Garlands Residential Care Home Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection of Garlands Residential Care Home took place on 30 and 31 October 2018 and was unannounced. We previously inspected the service on 27 September, 2 October and12 November 2017. At that time we found the registered provider was not meeting the regulations relating to safe care and treatment, supporting staff and good governance. The registered provider sent us an action plan telling us what they were going to do to make sure they were meeting the regulations. On this visit we checked to see if improvements had been made.

Garlands Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Garlands Residential Care Home accommodates a maximum of 20 people; there are communal areas located on the ground floor with bedrooms situated on both the ground and first floor. The home provides care and support to people who are assessed as having personal care and support needs. There were 18 people living at the home at the time of the inspection.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not adequately protected from the risk of fire. We saw gaps in the ceilings, in the event of a fire this would enable the fire to spread quickly throughout the home. The stair lift had not been tested to ensure it met with current safety legislation and we saw a wheelchair which was not safe to use. Some areas of the home were visibly dirty. We also identified some mattresses and cushions which were soiled inside their covers and needed to be replaced.

Risk assessments were not always sufficiently detailed or reflective of people's current needs.

We saw people's medicines were not always administered safely. There was a lack of guidance for staff regarding the administration of 'as and when' required medicines.

There were systems in place to reduce the risk of employing unsuitable staff. There were sufficient staff on duty to meet people's needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. However, records did not evidence lawful consent was consistently provided.

The staff team communicated with each other and shared relevant information. People were supported to access external health care professionals when their health needs changed.

When people had lost weight, appropriate referrals were made to the dietician. Where nutritional supplements were prescribed, records did not evidence these were provided in line with the prescriber's instructions. The care records we reviewed did not always include sufficient detail to ensure people's care needs were met. The content of some care records was conflicting. Care records did not include information regarding people's end of life wishes. We have made a recommendation about end of life care planning.

Relatives told us the staff were caring and kind. Staff clearly knew people well and spoke about people in a caring way. We saw evidence people's individual beliefs were respected but we also saw examples of staff not treating people with dignity and respect.

Verbal complaints were not recorded and had not been an opportunity to review the quality of the service people received and or make any improvements.

The registered provider and the registered manager were present in the home daily. Everyone we spoke with told us they were friendly, approachable and caring.

During our inspection we identified numerous concerns. These demonstrated that systems of governance were ineffective in assessing and monitoring the quality of the service. Audits on some aspects of the service were not sufficiently robust and audits on some aspects of the service were not completed at all.

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 act 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."

During this inspection, we found breaches of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014, related with dignity, consent, safe care and treatment and good governance. You can see what action we told the provider to take at the back of the full version of the report.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People, staff and visitors were not adequately protected from the risk of fire and we were not assured the premises and equipment were safe.

We found medicines were not always administered accurately and did not always follow the instructions of the prescriber.

Some equipment and aspects of the premises were not clean.

Is the service effective?

Requires Improvement

The service was not always effective.

The requirements of the Mental Capacity Act 2005 were not being consistently applied.

People's records did not evidence they were receiving their nutritional supplements as prescribed.

Staff received regular training and supervision.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was not always maintained.

People were not always served meals and drinks in a way which respected their personal preferences and choices.

Relatives told us staff were caring and kind. Staff spoke about the people they supported in a kind manner.

Is the service responsive?

Requires Improvement

The service was not always responsive).

Peoples care records were not always accurate and lacked sufficient detail.

Verbal concerns were not recorded or acted upon.

Activities were provided for people to participate in. □

Is the service well-led?

Inadequate

The service was not well led.

Systems of governance had not been established or operated effectively in order to assess, monitor and continually improve the quality of the service.

The home had a registered manager in post.

Feedback about the registered provider and the registered manager was positive.

Garlands Residential Care Home Limited

Detailed findings

Background to this inspection

This inspection took place on 30 and 31 October 2018. The inspection commenced on 30 October 2018. The inspection team consisted of two adult social care inspectors. One of the inspectors also visited the home again with another adult social care inspector on 31 October 2018. Both visits were unannounced.

Prior to the inspection we reviewed all the information we had about the service including statutory notifications and other intelligence. We also contacted the local authority commissioning and contracts department, safeguarding, infection control, the fire service and Healthwatch to assist us in planning the inspection. We reviewed all the information we had been provided with from third parties to fully inform our approach to inspecting this service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was used to help inform our inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time in the lounge and dining room areas observing the care and support people received. We spoke with one person who lived at the home and four visiting relatives. We also spoke with the nominated individual, finance director, registered manager, deputy manager, a senior care assistant and four care assistants, a domestic, a cook and the activity organiser. We reviewed four staff recruitment files. We looked at four people's care plans in detail and a further two care plans for specific information. We looked also looked at eight people's medication administration records and a variety of documents which related to the management and governance of the home.

Inadequate

Is the service safe?

Our findings

Our inspection in 2017 found the registered provider was not meeting the regulation regarding safe care and treatment. At this inspection we found improvements had been made to the provision of fire drills and water temperature checks but we also identified a number of other serious concerns.

People, staff and visitors were not adequately protected from the risk of fire.

When we reviewed the fire risk assessment dated February 2018, this identified a hole in the basement ceiling which needed to be sealed. We noted the gap in the basement ceiling was still there. This meant a fire originating in the basement could easily spread to the ground floor. The fire risk assessment also identified a hole in the ceiling where the gas boiler was located. This was in a room under the main staircase which led between the ground and first floor. A hand-written note on the fire risk assessment, written by Nominated Individual recorded 'had to remove it to gain access to fit new gas pipe, will replace asap 1/10/2018'. We saw the hole had still not been fixed. This meant a fire in this room could quickly spread to the stairwell, on to both the ground and first floor. This placed people living in the service, staff and visitors at risk in the event of a fire.

On the first day of the inspection we went into the basement where an office and a staffroom were located. The basement corridor was cluttered which could hinder a member of staff's exit in the event of a fire. We saw a hole in a ground floor lounge ceiling with wires hanging down. The registered manager told us there had been a water leak approximately two weeks prior to the inspection and the emergency light had been removed. It had not yet been replaced.

These examples demonstrate a continuing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We notified West Yorkshire Fire Service of our concerns on the first day of our inspection.

At the last inspection we identified fire drills had not taken place at regular intervals. At this inspection we saw a fire drill had taken place in March and September 2018. The registered providers training matrix evidenced staff had completed fire awareness training within the previous twelve months and 15 of the 23 staff listed on the matrix had attended a fire drill. The registered manager and the finance director had also completed fire marshal training.

We spoke with two staff who worked on the night shift. They told us they had received fire training and had discussed the action to take in the event of the fire alarm being activated, with the finance director. Although they had not received practical training on how to evacuate people from the building, in the event this was necessary.

Each of the care records we reviewed contained a personal evacuation plan (PEEP). This is a record of how each person would need to be supported if the home needed to be evacuated.

We were not assured the premises and equipment were safe.

We reviewed the Electrical Condition Report (EICR) dated 19 January 2016. The outcome was recorded as unsatisfactory but there was no evidence to suggest remedial work had been completed to rectify these failings or that a further inspection had taken place to ensure compliance.

People used a stair lift to transfer between the ground and first floor of the home. The stair lift had been serviced at regular intervals but a LOLER (Lifting Operations and Lifting Equipment Regulations 1998) examination had not been completed. This meant that we could not be assured of the lift's fitness for use. We brought this to the attention of the registered provider at the time of the inspection. They subsequently arranged for a LOLER to be completed, evidence of which was provided to us.

We also saw the rubber tyres on a wheelchair showed significant signs of wear and tear. The front left tyre was not securely attached to the metal wheel. This meant the wheelchair was not safe to use and at greater risk of tilting which could result in a serious injury to the person using the wheelchair. When we raised this with the registered manager they removed the wheelchair from use.

A member of staff told us a person was showered while sat in their wheelchair. This was because they had previously slipped from the bath seat while staff were bathing them. This meant equipment was being used by staff for a task for which it was not designed and therefore not suitable for and therefore there was a heightened risk of accidents. The registered manager told us they were not aware of this practice, they assured us they would look into the matter.

This also demonstrates a continuing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment were not always safe to use or used in a safe way.

At the last inspection we found checks on water temperatures at the home were not robust. At this inspection we found improvements had been made and water temperature checks were being completed on a regular basis.

Detailed risk assessments were not always in place. Risk assessments were not always an accurate reflection of people's current needs.

Risk assessments that were in place did not always show how risks were managed to reduce the risk of harm. For example, we reviewed the care records for a person who required a well mashed diet and thickened fluids due to their risk of choking. A choking risk assessment had not been completed. An assessment of the risk of choking reviews potential causes and details recommendations which aim to manage and reduce this risk wherever possible. A lack of consideration of this information could increase the risk of harm to a person from choking.

We reviewed the care records for a person who had slipped from the bath chair, they had also suffered a fall from a wheelchair on 8 October 2018. We observed the person had poor sitting balance and was supported in the lounge in a recliner chair. The risk assessment for the use of the stair lift did not include their poor posture when sat. This placed them at potential harm of falling/slipping while using the stair lift.

The care records for another person recorded '[Name of person] walks with two staff at all times'. A member of staff told us the person now used a wheelchair. This evidenced the risk assessment had not been updated to reflect the person's current needs. This placed them at risk of harm from inappropriate moving and

handling techniques.

These examples further demonstrate a continuing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The assessment of risk was not always robust.

Where people were assessed and identified as being at risk of falls we saw equipment was in place to alert staff and to reduce the risk of harm in the event of a fall. This included low rise beds, sensor mats and crash mats.

Medicines were not always administered accurately and in line with the prescriber's instructions.

On the first day of the inspection we saw a member of staff administering a person's medicines. The person was sat at a breakfast table and had a bowl of cereal and a hot drink in front of them. The directions on the Medication Administration Record (MAR) for one of their medicines noted it should be administered '30 mins before food'. We pointed out the instructions on the MAR to the staff member who admitted this medicine was not routinely given in line with the instruction. Not administering the medicine correctly may reduce its effectiveness.

On the second day of the inspection we observed a member of staff administer another person's medicines. One of the tablets was dispersible but we saw the staff member place the tablet directly on the person's tongue. Dispersible tablets should be placed in an amount of water and allowed to disperse prior to administration. Not following this instruction may mean the medicine is not effective and may cause harm.

Protocols were not in in place for all 'as required' and variable dose medicines to ensure they were administered in a safe and consistent way.

On the first day of the inspection we observed a member of staff administer dispersible pain relief tablets to two people. The MAR for both people recorded staff could administer either one or two tablets at a time but the staff member administered two tablets to each person without any discussion with them or any obvious assessment of their requirements. We could not see a protocol was in place for either person.

On the second day of the inspection we asked the registered manager about the lack of protocols for people who were prescribed 'as required' and variable dose medicines. The registered manager told us they had removed many protocols from the MAR file. This meant there were no guidelines readily available for staff to ensure these medicines were administered in a safe and consistent manner.

These examples also demonstrate a continuing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The management of peoples medicines was not always safe.

We reviewed the two most recent medicine audits dated October 2018. We saw the audit document did not include PRN protocols. The finance director showed us a more robust medicine audit which they had recently drafted but this had not yet been implemented.

Staff who were responsible for administering medicines had received training and an assessment of their competency had also been completed.

People, staff and visitors were not adequately protected from the risk of infection. The environment was not clean and did not meet the requirement of The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance.

On the first day of the inspection we saw a cat litter tray in the basement. It was placed in front of supplies of nutritional supplements and thickening agent. The litter tray contained faeces. This meant there was a risk the supplements could be contaminated due to their close location to the litter tray. The registered manager moved the litter tray as soon as we brought this to their attention.

Over the two days of the inspection we unzipped and looked inside three mattress covers and five pressure cushions. Each one was visibly soiled. The registered manager arranged for them all to be replaced. In two of the bedrooms where we had checked the mattress covers we were unable to wash our hands promptly as there was no hand wash soap available.

We looked at the kitchen on both days of the inspection. The kitchen walls, tiles and cupboards were visibly dirty. We also saw other areas of the home were visibly dirty. For example, skirting boards in a toilet and the dining room. The trolley used by the domestic member of staff was also visibly soiled.

These examples demonstrate a continuing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We notified Kirklees Infection Prevention and Control Team of our concerns on the first day of our inspection.

Accidents were recorded and reviewed. The registered provider completed a monthly analysis. This is important as it enables patterns and trends to be identified, providing an opportunity for action to be taken to reduce future risks. However, we noted the incident where a person had slipped while sat in the bath hoist had not been included in the analysis. The registered manager told us any identified learning was shared with staff at meetings and handovers.

We checked four personnel files. Each file contained an application form, employment history, two references and evidence candidates had attended an interview. A Disclosure and Barring Service (DBS) check had been completed for each staff member. Some staff had been employed at the home for many years. Two of the files recorded a DBS renewal date, but there was no evidence to suggest this had been done. Although it is not mandatory these checks are renewed, ongoing monitoring of DBS checks helps to ensure staff remain suitable to work with vulnerable people. We shared our findings with the registered manager at the time of the inspection.

None of the relatives or staff we spoke with expressed any concern regarding the staffing levels at the home. During the two days of the inspection we observed staff to be visible and people's needs were responded to in a timely way. The registered provider and registered manager were present on both days of the inspection, staff told us the registered manager was very hands on and worked on the floor to support staff with care tasks.

Each of the relatives we spoke with told us they felt their family member was safe.

Staff were aware of how to raise any safeguarding concerns both within the organisation and externally. One of the staff we spoke with said, "Any concerns I would report to the senior or to CQC (Care Quality Commission)." The registered manager was aware of how to raise a concern with the local authority safeguarding team. The registered providers training matrix recorded all staff had completed safeguarding adults training within the previous twelve months.

Requires Improvement

Is the service effective?

Our findings

Our inspection in 2017 found the registered provider was not meeting the regulation regarding supporting staff. At this inspection we found improvements had been made to the provision of staff supervision but we identified other areas where improvement was needed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible".

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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 had the appropriate legal authority and were being met.

Seven people who lived at Garlands had a DoLS authorisation in place. A further seven applications had been made to the local authority and were awaiting assessment.

At the last inspection we recommended the registered provider consulted best practice in this area to ensure mental capacity assessments and best interest processes were always recorded when decisions need to be made on behalf of people who lack capacity. At this inspection we still found lawful consent had not been consistently provided before any care or support was provided.

For example, the care records for one person instructed "safety belt to be used when transferring in wheelchair". There was a record of best interest decision making regarding the use of the safety belt but no assessment of capacity had been completed regarding this decision. We also reviewed the care record for a person who required a pureed diet and thickened fluids. There was no evidence an assessment of capacity had been completed regarding this decision or of best interestdecision making.

People's care records contained a document 'Assessment of Decision Making'. The document recorded the daily activities the person lacked capacity to make. The form lacked detail as to the specifics of the decisions each person could make and did not clearly evidence assessment of capacity in relation to each decision. The date the forms were completed was not recorded.

We saw consent forms were in people's care records. In many instances, we saw relatives had signed these forms but there was no evidence to suggest they had specific legal powers to do so, for example, health and welfare lasting power of attorney (LPA). The consent form for another person had been signed by the

registered manager of the home. The 'best interest decision' had not been completed and there was no evidence to suggest they had the legal right to do this.

The registered providers training matrix recorded of the 23 staff listed, 17 had received training in the MCA. But of these 17 staff, no-one had refreshed this training for over twelve months. We spoke with a staff member to establish their understanding of mental capacity in relation to the administration of medicines. They told us, "Its hard really, they are all really good with their medicines. If they lacked capacity we would go back to their GP and then consider DoLS." The staff member was unable to explain the difference between implied consent and informed consent.

These examples demonstrate a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The requirements of the Mental Capacity Act 2005 had not been met.

At lunchtime we saw staff offered people a disposable wipe so they could clean their hands prior to eating their meal. Some people were also prompted to use a clothing protector to prevent their outfit being soiled while they were eating. People could eat their lunch in either the lounge or dining room and we saw meals were served promptly to people. Where people needed assistance to eat, we saw they were served their meal in a timely manner and staff sat with them to help them with their meal.

One person told us the food was good and they had put on weight. A relative we spoke with told us, "[Relative] is on a blended diet and thickened fluids. [Relative] always gets the correct diet. Their eating has improved since they have been here".

Staff received induction when they commenced employment but the records relating to this needed to be improved.

We spoke with a member of staff who had recently joined the service. They told us they had received an induction when they had begun to work at the home. We saw a record of their induction in their personnel file although not all the sections had been signed as completed. This included aspects of health and safety and duty rotas. We also reviewed the induction for another staff member. They had been employed at the home and then left for a couple of years before returning to work at Garlands again. However, the only induction completed had been when they first started working at the home in 2014.

The registered manager told us new staff attended a two day training course with an external company prior to them commencing work. They said staff then returned annually for a day's refresher training. The training included moving and handling, health and safety, infection control and safeguarding. This was confirmed when we spoke with staff. Ensuring staff receive thorough training and regular updates mean staff have up to date skills and knowledge to enable them to meet people's needs in line with current standards of good practice.

At our last inspection we found staff had not received regular supervision. At this inspection improvements had been made. Each of the staff we spoke with told us they were now receiving regular management supervision and annual appraisals had been implemented. This was corroborated when we reviewed staff personnel files. Supervision and appraisal are used to develop and motivate staff, review their practice or behaviours, and focus on professional development.

Staff received a handover at the start of each shift. We attended the handover on the second day of the inspection. Staff communicated with each other in a professional but friendly manner and ensured relevant information was shared appropriately. We spoke to a member of the night staff regarding a specific matter,

from our conversation it was clear that important information had been shared with them at the start of their shift. This information was important in ensuring the safety of a person who lived at the home.

People had access to external healthcare professionals. A relative we spoke with told us, "They [staff] always ring if [name of person] is unwell or needs the doctor." Care records showed people had access to external health professionals. This included GPs, community nurses, chiropodists, dentists, speech and language therapists. This showed people received additional support when required to meet their needs.

In the event a person needed to be admitted to hospital the home operated a 'grab bag' system. The bag contained information about the person's general health, existing medical conditions medication they were taking, as well as highlighting the current health concern. This meant ambulance and hospital staff could determine the treatment a person needs more effectively. The member of staff told us the bag was sent with the person and remained with them during their stay at hospital.

Garlands had two communal lounges and a dining room on the ground floor with bedrooms to both the ground and first floor. The lounges were homely and comfortably furnished. There was also a secure garden, to the rear of the home.

At the last inspection we saw the registered provider had painted one person's bedroom door to look like an external door, with a letter box. They told us this had received a positive response from people and their families. A further five doors had subsequently been painted. This can help people who are living with dementia to recognise their own bedroom door. The work had not progressed any further but the provider told us they did want to continue with this initiative.

Requires Improvement

Is the service caring?

Our findings

A person we chatted with spoke with fondness about the home and the staff. Relatives we spoke with told us staff were caring and kind. One relative said, "They [staff] are lovely with [person]. [Name of person] always seems happy with the staff." Another relative said, "We chose it here. It isn't posh, but the care is excellent and that's what matters."

Despite the positive feedback, during the inspection we noted some examples when staff did not treat people with dignity and respect.

We observed two staff transferring a person using a hoist. Although this was done safely and staff explained what they were doing, we saw the person's skirt was positioned mid-thigh. This meant their legs were naked and exposed from mid-thigh to ankle. When the registered manager saw this, they intervened and instructed staff to get a blanket to cover the person's legs.

People were not always served meals and drinks in a way which respected their personal preferences and choices. For example, we observed a member of staff served lunch and a drink of tea to a person. The member of staff did not give the person any information about the content of the meal they were about to eat or give them a choice of drink. We also saw a staff member take lunch to another person. They sat with them and assisted them to eat but did not tell the person what the meal consisted of. After a few moments another member of staff was heard to ask the staff member "Do you want me to get them a drink?" No choice was offered to the person by either member of staff.

The care records for one person recorded "would like bedroom to be locked". In the afternoon we checked the person's bedroom door and found it unlocked. A member of staff told us the bedroom door was never locked.

These examples demonstrate a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's dignity was not consistently respected.

We also found examples of staff demonstrating a kind, caring and respectful approach to the people who lived at Garlands. Staff spoke with us about people in a kind and caring manner. It was also very clear from talking to the registered provider, registered manager and each of the staff we spoke with they knew the people they supported very well.

People were offered a choice of where to spend their time or in which room they would like to eat their meals. Night staff told us people could get up and go to bed at a time of their own choosing. People were offered regular baths and showers.

Staff respected people's individual beliefs. One of the staff we spoke with told us about a person who prior to their ill health had chosen not to eat meat. They said when the person was offered a choice of meal, they ensured their beliefs were respected and they were offered and provided with a meat free meal. A relative

told us when their family member's health had deteriorated, staff had arranged for a minister in the person's faith to come and see them.

We saw people were encouraged to retain their independence. Care records noted the tasks people could manage either independently or with staff support. For example, one care record noted, "[Name of person] can wash own hands and face with encouragement".

We saw little to evidence people or their relatives were involved in the care planning process. Although one relative told us they had been involved when their relative had initially moved into Garlands. Another relative told us they were aware of their family member's care records. Involving people and their families ensure care records are person centred and reflective of people's individual likes and preferences.

Requires Improvement

Is the service responsive?

Our findings

People's care records were not always sufficiently detailed or reflective of people's current needs, information within individual care plans was sometimes conflicting.

The mobility care plan for one person recorded they were to be transferred using a hoist but a risk assessment recorded "use stand aid/hoist". A member of staff had told us, following the incident when the person had slipped from the bath seat, they were no longer using the bath. We saw they had two risk assessments in their care records, one of which recorded "uses bath hoist and shower chair for bathing and showering". Their mobility care plan also still referred them using both the bath hoist and shower chair. We brought this to the attention of the registered manager at the time of the inspection.

This person had also lost weight during 2018. Their eating and drinking care plan simply recorded "has a good appetite and likes most meals, a well balanced nutritional diet to be provided at all times with high calorie snacks due to weight loss". The care plan lacked detail or direction. For example, there was no reference to how often they should be weighed, staff were completing food and fluid records but this was not in the care plan. The care plan did not provide any detail regarding the specific food and drink they enjoyed.

Where people were prescribed nutritional supplements records did not evidence these were being administered as prescribed or that individual needs were being met in line with people's care plans. For example, the care records for one person noted, "To be provided with high calorie snacks due to weight loss" and "likes to have supper before retiring". We reviewed their eating and drinking records for weeks commencing 15 and 22 October 2018. A mid-morning snack was recorded on only 5 out of a possible 14 occasions as being offered or consumed and supper was recorded as offered or consumed once out of a possible 14 occasions.

The care records for another person noted "enriched diet to be provided at all times with high calorie snacks throughout the day due to weight loss". We reviewed their eating and drinking records for weeks commencing 1, 8, 15 and 22 October 2018. They did not provide any evidence their meals had been fortified and there were gaps in the records on seven of the 14 days.

These examples demonstrate a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. An accurate and contemporaneous record of people's care and support was not always maintained.

The registered provider had a complaints procedure in place which included, "Details of all verbal complaints are recorded in the complaints book by the staff or managers who receive the complaint and on the individual's care records with information on how a specific matter was addressed". This was not being adhered to.

One of the relatives we spoke with told us, "The laundry was a problem, [name of person] was wearing other

people's clothes, but we think we have got it sorted now". The complaints log recorded the most recent complaint as 2016. The registered manager told us no formal complaints had been received, however, they said, "There have been a few verbal comments made regarding the laundry service". These had not been recorded and there was no evidence that action had been taken to review the laundry service or make any improvements.

These examples demonstrate a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Feedback was acted upon to evaluate and improve the service.

Care plans did not provide details regarding people's end of life wishes. Advance Care planning is key means of improving care for people nearing the end of life and of enabling better planning and provision of care, to help people live well and die well in the place and the manner of their choosing. It enables people to discuss and record their future health and care wishes and also to appoint someone as an advocate or surrogate, thus making the likelihood of these wishes being known and respected at the end of life. We recommend the registered manager seeks guidance from reputable course regarding end of life care planning.

People were supported to engage in a range of activities. An activities organiser was employed at the home working two to three days each week. They told us recent activities included watching films, crafts, reminiscence and armchair exercises. Where people preferred to stay in their room, they told us they ensured they spent 1:1 time with them so they were not socially isolated. They told us some people had also been on a trip to Blackpool the previous week. This was also confirmed by one of the relatives we spoke with. Details of the weekly activity programme was displayed in the reception area.

Inadequate

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of our inspection and therefore this condition of registration was met.

The registered provider and the registered manager were involved daily with the operation of the home. They were a visible presence and well known to people, visitors and staff. Visitors and staff told us they were friendly, approachable and supportive. One of the staff told us, "[Name of registered manager] is really hands on. She is a really nice person and a good manager. I feel supported and part of the team."

Our inspection in 2017 found the registered provider was not meeting the regulation regarding good governance. At this inspection we found improvements had not been made. The registered provider and registered manager had failed to ensure systems of governance were established and operated effectively in order to assess, monitor and continually improve the quality of the service.

Audits on some aspects of the service were not completed at all, other audits were infrequent and not sufficiently robust.

We reviewed the medicine audits dated 1 and 10 October 2018. The audit document did not include protocols for 'as required' or variable dose medicines and had not identified the issues raised during this inspection regarding medicines which should be administered before food. This meant the audit had not included all aspects of medicines management and administration.

We asked to see the care plan audits completed during 2018. We were provided with a file which contained three care plan audits dated March 2018 and two audits dated June 2018. There was no evidence any other care plan audits had been completed. The registered manager told us they wrote and reviewed everyone's care plan and also completed the audits of the care plans. This demonstrated there was no system in place to ensure regular and robust auditing of people's care records.

A cleaning audit had been completed in July 2018 but no other cleaning or infection control audits had been completed during 2018. We checked to see if the audit included checking mattresses and pressure cushions were clean. The only reference was for staff to ensure the mattress was clean and not torn. This demonstrated there was no system in place to ensure regular and robust auditing of the cleanliness of the premises and equipment.

We also reviewed the premises audits which had been completed in February, May and August 2018. These audits included the checks on water temperatures in communal bathrooms and people's bedrooms. We noted the audits dated February and May 2018 did not record the individual temperature recordings, they simply noted 'tick' to indicate the temperatures were satisfactory. Although improvements had been made to the audit completed in August 2018 which included each individual temperature recording. Recording the temperature provides an accurate record and enables any concerns or trends to be easily identified.

We noted the premises audit dated August 2018 recorded one person's radiator cover in their bedroom was broken. We visited the bedroom and saw the radiator cover had been removed but not replaced. We had seen this person was independently mobile, although they had an unsteady gait. The lack of radiator cover in their bedroom put them at risk of burns in the event they fell against the radiator.

Following the last inspection, on 27 September and 2 October 2017, an action plan was submitted to evidence the action that would be taken to ensure compliance with regulation 17 of The Health and Social Care Act 2008, Regulated Activities Regulations 2014. The action plan recorded the registered provider and registered manager would be responsible for completing regular audits. The concerns highlighted at this inspection, evidence the action plan had not been adhered to.

Regular meetings were held although we noted where issues were raised it was not always evident action had been taken to address the shortfall or if improvements had been made. Resident and relative meetings had been held in January and June 2018. Regular staff meetings had also taken place. These included meetings for all staff as well meetings for specific staff groups, for example senior staff or kitchen staff.

These examples demonstrate a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems of governance were not established and had not been operated effectively in order to assess, monitor and continually improve the quality of the service.

Links were maintained with other agencies. This included Locala, an independent company who provide NHS community services to people living in care homes. The registered manager also told us they had recently attended a college and delivered a talk to students about a future career in care homes.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Peoples dignity was not consistently respected.

The enforcement action we took:

We imposed a condition on the registration for the regulated activity; Accommodation for persons who require nursing or personal care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The requirements of the Mental Capacity Act 2005 had not been met.

The enforcement action we took:

We imposed a condition on the registration for the regulated activity; Accommodation for persons who require nursing or personal care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not adequately protected from the risk of fire. Premises and equipment were not always safe to use or used in a safe way. The assessment of risk was not always robust. The management of peoples medicines was not always safe. People were not adequately protected from the risk of infection.

The enforcement action we took:

We imposed a condition on the registration for the regulated activity; Accommodation for persons who require nursing or personal care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems of governance were not established and had not been operated effectively in order to assess, monitor and continually improve the quality of the service. An accurate and contemporaneous record of peoples care and support was not always maintained. Feedback was acted upon to evaluate and improve the service.

The enforcement action we took:

We imposed a condition on the registration for the regulated activity; Accommodation for persons who require nursing or personal care.