported by the manager and could come to see them for advice. The meetings were also used to reflect on practice and suggest ideas for improvement.
●The manager also involved senior staff to conduct supervision sessions and this was regularly monitored.

We are satisfied that the service has achieved compliance with Regulation 18 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider ensured staff supporting people were appropriately trained, supervised and able to obtain further professional development in order to perform their work.

Supporting people to eat and drink enough to maintain a balanced diet
●People liked the cooked food most of the time. They agreed choices were offered to them. They said snacks and drinks were available at any time and they were encouraged to drink regularly.
●People were supported to have their meals and they ate at their own pace. Some people chose to eat their meals in their bedrooms and they were served promptly.
●Staff helped some people make choices by plating up food and showing to them, so they could choose what they preferred. If people did not want it, they were offered other options available.
●Staff continuously offered various drinks to people and there were drinks available throughout the day.
●The staff and the kitchen staff were aware of people's dietary needs and preferences.
●Referrals were made to the GP or the dietitian where there was a concern with someone's weight.
●The chef had introduced fruit smoothies and cheesecake lollies, which included food substitutes. These were very popular and had enhanced the diets of those people with poorer appetites. We saw people really enjoyed them.
●The chef worked with the manager who was very supportive, to have visual or picture menus, on a computer tablet, which could be taken to the people who ate in their rooms to ensure they were aware of the menu for the day.

Adapting service, design, decoration to meet people's needs
●The design of the premises was mostly suitable for the needs of the people with dementia.
●In the courtyard side, some elements of the interior helped people living with dementia. For example, the doors to people's rooms were depicted as their front door, brightly painted and furnished with door handles and knockers.
●People were assisted to locate their rooms using these colours and photographs. The décor had some points of interest such as artwork dedicated to being at the beach and sensory decorations in the relevant corridors.
●There was dementia signage indicating what other doors were, for example toilet or dining room door.
●Toilet seats were white and did not stand out against the décor in the toilet's rooms. Best practice

guidance states ensuring good colour contrast on sanitary fittings makes toilets easier to find and see, helping people to maintain continence.
●We observed aids such as coloured crockery used to support some individuals when eating, were not used. Only cups were of red colour.
●The service did not use colours to highlight light switches. This could be done by having coloured switches or making sure white switches show up against the wall colour. This would help people to find and use light switches independently.
●People were able to walk around the corridors and there were a couple of areas to sit down for quiet time. However, the signage to guide people where to go when coming out of their bedroom was minimal.
●The main house presented a light, bright environment where people moved around freely.
●There were areas available for people to enjoy activities, spend time following personal interests and places to entertain visitors.
●The outside areas were well designed and provided a pleasant place for people to sit outside or enjoy outdoor activities.

We recommend the service explores all relevant guidance on how to ensure they make environments used by people with dementia more dementia friendly.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes this is usually through MCA application procedures called the Deprivation of Liberty Safeguards.
●We found the service was working within the principles of the MCA, restrictions on people's liberty had been authorised and any conditions on such authorisations were being met.
●People's rights to make their own decisions, where possible, were protected.
●Staff were trained in the MCA and understood the importance of seeking consent before supporting people and helping them make decisions.
●Throughout our inspection we saw staff asking consent and permission from people before providing any care or assistance.

Requires Improvement

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect
Requires Improvement: People were mostly supported and treated with dignity and respect; and involved as partners in their care however ongoing improvement was needed to ensure the culture was consistently caring.

Ensuring people are well treated and supported; respecting equality and diversity
●At the last inspection we found the people who use the service did not always receive dignified, respectful care. Staff did not always take time when people were distressed to reassure them. Staff did not always show concern for people's wellbeing in a caring and meaningful way and did not respond to their needs quickly.
●At this inspection, there was improvement however there were still occasions where we observed staff not always being kind, considerate or thoughtful. We informed the manager who addressed it with the staff.
●Being caring was not only about being polite when speaking to people. It was also caring about people's health and wellbeing. We acknowledged the improvements made in this domain. However, we found a number of occasions when staff did not show care and compassion to ensure people were looked after in a caring and consistent way. The service had still to make improvements to ensure the staff consistently treated people as individuals and quickly responded to their changing needs.
●Some staff showed they had knowledge of people well and were able to anticipate their needs. We observed members of staff kneeling down by the chairs of people while speaking to them ensuring they could maintain eye contact and were not looming over them when they spoke.
●Another staff member was sitting at the table with a person and informing them what she was writing in the care record and asking them if the person was alright with what she had written.
●We observed a person being given a hand massage and they repeatedly asked the member of staff how much they owed her. The member of staff dealt with this calmly and kindly saying, "One hug and two smiles." This made the person smile.
●One person became distressed and a member of the staff promptly responded to them and tried to reassure them verbally. However, the person became more distressed. The member of staff took some hand cream and applied to her hands inviting the person to assist her. This helped the person to be less stressed. This was a timely and kindly intervention which did briefly impact positively on the person's wellbeing.
●People and relatives agreed staff were caring and kind. They said, "I can't fault them - just one or two who I'm not keen on", "Well yes, one or two are like family and make me feel normal and it's important for me" and "Staff are very caring."
●In the Courtyard three staff and three people sat in a group having a conversation and engaging in an activity in which everyone was included. Staff sat with people at lunchtime and engaged them in conversation when they were waiting for their meals.
●People agreed staff knew how they liked things done when supporting them.

Supporting people to express their views and be involved in making decisions about their care
●People and those important to them were encouraged and involved in making sure people received the

care and support they wanted. People's views were sought through verbal feedback, residents and relatives' meetings, annual surveys and a programme called 'Resident of the day'.

●Staff respected people's choices about how and where they wanted to spend their time.

●People's bedrooms were personalised and decorated to their taste including pictures of friends and family, paintings and other items important to the person.

Respecting and promoting people's privacy, dignity and independence

●People and relatives agreed staff showed them respect and said they were "lovely". People and relatives agreed staff protected their dignity and privacy. Staff respected people's privacy and explained how they would support someone with personal care. We saw that staff knocked on people's doors before entering their room.

●We observed people and their appearance. They looked well cared for with clean clothes and appropriate footwear.

●People were encouraged and supported to be independent. Staff supported people to do as much for themselves as possible.

●Most of the staff understood the importance of treating people with respect and compassion, so they could live their life as chosen. They said, "Treat everyone as individual and allow privacy and dignity at all times", "When doing any tasks with a resident, we treat them with respect and dignity" and "Talk respectfully and respect what they would like to do. Always make them feel good."

●People's right to confidentiality was protected. All personal records were stored on the computer with password protection and kept locked away and were not left in public areas of the service. Staff understood the importance of keeping information confidential. They would only discuss things in private with appropriate people when necessary.

Requires Improvement

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs
Requires Improvement: People's needs were not always met. Regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- At the last inspection we found the registered person did not ensure there was sufficient information for staff to respond and to allow people to be supported appropriately and to remain safe.
- At this inspection we found people's information was transferred to the online system completely. The work was in progress to ensure accurate records were in place. However, people's care, support and treatment plans were not always detailed or described routines specific to each person. Some of the words used were too general and not explained, such as "conducive", "least restrictive way or "diversion techniques". This meant the staff may not be clear about the specific personalised support a person needed.
- Some care plans included more information to help staff monitor the well-being of the person. However, this was not consistent throughout the care plans and notes we reviewed. Although there was improvement in the standards of the care plans, some of them did not have the most up to date information that would enable staff to respond to people's needs in an effective and timely way.
- Where a person's health had changed, the daily notes varied in describing if the staff worked with other professionals to support the person. The daily notes did not indicate if the support was actually provided.
- If the person refused medicine, it was not always clear if the staff came back to try it again or how many times before noting it was not administered. If a blood test or urine sample was requested by the GP or other professionals, the daily notes did not indicate if and when the samples were obtained, or the attempts made. Therefore, it was not clear if it was difficult to do or not actioned in a timely way.
- We had to ask the manager on several occasions if the support from a health care professional was provided as we could not find the information recorded. Some of the information about people's care and support was recorded three to five times. It was confusing to read as it was not clear if it was the same situation or a different one.
- Having continuous and clear recorded evidence to indicate people were supported appropriately would ensure the manager and the staff had an overview of people's conditions and their wellbeing and staff would able to respond and seek appropriate support when needed.
- There was a programme to engage people in activities, maintain their social skills and achieve emotional wellbeing. Activities were listed and available to people, visitors and staff throughout the service. We observed a few activities going on and we saw people enjoyed getting involved, chatting to others in between.
- We also observed when activities were not happening, some people were sitting in the lounges in a circle with the television or music on. Sitting in smaller circles would have encouraged more interactions between people.
- We observed an activity which was taking place in the lounge in the morning. The people that were present took little interest in it and were not taking part in the movements. Two people expressed dissatisfaction as it was clear this was not their preference or interest.
- We discussed with the manager the need to explore people's interests, hobbies and vocations so they could tailor the activities. This way activities would be individual, meaningful and relevant to people.

This was a repeat breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person did not ensure care and treatment was appropriate, met people's needs and reflected their preferences in a consistent way.

●People were supported to develop and maintain relationships with people that mattered to them and avoid social isolation.
●Relatives were visiting people throughout our inspection. Relatives could stay and spend as much time as they wanted with their family members in their rooms, lounge or dining room or out in the garden.

Meeting people's communication needs
From August 2016 onwards, all organisations that provide adult social care are legally required to follow the Accessible Information Standard (AIS). The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people who use services. The standard applies to people with a disability, impairment or sensory loss and in some circumstances to their carers.
●There was some guidance in communicating with people in a manner they could understand. We discussed the five steps of AIS with the manager to ensure all information presented was in a format people would be able to receive and understand.
●Staff were aware of different ways of communicating with people, for example, using visual aids, pen and paper, simple questions, observing body language and "take time to listen".

We recommend the service seeks advice and guidance from a reputable source about meeting all five steps of AIS.

Improving care quality in response to complaints or concerns
●The manager took complaints and concerns seriously and used them as an opportunity to improve the service.
●There had been two complaints since the last inspection. These were investigated and responded to appropriately.
●We saw the service received some compliments regarding the care and support provided to people. The manager thanked the staff and appreciated their work in bringing improvements to the service.
●The people and relatives felt they could approach the manager or one of the staff members in the team if they had any issues to report. The staff felt they could approach the manager with any concerns should they need to.

End of life care and support
● At the time of this inspection the service was not providing end of life care to anyone living at the service.

Inadequate

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture Inadequate: Service management and leadership was inconsistent and there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not always assure the delivery of consistent and high-quality care. Some regulations were not met.

How the provider understands and acts on their duty of candour responsibility

- At the time of the last inspection, there had been a number of serious injuries that were notifiable incidents indicating the duty of candour was applied. Duty of Candour, Regulation 20, is intended to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to where care and treatment goes wrong or causes or has the potential to cause harm or distress. During the last inspection we found the registered person did not ensure there was evidence to show the staff had followed the regulation and their own policy to complete all the actions set out.
- After the last inspection, the previous nominated individual sent us an action plan setting out how they would ensure this regulation would be met and told us that actions had been completed by 5 December 2018.
- At this inspection we asked the management team to provide us with evidence the regulation had been followed when the serious injuries had happened. Due to the changes in the management team, the manager and the nominated individual informed us they could not find any documented evidence to show that Duty of Candour principles had been applied in all cases, as per the regulation and their own policy.

This was a repeated breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to record and keep a copy of actions taken as required in the Duty of Candour regulation when a notifiable safety incident occurred.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The nominated individual who was overseeing the service during the last inspection, resigned and left the company. An interim nominated individual had been appointed until a permanent post was recruited to.
- There was an interim manager managing the service since February 2019 with the support of operations managers and the nominated individual.
- During the inspection, we found the manager and the nominated individual to be accessible, honest and transparent. There was a clear want to drive improvements within the service.
- They both took on board all queries or issues we raised during our inspection over three days and started to address them promptly.
- At the time of our inspection the service did not have a registered manager in post. The registration process was ongoing. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, 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.

●Services registered with the Care Quality Commission (CQC) are required to notify us of significant events and other incidents that happen in the service, without delay. At the last inspection we found the registered person had not notified CQC about significant events consistently.

●During this inspection, we found again the registered person did not ensure CQC was consistently notified of reportable events within a reasonable time frame. This meant we could not check that appropriate action had been taken to ensure people were safe at that time.

This was a repeated breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The registered person failed to notify the Commission of notifiable events, 'without delay'.

●At the last inspection, we found that whilst the provider had quality systems in place, these were ineffective in identifying and mitigating the risks posed to people, such as in regard to pressure area care and medicine management.

●After the last inspection, the previous nominated individual sent us an action plan indicating the improvements had been made and the service was operating well. However, during this inspection we found a number of issues indicating the systems and processes were not established and embedded well by the previous management.

●We reviewed various audits which had been recently implemented since the change in the management. The manager had identified a number of issues and concerns and actions that needed to be taken. However, the audits did not highlight all of the concerns found during this inspection. The manager advised they were regularly reviewing this document and action areas for learning to ensure that the service was continually improving.

●During this inspection we identified areas, not identified by the provider's audit systems, where action was needed to make sure people were protected and safe and where regulations were not being met.
For example,

- the management of medicine remained unsafe.
- staff recruitment procedure was not operated effectively to ensure people were not put at risk by being supported by unsuitable staff.
- actions had not always been taken to mitigate risks to people's health, wellbeing and safety.

● Failure to identify and act on these issues potentially placed people at risk of harm or abuse.

●Records were not always completed accurately or updated when necessary. A number of care records we reviewed were not always clear and legible to indicate people's needs, outcomes or support provided. The registered person did not always ensure people and staff were protected against the risks of unsafe or inappropriate support and practice because accurate records were not maintained.

●The new management team were working hard to review, monitor, assess and improve the quality of the service.

●The manager was aware he had to review the service, the processes and systems in place. This was to ensure they had an overview of the service and could start addressing the issues and implement systems. Even though we saw some improvements had been made, there was still a lot of work to do and we were not able to judge the improvements would be sustained.

The above is a repeat breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had not established an effective system to enable them to ensure compliance with their legal obligations and the regulations. The registered person had not established an effective system to enable them to assess, monitor and improve the quality and safety of the service provided consistently.

Planning and promoting person-centred, high-quality care and support with openness

●The manager and the staff team demonstrated a shared responsibility for promoting people's wellbeing, safety, and security. The manager was working on establishing a 'whole team approach' and culture in the service so it would continue to develop and grow. People and relatives agreed the service was managed much better since the manager came in.

●Staff felt listened to and the manager was approachable. Staff spoke positively about them and felt they were supportive.

●The manager praised the staff team saying, "I am very proud of the staff team that they stuck it out. There is loyalty here and they are very willing to get things right. They are a very strong team and I find it easy to work with them. They take responsibility for what they do, and they are really trying to do well. It is a slow development, but I am confident staff will get there."

●The manager added he felt supported by the seniors and the provider keeping in regular contact with them.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

●The manager and the nominated individual were working on promoting a positive, caring, transparent and inclusive culture within the service. There were improvements ongoing and the manager and the staff team were very motivated to provide better care and support to people.

●The manager and provider held meetings for people who use the service and relatives to listen and gather any views or concerns they had.

●The manager established and held more regular staff team meetings to ensure any items arising from audits, reviews or relatives and people's meetings were shared with the staff team. This was to ensure all team members were aware of any issues, actions to take and to pass on positive feedback.

Working in partnership with others

●People's care plans contained records of visits or consultations with external professionals. Those seen included GPs, community nurses, hospital consultants, dietitians, chiropodists and members of the community mental health team.

●We saw the manager established better working relationships with professionals such as having regular contact with community nurses, dietitians and the local authority.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>This was a repeated breach of Section 1 and 2 of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The registered person failed to notify the Commission of notifiable events, 'without delay'. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>This was a repeated breach of Regulation 9 (1) (3) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not ensure people's care and treatment was appropriate and met their needs. The registered person did not ensure care and treatment met people's needs and reflected their preferences in a consistent way. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>This was a repeated breach of Regulation 12 (1) (2) (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not ensure care and treatment was provided in a safe way. They did not ensure the proper and safe management of medicines. The registered person did not ensure risks relating to the safety and welfare of people using the service were consistently assessed, |

recorded and managed. They did not consistently assess the risk to health and safety of service users or mitigate such risks.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>This was a repeated breach of Regulation 19 (1) (a) (2) (3) (a) and Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not followed their established recruitment procedures or obtained the information required by the regulations to ensure the suitability of all staff employed. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 20 HSCA RA Regulations 2014 Duty of candour<br><br>This was a repeated breach of Regulation 20 (3) (e) (6) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to record and keep a copy of actions taken as required in the Duty of Candour regulation when a notifiable safety incident occurred. |