Curzon Professional Services Limited

Curzon Park Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection was unannounced and took place on the 24 and 25 October 2017. This inspection looked at issues we had identified at the previous inspection in May 2017. At the previous inspection we identified continued breaches of Regulations 12, 15 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because of on going issues relating to fire safety, infection control, the suitability of the premises and poor auditing and quality monitoring processes. At this inspection we found that the required action had not been taken to address these issues. We also identified additional breaches of Regulations 10, 11 and 18 because people's dignity was not always fully maintained, the service was not meeting the requirements of the Mental Capacity Act 2005, and staff training was not being delivered to an adequate standard.

Curzon Park had been without a registered manager since May 2016. Whilst there was a manager in post, they were not registered with the CQC. 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.

Curzon Park 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.

The service is registered to accommodate up to 25 people in one building. At the time of the inspection there were 14 people using the service. The service is registered to support older people living with dementia. The service is situated close to Chester in Cheshire West. It is situated over two floors and has access to gardens.

People were at risk because parts of the service were not safe. Wardrobes in some of the bedrooms were unsteady and not fixed to the walls. Window restrictors in some bedrooms were broken, and one window at the top of the stairs was not restricted and would not close. This provided access to the roof. In the upstairs toilet we also found the boiler was accessible and that the exposed pipework around this was very hot to the touch. We asked that the registered provider take immediate action to address these issues and received confirmation that this had been done.

The fire service had an enforcement notice in place which had required the registered provider to ensure the premises were meeting standards required by fire safety regulations. The enforcement notice had required works to be completed by the 22 June 2017. The registered provider had failed to meet this deadline, and had commenced works on part of the requirements on or around the 28 August 2017. These works were still on going, whilst other works had yet to be commenced. Some of the work being completed had not been carried out to a high standard. For example, some fire doors did not fully close, and others had gaps between their base and the floor. We asked that action be taken around this, and following the inspection

received confirmation from the manager that this had been done.

Infection control processes were not robust and posed a risk to people's health. The laundry was located in an outhouse that was dirty and ill maintained. There were cobwebs around the ceiling, dirt under the shelves and a piece of tarpaulin covering part of the roof. There were no hand washing facilities for staff to use after handling dirty laundry, and there was a large crack in the floor.

Pest control records showed that there was rodent activity in the garden which posed a 'risk to the site'. Actions to address this had not been acted upon, despite these recommendations having been made following three visits carried out in August 2017 and September 2017. During the inspection we observed the back door to the kitchen being left open which made this area susceptible to pests.

The environment was poorly maintained. It was identified that a number of downstairs bedrooms, the downstairs toilet and bathroom were without hot water. Staff and the manager confirmed that issues with the boiler had been ongoing for at least eight months, however the past two weeks this had become worse. Two radiators were found to be leaking with plastic containers placed underneath, collecting dirty water. The inside and outside of the building contained areas of disrepair and no adaptations had been made to meet the needs of people living with dementia, in line with best practice.

Staff had received training, however a majority of this had been provided through DVDs that dated back to 2010. This meant these may not be up-to-date with best practice or current legislation. There was no formal process of assessing whether staff were competent following training sessions, however the manager told us they carried out observations but did not document these.

Whilst we found evidence of people being supported to have maximum choice and control of their lives and staff supporting them in the least restrictive way possible; the policies and systems in the service were not always supportive of this practice. Mental capacity assessments were not always completed in line with the requirements of the Mental Capacity Act 2005, and there was no centralised record kept of those people who were subject to a Deprivation of Liberty Safeguards (DoLS), which meant the manager could not be sure when these needed to be reapplied for.

During the inspection we identified examples where people's dignity had not been upheld. Some people appeared unkempt whilst others appeared well groomed. Following the inspection a member of staff contacted us with concerns that one person had not been appropriately washed after an episode of incontinence due to hot water not being readily available.

At the last inspection in May 2017 we found ongoing issues relating to audit and quality monitoring systems. During this inspection we identified that the registered provider had employed an external quality monitoring company to assess the service. Whilst actions had been identified as part of this process, not all of these had been acted upon.

Audit systems remained ineffective and were not robust. For example, Infection control audits had not considered issues relating to pest control or the availability of functioning hand washing facilities. In one instance an issue had been identified on a monthly basis since December 2016, however action had not been taken to address this.

Health and Safety audits were not being completed and had failed to identify or act upon issues that we found during the inspection.

There was no support in place for the registered manager. No supervisions were held with the manager and the registered provider communicated primarily via text. This meant they were not readily available to support with making decisions that needed their input.

Staff had a good knowledge of safeguarding procedures and processes and knew how to report any concerns they may have. The manager had previously reported issues to the local authority in line with the local authority's safeguarding policy. This helped ensure people were protected from the risk of abuse.

People were supported to take their medication as prescribed. Medication administration records (MARs) were signed by staff which showed this had been given as required. We identified that protocols were not in place to inform staff when to 'as and when' (PRN) medication. We asked the manager to ensure this was addressed.

People were supported to have a diet that was appropriate to meet their needs. Meals were well presented and looked appetising. Staff were aware of those people who needed encouragement and ensure this was given in a respectful manner. This helped protect people from the risk of malnutrition.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

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.

We identified areas of the service that needed immediate action to protect people from the risk of harm.

There were on going issues relating to fire safety. The registered provider had failed to take timely action to make improvements required by the fire service.

Infection control procedures were not robust and had the potential to impact upon people's health and wellbeing.

Is the service effective?

Inadequate

The service was not effective.

The premises had not been suitably maintained for the purposes for which it was intended. Adaptations had not been made to meet the needs of those people living with dementia.

The requirements of the Mental Capacity Act 2005 were not always being met.

Staff training was not adequate to ensure they had the skills and knowledge needed to carry out their roles effectively.

Is the service caring?

Requires Improvement

The service was not always caring.

People's confidentiality was not always maintained.

People did not always present as well kempt or tidy.

Positive relationships had developed between people and staff.

Staff were respectful of people's privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records did not always contain the information necessary to inform staff about people's support requirements.

Review processes had not been effective at identifying where care records needed to be updated.

There were activities in place for people to help minimise the risk of social isolation posed to people.

Is the service well-led?

Inadequate

The service was not well led.

Adequate support was not made available from the registered provider to the manager. The registered provider had not completed any supervisions with the manager.

Quality monitoring and audit processes were not robust and had failed to address and/or identify issues within the service.

There were no processes in place to ascertain the views of people, their families or staff. This meant that issues could not be identified and dealt with.

Curzon Park Residential Home

Detailed findings

Background to this inspection

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

The inspection was unannounced and took place on the 24 and 25 October 2017.

The inspection was carried out by two adult social care inspectors.

Prior to the inspection we contacted the local authority for their views on the service. We also contacted the Cheshire West and Wirral infection control team and Cheshire West and Chester fire service.

During the inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with three family members and spoke with five staff and the manager. We looked at four people's care records. We looked at other records relating to the day-to-day running of the service. For example audits, medication records and environmental records.

Inadequate

Is the service safe?

Our findings

At our last inspection in May 2017 we identified a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Improvements were required in relation to fire safety, infection control and the completion of risk assessments. At this inspection we found these breaches had not been addressed.

Four bedrooms on the ground floor, the downstairs bathroom and downstairs toilet were without hot water for people and staff to wash their hands. The laundry room is located in an outbuilding and the registered provider had failed to address the large crack in the floor. The laundry room did not have any hand washing facilities for staff to use after handling unclean laundry. We observed staff and visitors to the service accessing the kitchen area without appropriate personal protective equipment (PPE) to minimise the risk and spread of infection. The bin in the kitchen did not have a lid which posed an infection control risk.

Parts of the environment were not clean. The laundry room contained dust and dirt under the shelves and cobwebs all around the ceiling. Two bedrooms had a very strong malodour, which we had previously raised with the registered provider following our inspections in December 2016 and May 2017. In one lounge there was a jug under a leaking radiator that was three quarters full of dirty liquid. In the kitchenette adjacent to one lounge part of the flooring was dirty, and in one person's bedroom there was a gap between the carpet and the wall, between which there was discarded food and dust. The tiles around one of the kitchen sinks were dirty and the kitchen sink was loose and not attached to the worktop which enabled dirt to get trapped underneath.

We looked at records relating to pest control and found that a pest control contractor had made recommendations regarding preventative measures on the 22 August 2017, 29 August 2017 and 7 September 2017. Action had not been taken to implement these, and subsequently on the 29 August 2018 and 7 September 2017 the pest control reports stated that rodent activity had been identified which posed "a risk to the site". The manager informed us that a dead rat had been found in the basement approximately two weeks prior to our inspection visit. During the inspection we observed the kitchen door leading into the back garden was left open, which had the potential to allow pests into the kitchen.

At our last inspection in May 2017 we identified ongoing concerns relating to fire safety. During this inspection we found that the registered provider had started to undertake the work needed to address these issues. The loft space had been cleared of combustible material, and a majority of people had been moved to the ground floor to help ensure their safety in the event of a fire. Fire doors were being replaced to meet the requirements of the fire service, however we identified that these had not all been installed to a high standard. For example we identified seven fire doors that did not fully close and four doors that had a gap between their base and the floor. This undermines the effectiveness of the doors at preventing the spread of smoke and fire. We raised these issues with the registered provider and the manager, and contacted the fire service to make them aware.

During this inspection we identified other areas of the service that were not safe. Wardrobes in eight of the

bedrooms were unsteady and not bolted to the walls. In four of these examples the wardrobes required immediate action to ensure people's safety was maintained. Some of these wardrobes were in bedrooms that were not in use, however these rooms were unlocked and accessible to people walking around the service. In one lounge there was a unit which contained panes of glass. This was very unsteady and was a potential risk to people if it fell on top of them. The window restrictors in three bedrooms were broken, and a window on the first floor would not close and was not restricted, providing access to the roof. This posed a risk to those people living with dementia who were not able assess risks for themselves, and placed them at risk of injury. One of the grab rails at the top of the stairs was not firmly fixed to the wall which placed people at risk of falls if it came off whilst they were using this. A cubicle in an upstairs toilet contained unrestricted access to a boiler and pipe work which was very hot to the touch. We raised all of these issues with the registered provider and manager and saw that these issues had all been rectified by the second day of the inspection visit.

Prior to the inspection an incident had occurred in July 2017 where one person was able to leave the premises without the required level of support. This person left the service, crossed the road outside the care home and fell sustaining significant bruising to their face. The local authority safeguarding team investigated the incident and determined that the registered provider had failed to safeguard this individual. This was because this person had been able to leave via an unlocked back door, and through an unlocked gate. This showed that the registered provider had failed to carry out effective risk assessments in relation to the environment. The registered provider had acted to put appropriate locks in place in response to this incident. During the inspection we found the premises were secure.

Appropriate risk assessments were not always in place. For example, one person had bed rails in place however a risk assessment had not been completed around whether these were safe for this person's use. Only one person's bedroom had a call bell in place and this was not positioned near to their bed. Other people's bedrooms contained pressure pads to alert staff if they got out of bed at night. Risk assessments were not in place to determine whether it was appropriate not to make call bells available to people. Rooms that were not in use had not been secured and some of these were cluttered. For example, one bedroom was being used as a store room whilst another was being used by workmen who were fitting the fire doors. These rooms contained trip hazards for people which placed them at risk.

These are continued breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had completed training in safeguarding vulnerable adults and demonstrated an understanding of how to raise any concerns they may have. The manager had reported safeguarding incidents to the local authority, and provided updates to them on a monthly basis regarding any 'low level' concerns as required by the local authority's safeguarding policy.

At the last inspection in May 2017 we looked at recruitment processes and found that these were safe. Since the last inspection the manager confirmed that no new members of staff had started. Therefore we did not need to look at any further recruitment records.

During the inspection there were sufficient staff in place to meet people's needs. A dependency tool was in place to determine the number of staff required. Agency staff were used to fill in for staff sickness or annual leave where required. The manager informed us that over the past two weeks they had been required to work as a carer due to staff absence and a member of staff leaving the service. The manager was going through the process of recruiting a new member of staff to fill this vacancy.

A record of accidents and incidents was being maintained. These showed that there had been 18 falls from 1 September 2017 to the 24 October 2017. Where people had fallen multiple times, records showed that they had been referred to the relevant health professionals for support, for example their GP or the local falls clinic. Records showed that a majority of falls had occurred whilst people were in their bedrooms. The manager had placed pressure mats in people's bedrooms to alert staff if people fell, and staff also completed routine nightly checks on people to ensure their wellbeing.

People received their medication as prescribed. Medication administration charts (MARs) were signed by staff to show that medication had been given as required. Controlled drugs were being stored securely and in line with legal requirements, and were being signed by two staff when administered. Controlled drugs are medications which have associated legal requirements around their storage, administration and disposal due to the potential for their abuse. We identified that PRN ('as required') medications did not have a PRN protocol in place to outline to staff how and when these should be administered. Therefore there was a risk that people may not receive these medicines as prescribed and intended. We raised this with the manager for them to rectify.

Checks were being completed on aspects of the service to ensure they were safe. For example, electrical equipment had been PAT (portable appliance test) tested to ensure they were safe for use and the stair lift and hoists had been serviced in May 2017. Fire alarm tests were being carried out on a regular basis, and fire drills had also been completed.

Inadequate

Is the service effective?

Our findings

At the last inspection in May 2017 we identified a continuing breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had failed to address concerns relating to the design and adaptation of the premises as identified during our inspection in December 2016. At this inspection we found that action had not been taken to make the required improvements. In addition to those issues we had previously identified we also found additional issues relating to the environment.

A majority of people living at the service did not have the option of having a bath. The downstairs bath was not in use as it did not have a supply of hot water, and the water pressure was poor. Whilst there was a bath on the first floor, this was not accessible to people who could not use the stairs or required a bath hoist. Whilst we had previously identified this as an on going issue, no action had been taken to address this.

There was no hot water supply to the hand basins in four bedrooms, the downstairs bathroom and the downstairs toilet. Staff and the manager informed us that there had been on going issues with hot water to some parts of the building for the last eight months, however over the past two weeks this had deteriorated further. The length of time over which this issue had persisted showed the poor responsiveness of the registered provider in addressing issues which had the potential to impact upon people's wellbeing.

There was significant wear and tear to the premises. Window ledges were rotting and we identified two radiators which were leaking and had containers placed under them to prevent this going onto the carpets. The laundry room had a piece of tarpaulin covering a section of the roofing to prevent rain and other elements coming in. The manager's office had a hole in the ceiling and wall paper peeling away from the walls and ceiling. The kitchen sink was coming away from the work top; however following the inspection the manager informed us that the kitchen sink and tap had been replaced. In one person's bedroom the plastic casing to an electrical socket had been chipped and damaged, and around some doorways there were marks where the wood had been damaged. In one person's en-suite pipework and a wooden frame underneath the sink was exposed which had large splinters of wood sticking out from it. This was where work had been commenced, but not finished, on boxing off the under sink pipework.

At the last inspection in May 2017 we made a recommendation to the registered provider around improving the environment for people living with dementia. During this inspection we found that action had not been taken to address this. Corridors were dimly lit and did not contain any objects of interest to help people with orientating themselves to their environment. There were no distinctive markers to people's bedroom doors to help them identify which bedroom was theirs. The carpets in some people's bedrooms had been replaced however these had not been chosen in line with best practice. For example where carpets have freckled patterns, people living with dementia can perceive this as bits on the floor.

This is a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Training in areas such as infection control, dementia care, pressure ulcer prevention and food hygiene were provided through training DVDs which the registered provider had purchased. These DVD's had been produced in 2010 which meant that they may not be up-to-date with best practice or changes in legislation. At the last inspection in May 2017, we raised the reliance of training DVDs with the manager who told us that they were going to source alternative training. However, at this inspection the manager informed us that sourcing up-to-date and effective training had been limited by lack of funding being made available by the registered provider. Only fire safety and first aid had been provided through face-to-face training with a trainer. The manager informed us that they assessed staff competencies following training, by observing their practice. However this was not recorded and there was no structure to these observations to ensure key competencies were being met in relation to specific training areas. This demonstrated that the current method of ensuring staff had the skills necessary to carry out their roles was not effective.

We spoke to one health professional who informed us that they observed a lot of minor bruising and trauma to people living at the service. They believed that this may be caused by moving and handling techniques employed by staff. Training records showed that moving and handling training was provided via a training DVD rather than via face to face learning. This may impact upon the effectiveness of the training provided because of the practical nature of moving and handling tasks. We raised this with the manager for them to investigate.

Supervision meetings with staff had last been completed by the manager in January and February 2017. Supervision meetings give staff the opportunity to sit with their manager and discuss their role and identify and development needs. The manager informed us that these were in the process of being done at the time of the inspection.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in May 2017 we made a recommendation to the registered provider around the completion of mental capacity assessments for those people who required them. At this inspection we found that action had not been taken in relation to this.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met and found that this was not always being done. For example, one person had bed rails in place, however a mental capacity assessment had not been completed to ensure their ability to consent to this, or that this was in their best interests. In another example a person had been prescribed covert medication; however there was no mental capacity assessment or best interests decision in place for this. Other people's care records did not contain information regarding their ability to consent to the care being provided. At the inspection in May 2017 we had previously raised an issue around mental capacity assessments not being completed in relation to the

use of covert medication. This showed that action had not been taken, and that learning had not been embedded.

The manager had applied for DoLS as required for those people who needed them. However a centralised record of people with DoLS in place was not being kept which meant that the manager would not know when these had expired and when these needed to be reapplied for.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we observed staff giving people choice and control over their care. For example, during meal times we observed a member of staff encouraging a person to eat more of their main meal, however did not force them to do this. People were also given the option of where to sit and eat their meal, such as in the lounge area or in the dining room.

At the last inspection the manager informed us of issues around funds being made available from the registered provider to buy food. At this inspection the manager confirmed there had been no recent incidents where funds had not been available.

People received the support they needed during meal times. Staff knew those people who were at risk of malnutrition due to poor appetite, and we saw examples where they offered encouragement and support. Meals looked appetising and were well presented. Those people who had special dietary requirements, such as pureed or softer options received these. People were offered a choice of meals and there was plenty of food available for people. There was a good stock of frozen produce available for meals, and high calorie foods such as full fat milk, cream and butter. We did not see any fresh fruit or vegetables, however a member of staff informed us that they were awaiting a delivery..

People were supported to access health professionals where required. People's care records contained evidence of referrals being made to GPs, dentists, opticians and hospital appointments being attended. This helped to ensure that people's health and wellbeing was maintained.

Requires Improvement

Is the service caring?

Our findings

During the inspection we spoke with two relatives who spoke very highly of staff. Their comments included, "The building isn't great but the care outshines the rest", "They (staff) have become family rather than carers" and "The staff make it. They're always smiling". Whilst we received positive comments about staff, the findings included within other domains can impact upon the rating that is awarded.

During the inspection we noted that some people did not always look well kempt, whilst others looked well dressed. We noted that one person had dirt under their fingernails, whilst another person's hair was not brushed. We saw one person lying in bed without a duvet cover on and had to ask staff to put a clean one on. We enquired about whether a hair dresser visited the service, and were told they did not. However, we also noted other people who looked well dressed. One person's relative told us, "[Our relative] is always dressed smartly in the clothes they like to wear". Staff told us that the lack of hot running water to some parts of the service did not impact upon ensuring people received a wash. This was because they were able to get hot water from other parts of the building. However, following the inspection we were contacted by a member of staff who told us they had seen an example where a person who had been incontinent of urine and had not been supported to have a wash because hot water was not readily available in their bedroom.

A majority of records containing people's personal information was stored securely in the manager's office. However we identified a hand over sheet which contained sensitive information being kept on the medication trolley in the dining room. This included information around one person's continence needs, and information around one personal care support being provided to another person. Information about people's dietary and fluid intake was also available. This has been an on going issue identified at previous inspections in December 2016 and May 2017.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were respectful of people's privacy. We observed examples where staff knocked prior to entering people's bedrooms. There were blinds and curtains in place in bathrooms and people's bedrooms to help maintain their privacy during personal care tasks.

We observed examples that demonstrated positive relationships had developed between people and staff. For example we overheard one member of staff speaking kindly to people whilst they were sat in the dining room, and another member of staff sensitively prompting a person to eat more food. We heard people and staff laughing together, and people's interactions with staff showed that they were comfortable and familiar with them.

Staff acted to alleviate people's distress. For example they ensured that people were aware that a fire alarm test was due to take place so that they did not become startled when the alarm went off. In another example where a person needed support we overheard staff offering reassurance and acting quickly to make sure they were ok.

People's family members told us they were made to feel welcome when they visited the service. They were offered refreshments by staff and we observed them speaking in a warm and familiar manner with staff. This helped ensure that people could maintain relationships with those people who meant a lot to them.

People who required glasses were wearing these and we observed one person wearing hearing aids. During the inspection we heard the manager taking time to explain things clearly and loudly to one person who was hearing what they were saying. We looked at one person's care record which included details of their sensory impairment and what staff should do to support them with this. This showed that staff were working to meet the needs of those people living with a sensory impairment.

Requires Improvement

Is the service responsive?

Our findings

People each had a care record in place which outlined their needs. We looked at four people's care records. One of these contained a good level of personalised detail relating to their biographical history, likes and dislikes. However the other three did not contain any personalised information such as people's preferred daily routine, favourite foods or activities they may enjoy engaging in.

People's care records did not always include sufficient information about their needs. One person's care record contained notes from professional visitors which stated that this person had recently moved from another care service; however there was no handover information relating to how this person had presented whilst at the previous care service which may have supported staff at Curzon Park with meeting this person's needs. Daily notes included information about this person's preferred foods, however this had not been transferred into a care plan. In another example, one person's care record outlined that they could demonstrate 'agitated behaviour'. We also observed a member of staff reluctant to provide support to this person, stating they were showing signs of being agitated. However we did not observe any behavioural support plans in place. One person's care plan showed they were spending time at the service for a period of rehabilitation. However, there was minimal information in their care records relating to their needs. This meant that staff may not be fully aware of their responsibilities in relation to supporting this person with the rehabilitative process. We spoke with this person who was happy with the care that was being provided to them.

Reviews of people's care records had been completed. This process is meant to ensure that information in care records is accurate and up-to-date. Whilst care records were being reviewed, this process had failed to fully address issues relating to sufficient information being contained within care records. The manager was aware that information in care records was not adequate and was in the process of updating these.

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

Daily and monthly monitoring of people's needs were being completed. Staff recorded support that had been provided to people on a daily basis, and a handover was completed at the beginning and end of each shift. People weights were being monitored on a monthly basis, which was then used to determine their risk of malnutrition. We saw examples where this information had been used to refer people to the relevant health professionals to ensure they received the care they needed.

There was an activities co-ordinator in post who was enthusiastic about their role. One person's family member commented that their relative was difficult to engage in activities; however efforts had been made to get them some paints as they had previously enjoyed painting. The activities co-ordinator had spent time at another local service to get ideas for activities, and had put an activities plan in place. Throughout the inspection we observed staff sat talking with people, and we also heard people singing in the lounge area.

A complaints process was on display for people and their family members to use if they needed to raise any

concerns. The manager confirmed that no complaints had been received. People's family members told us that the manager was responsive to their needs and that they would feel comfortable approaching them with any concerns they may have.

Inadequate

Is the service well-led?

Our findings

There was a manager in post within the service, however they were not registered with the CQC. The manager told us they were waiting for a check to be completed by the disclosure and barring service (DBS), which is required prior to submitting application to register. The manager had been in post for ten months. The service had been without a registered manager since May 2016.

At the previous inspections in December 2016 and May 2017 we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider did not robust quality monitoring systems in place to identify and address issues within the service. During this inspection we identified that sufficient improvements had not been made.

There were minimal processes in place from the registered provider to support the manager. There had been no management supervisions, and the only way the manager could contact the registered providers was via text. During the inspection the manager presented with very low morale and commented that they did not feel well supported.

Audit systems in place were not robust. A health and safety audit of the premises had last been completed in 2016. During the inspection we identified multiple issues relating to the safety of the premises. Parts of the environment were not safe, for example we found unstable wardrobes, broken window restrictors and exposed pipework that was very hot to the touch. We raised issues relating to the window restrictors with the registered provider, who told us that this was a known issue. Despite this having been identified no action had been taken to address this. During our December 2016 inspection we had also identified wardrobes that were unstable and not secured to the wall. This showed that learning in relation to the management of health and safety risks within the environment had not been embedded.

An infection control audit had been completed on a monthly basis. The August 2017 and September 2017 audits did not give due consideration to the rodent infestation in the garden, lack of hot water available in the downstairs bathroom, toilet and some of the bedrooms. We also observed poor infection control processes such as staff not wearing PPE when accessing the kitchen. This showed that infection control processes were not robust, highlighting the ineffectiveness of the audit process.

A 'home cleaning' audit had been completed on a monthly basis. Since December 2016 this had identified that two of the bedrooms had a strong malodour and that the carpets needed replacing. Despite this having been identified, no action had been taken to address this. This issue had also been raised during our inspections in December 2016 and May 2017, which showed a poor approach by the registered provider towards making the required improvements.

We spoke with the infection control team who reported they had been raising on going issues regarding the environment with the registered provider, however sustained action had not been taken to address these issues. In our December 2016 inspection we reported on the lack of investment in the environment by the registered provider, as evidenced by deterioration to the inside and outside of the premises. Whilst we noted

some improvement in our May 2017 inspection in relation to the décor in the lounge areas, it was apparent during this inspection that action was not being taken to maintain essential parts of the environment. For example, on going issues with the boiler.

There were on going issues relating to the environment. A fire enforcement notice had previously been issued by the fire service, which had required the registered provider to make changes to the environment to meet fire regulation standards by the 22 June 2017. Despite this, work on some of the required improvements had not started until approximately the 28 August 2017 and were still not complete during this inspection. Other works had not yet been started, for example compartmentalisation of the first floor to meet fire regulations around containing the spread of fire.

The registered provider had commissioned an external quality monitoring company to assess the service being provided by Curzon Park. The findings of this assessment had been made available to the registered provider on the 30 August 2017. Whilst action was being taken to address some of the issues identified, other actions had not been undertaken. For example, the introduction of protocols for PRN medication, the malodour in one of the bedrooms, the use of PPE by staff when entering the kitchen and the introduction of formal support processes for the manager by the registered provider.

The registered provider did not have a process in place to ascertain the views of people, their family members or staff. One person's family member commented that they had not been asked their opinion of the service, however the manager operated an open door policy for them to raise any concerns. This meant that the registered provider could not rectify any issues identified by people, their families or staff.

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

Other audits being completed by the manager included an audit of accidents and incidents and medication audits. An analysis of accidents and incidents was being completed which could be used to identify patterns and trends. This also ensured that appropriate action had been taken to keep people safe. Medication audits were detailed and had successfully identified areas of improvement. Whilst we identified issues relating to people's care records, the manager had identified this and was in the process of reviewing these and bringing these up to standard.

People's family members commented that they found the manager to be approachable and supportive. One family member commented, "The manager is a breath of fresh air. They deal with any issues you bring to them". Staff also commented positively on the manager, telling us they good at their job and "supportive".

The registered provider is required by law to display their current CQC rating in a prominent place within the service. During the inspection we observed that this had been done.

The registered provider is required by law to notify the CQC of specific events that occur within the service. Prior to the inspection we reviewed those notifications that had been submitted by the registered provider and found that this was being done.