Vivo Care Choices Limited

# Curzon House

## Inspection report

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13 February 2018

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| Is the service safe? | **Requires Improvement** |
| 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

We carried out an inspection of Curzon House on the 12th and 13th February 2018. The first day was unannounced and on the second day, the registered provider was aware of our intention to visit.

We previously inspected Curzon House on the 21st and 24th August 2017. The service was rated Inadequate overall and placed into special measures. We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of Regulations 9, 11, 12, 17 and18. This meant the registered provider had failed to ensure people were fully protected from the risk of unsafe care, their capacity to consent was not assessed, care was not personalised and there was ineffective oversight of the service. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to breaches.

At this inspection we identified repeated breaches of the regulations in relation to assessing and mitigating risks to people's health and wellbeing, the safe management of medicines, records and good governance.

We will update the section at the end of this report to reflect any enforcement action taken once it has concluded.

Curzon House 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. Curzon House accommodates 35 people in one adapted building. At the time of our visit, 11 people were living at Curzon House either permanently or for respite care.

There was no registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service had appointed a new manager and they took up this post in November 2017.

On our previous visit adequate risk assessments were not in place. This visit found that whilst some improvements had been made risk assessments required further developments to be made. They did not always clearly identify all risks to people supported and actions staff needed to take in order to minimise the risk of harm.

Our last visit we found that care and records were not person centred. Although improvements in day to day care and support were evidenced, records were still not personalised. Consideration was paid to the proposed introduction of an electronic care planning system that was to be introduced during the weeks following this visit. We were able to look at the new system and found how this potentially would make care plans more person specific. However, in the meantime and before this system was introduced, care plans

remained vague and not person centred. Care plan audits had not been undertaken as it was stated that the present care plans were not appropriate.

While people received medical assistance from other agencies such as GPs and hospitals; the registered provider had not always taken after-care into account through care planning. This had been clear through the lack of care planning in health conditions following hospital stays.

Staff demonstrated some understanding of the principles of the Mental Capacity Act 2005 and had received re-training in this. We found that while this training had been provided; it had not been fully embedded into care practice. There was a lack of a best interest decision making into aspects of a person's care such as covert medication or other restrictive practices to protect people from the risk of harm. This meant that people were not fully consented about the care and support they received.

People received regular opportunities to access food and drink during our visit. However, records reflecting people's intake of food and fluids were not robust. We found examples of records being incomplete and not including a daily target for the intake of fluids. The amounts of fluids taken were vague and imprecise. Where the nutrition of people had to be carefully monitored; no reference was made to portion size.

People had their weight monitored yet records noted that wide discrepancies in weight had occurred. Records indicated that people were weighed at different times of the day. The manager told us that the weighing scales had been identified as inaccurate and had been replaced.

The recording of medicines was not always safe. Some medication records were handwritten and transcribed from other records. These were inaccurate and had not been double checked. This meant that people were at risk of being given the incorrect medication or the wrong dosage at the wrong time.
PRN medication (that is medication given when needed) had been prescribed to people but care plans were not in place for the staff team to know when to offer these. This meant that people were at risk of not receiving medication to assist their health. The storage and disposal of medication was safe.

Some people had been provided with pressure mattresses to ensure their skin integrity was maintained. However, staff had not received training in their use. We found that the air pressure within the mattresses was incorrectly set meaning that there was a risk of further skin damage to the person using it.

Audits undertaken at the service had had not picked up on issues such as medication, risk assessments and nutritional concerns identified at this visit. The current care planning system was not person centred but had not been audited as it the manager felt they were not 'fit for purpose'. The new care planning system had not yet been introduced in line with expected timescales. This meant that oversight of the care planning system was not in place and did not ensure that people received safe, effective and responsive care.

The manager had recognised that the staff team required training in a number of key aspects of practice. The staff team had all been enrolled on a programme of training linked to the Care Certificate which is designed to reinforce good practice and values of care. This had been welcomed by the staff team. Our visit found that although staff had undertaken training, this had not yet becoming fully embedded in care practice. Staff confirmed that they received regular supervision and appraisals to help them reflect on their developmental needs.

This inspection found that improvements had been made in respect of the systems that were used to ensure safe care. Assistive technology and managerial oversight had minimised accidents resulting in serious harm

with the result that these had been drastically cut. The new manager had sought to have direct control over the auditing process of analysing reasons for accidents.

Staff understood the types of abuse that could occur and had received appropriate training in this. Staff were clear about how to raise concerns and report them. Safeguarding protocols were in place to ensure that these could be investigated appropriately. Staff were also aware of external agencies they could report care concerns to.

The premises were clean and hygienic. All equipment such as hoists had been serviced to the required frequency and the building was well maintained.

People were able to move through the building independently. The building included signs to orientate people and was decorated in contrasting colours to assist those living with dementia.

Improvements had been made in respect of the service adopting a caring approach to the people they supported. Previously, the registered provider's response to dealing with people and their families when they had experienced serious injuries had not been timely. This had now been addressed. There was evidence that staff adopted a caring and respectful level of care to the people they supported. People told us that they felt well looked after and had their best interests at heart. One person outlined the personal consideration that staff had made to them moving into long term residential care and this had been greatly appreciated by the person.

Support was provided to people in a respectful and dignified manner. People were supported in an unhurried and caring way. Staff were able to give us practical examples of how they would uphold the privacy and dignity of people. Improvements had been made in the way staff assisted those who required assistance with eating. Previously this had come across as a task orientated process yet this visit found that real attention had been given to the person being supported. Responsiveness to concerns raised by relatives had also improved.

Compliments received by the service were put on display for staff to refer to

Our last visit found that activities were not provided to people. This visit found that this had been reinstated with the activities co-ordinator playing a major role in the care and support of people through the organising of activities within the service and in the wider community. Activities we observed were meaningful and gave people the opportunity to mix with others and recall their memories about specific events in their lives.

Our last inspection found that there was a lack of oversight both at registered provider and registered manager's level. This had led to several breaches of regulations being identified which meant that people were at risk of receiving poor care. This visit found that the new manager had sought to address the deficiencies by devising and action plan and seeking to bring some systems such as auditing of accidents under their scope. The registered provider gave us evidence of how progress to address issues had been discussed and actioned at provider level.

A new manager had come to work at the service since our last inspection. Staff felt that the manager was approachable and 'hands on' and had provided them with this a good level of support. This person had applied to us to become the registered manager of the service. There had been a delay between the purchase of and implementation of assistive technology. The new manager had stated that this was one of their first priorities. The introduction had been positive as no falls were recorded in January 2018. From a registered provider perspective, the delay in introducing this technology put people at risk of serious injury.

The registered provider always informed us of incidents that adversely affected the well-being of people. The registered provider had also been transparent in informing people of their most recent rating from CQC.

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

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

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

Medication management was not safe and placed people at risk of harm.

The risks faced by people in their everyday lives had improved but were not fully covered or detailed to provide effective protection from harm.

The premises were clean and hygienic.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

The registered provider did not fully gain people's consent within the principles of the Mental Capacity Act 2005.

Risk associated with poor nutrition and hydration was not always taken into account.

All staff had received training in basic care yet this was yet to be fully embedded within care practice.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

Breaches in safety, nutrition, care plans and governance meant that improvements were still needed in this key question

Staff provided care in a respectful and friendly manner with support being provided in an unhurried manner.

People had their privacy promoted by the staff team and staff were able to outline how they achieved this in everyday practice.

People had their emotional needs respected by the staff team.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Care plans continued to lack a person centred approach although a new care planning system was being developed.

Meaningful activities were now in place for people.

An effective process for dealing with complaints was in place.

## Is the service well-led?

**Inadequate**

The service was not well led

Care plan audits, risk assessments and medication management were not effective.

Improvements to respond to deficiencies from the last inspection had not been completely addressed or had not been addressed in a timely manner, for example, the introduction of assistive technology to minimise avoidable harm. .

The registered provider always informed us of incidents that adversely affected the wellbeing of people who used the service.

# Curzon House

**Detailed findings**

## Background to this inspection

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

The service was rated as inadequate during our last visit in August 2017 and as a result the service was placed into special measures. As a result, we were required to re-visit this service in order to comment on the support provided within the service.

This inspection took place on 12th and 13th February 2018. The visit on the first day was unannounced with the second day being announced.

The inspection team consisted of two Adult Social Inspectors with an Inspection Manager present for part of the first day.

As part of our inspection, we ask registered providers to complete 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. No PIR was requested by us for the purposes of this inspection.

Before our visit, we reviewed all the information we had in relation to the service. This included notifications, comments, concerns and safeguarding information. Our visit involved looking at six people's care plans, training records, policies and procedures, medication systems and various audits relating to the quality of the service. We also observed care practice within the service. In addition to this we spoke with four people who used the service and three relatives. We also spoke with the manager and five members of staff. We also observed care practice and general interactions between the people who used the service and the staff team.

Requires Improvement

# Is the service safe?

## Our findings

In August 2017 we found that robust systems were not in place to ensure care and treatment was provided safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. These had included arrangements to monitor and prevent falls, gaps in supervising of service users at night and ineffective risk assessments. In addition to this, personal evacuation plans designed to assist people in an emergency were not up to date. This lead to us rating the service was inadequate in the area of safe.

We received an action plan from the registered provider in response to this. On this inspection, we found that improvements were not fully evidenced and we identified ongoing concerns in regards to the safe care and treatment of people living at the service. The registered provider remained in breach of this regulation.

Medication management was not completely safe. While medication storage, receipt and disposal systems were in place and worked effectively, recording of medication administration meant that people were at risk of harm.

Medication Administration records (known as MARS) included details of the type, dosage and frequency of medication given. In some instances, these had been handwritten and transcribed from medication packets. We found these to be inaccurate. There was no record of who had completed this transcribing or that its accuracy had been double checked by another person. This meant that people were at risk of receiving medication at the wrong time, frequency or wrong dosage. For example: One person had been prescribed medication which needed to be given at a set time before any food or fluids had been taken. This information had not been transcribed to the medication administration record and the medication had not been given in the correct way.

PRN medications are those which are given to people when needed, for example, if they have pain and need medication to relieve this. There were no care plans in place indicating how staff would determine when the offering of PRN medication would be appropriate. As a result, this was left to the judgement of each staff member and as a result medication administration was not always given as required and prescribed.

Some medications were given by the staff team at differing times for each day. There was no evidence that medical advice had been sought to ensure that the effectiveness of this medication would be unaffected by the variation in times. For example, one prescribed medication clearly stated that it was necessary to take it at a set time in the day as its effectiveness would be diminished otherwise. Records indicated that for this person there was a wide variation in the times it was given. This meant that staff practice was putting this person at risk.

At our last visit, we found that personal risk assessments were not robust, lacked detail and were vague. We found on this visit that while improvements had been made, further work was needed to ensure that people were kept safe from harm.

Some risks to people had not been assessed. One person did not have a falls risk assessment in place despite there being a risk of falls. A person was at risk from experiencing a temporary health condition yet no risk assessment had been devised for these instances to aid staff in managing this condition. Another person had experienced a similar temporary health condition which had resulted in hospitalisation. After the person was discharged from hospital, no risk assessment was completed to direct staff on how to manage this or prevent re-occurrence.

Risk assessments were in place in respect of medication, choking and the management of health conditions such as diabetes. These were not always comprehensive. One risk assessment for choking only related to risks faced by a person when receiving their medication. There was no information recorded as to whether these risks were present when the person ate or drank.

Some people had come to live at Curzon House the week prior to our visit. A number of people used airwave mattresses in order to assist with preventing pressure ulcers. Staff had not received training in how these worked and on the first day of this visit we found that settings on each mattress were not accurate. This meant that people were at risk of developing pressure ulcers. We brought this to the attention of the manager and by the second day of our visit, these had been set correctly to reflect people's weight. The lack of training for staff in this area meant that they were not aware of the actions they needed to take if a person's weight changed. People were also at risk of having their skin integrity compromised and people were not entirely protected from harm.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medication otherwise was appropriately stored. We checked the stocks of medication against records and found that they tallied. All other medication was found to be stored securely. Staff told us that they had received medication training and had had their competency to do this checked. A check on medication arrangements had been made in January 2018 by the pharmacy supplier yet this focussed on storage of medication.

Our last visit found that people were at risk of serious harm through the care practices of the service in supervising people and preventing falls. All bedrooms had a call alarm available enabling those who were able to use them to summon help, however, there was no indication whether the capacity of people to use their call alarm had been assessed. In those cases were people lacked capacity to understand the purpose of the call alarm to summon help; no additional assistive technology such as sensors or pressure mats had been installed to alert staff that people were at risk of injury.

In response to our last visit, the registered provider had outlined that assistive technology such as motion sensors were to be introduced into each bedroom so that staff could better monitor the movement of people. This visit found that the assistive technology such as motion sensors were in all bedrooms. Staff had received training in it use and were able to give an account of how the system worked. Staff told us that the introduction of assistive technology had been a very positive step for them and they felt more confident that they could protect people from serious injury. The manager was able to produce records for January 2018 which indicated that no person living at the home had had a fall for all that month. This demonstrated that the introduction of the system had had a positive benefit for people.

Our last visit found that there had been no analysis of falls to determine patterns and to minimise future occurrence. This meant that people had been at risk as opportunities to prevent future falls had been missed. The manager was able to evidence how all accidents and incidents within the service had been

personally analysed by them to assess trends or patterns. The manager had looked at each individual accident and ways in which to prevent them reoccurring in the future. The manager took responsibility to personally oversee the analysis of accidents rather than rely solely on statistics reported to provider level. This meant that the manager could have a better oversight of accident and incident statistics.

Our last visit found that while Personal Evacuation plans (known as PEEPS) were in place; these were no always up to date and had not reflected changes to people's mobility. Improvements had been made and these plans were now designed to safely assist people in the event of an emergency requiring an evacuation of the building. PEEPS we looked at during this visit were up to date.

No new members of staff had come to work at Curzon House since our last inspection. As a result, we did not look at recruitment records. The manager was seeking to employ more staff. Prospective staff were invited to meet with people who used the service and their families during an informal tea and cakes session which took place during our visit. This provided an indication of how prospective staff interacted with people in an informal setting. It also gave the opportunity for people to feedback their views on the qualities of prospective candidates. This meant that people were involved in the recruitment and selection of new staff.

Staff we spoke with had a clear understanding of the types of abuse that could occur. They were clear about the actions to take if allegations of abuse were made known to them or they witnessed poor practice. They were confident that the management team would take appropriate action to protect people from harm. Training records confirmed that staff had received training in safeguarding and this was confirmed by the staff team. Staff were aware of how to raise concerns of poor practice within the service through whistleblowing and which agencies they could contact. Evidence was available that the registered provider had recorded and sent low level safeguarding concerns to the local authority. Low level safeguarding concerns are those issues which do not meet the threshold for a full investigation. This had been an improvement on practice from our last visit.

The premises were found to be clean and hygienic during our visit. The registered provider employed domestic staff and these attended to their task throughout the building to ensure that standards of hygiene were met. Domestic staff had access to personal protective equipment (known as PPE) and these were used by staff. There were sufficient stocks of PPE for staff to use. In addition to this, there were sufficient stocks of paper towels and hand soap for staff to maintain hygiene as well access to hand sanitizer.

Records provided evidence that there was regular servicing to equipment used within the building. Firefighting and detection equipment was regularly serviced and checked to ensure that they would be effective during an emergency. Portable appliances had also been tested to ensure their safety. Portable hoists had been subject to regular servicing. Tests had been done within six month intervals as legally required.

Requires Improvement

# Is the service effective?

## Our findings

At our last inspection, we found that there was no evidence how people with limited capacity could best be assisted to make decisions for themselves. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On this inspection, we found that improvement was not demonstrated and there was a continued breach of regulation.

On this visit, we found that consent was not always gained from people who used the service and that there remained issues with including consent and capacity into the everyday lives of people.

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. Three people had been the subject of a deprivation of liberty safeguards. Applications had been submitted for all other people who lived there. Only one application had been granted at the time of our visit. Staff confirmed that they had received training in this and were able to outline the principles of the Mental Capacity Act. Staff also told us that they had information to hand on the principles of the Act.

We saw in practice, however, that the principles of MCA had not been fully embedded within care practice. For example, staff employed restrictive practices over people's intake of alcohol. This had not been included within the person's care plan. There was also no reference as to whether this person consented to the monitoring or had the capacity to do so. The person told us that while they felt that this monitoring was intrusive; they considered that staff did have their best interests at heart.

Medication risk assessments were in place but in those cases where people relied on staff to manage and administer medication; there was no indication whether this was due to some form of incapacity meaning that people could not manage medication themselves.

Staff had received a letter from a person's doctor consenting to the use of covert medication. There was no evidence that this had been discussed with anyone else and no evidence that a best interest process had taken place in respect of this.

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

We looked at how the registered provider promoted the nutrition of people who used the service. We identified gaps in the recording of people's weights. Weights were being monitored at different times of the day and did not take into consideration potential fluctuations in weight that could be experienced at different times. The manager told us that they had identified that the scales used to monitor weights were not appropriate and potentially had given the incorrect readings. A new set of scales had been obtained in the month previous to our visit.

Our discussions with staff included how they would respond if people experienced significant weight loss. Staff were not clear about the action that needed to be taken in the event of a person losing weight. This was despite them having just received training in nutritional risk assessments and demonstrated that training had not been embedded into care practice.

Food and fluid intake were recorded however; records did not always indicate the exact amount of fluids that had been taken by individuals. Records referred to 'cups' and 'mugs' of fluid being taken and no reference to the precise volume. This was important as people who required close monitoring of fluid intake need precise amounts to be recorded. In addition to this there was no indication as to the target of fluid intake people had to reach to ensure they were fully hydrated. Gaps in records were also noted. One record indicated that no fluids had been taken by a person after teatime until the following morning. Observations during our visit and discussions with people and staff confirmed that this was a recording issue rather than no fluids being given.

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

The kitchen was well equipped, clean and organised. The facility had recently been awarded a five start rating from the local authority food hygiene authorities. Food stocks were adequate. We observed lunch paying particular attention to how people who required assistance with eating were supported. Our last visit had identified that staff support with people who required assistance was not always appropriate. This visit noted that staff who supported people to eat sat at the person's level, interacted with the person appropriately and gave them information as to what food was available.

We looked at training received by the staff team. The manager had identified that staff training needed to be improved. This had been identified when the manager had started their role after our last visit in August 2017. The manager considered that all staff required to go back to basic training and used they advised that the Care Certificate as a basis for training within the service. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It's made up of the 15 minimum standards that should be covered if people are 'new to care' and should form part of a robust induction programme. Staff we spoke to considered that this had been of benefit to them and that it had helped with their care practice. Training was provided to all staff over a two week period and our visit coincided with one such session. Despite staff having training, we found that this had not yet been fully embedded within care practice and that this had not yet been identified as part of the quality assurance process.

Staff confirmed that they received regular one to one supervision with their line manager and that this extended to annual appraisals on their performance.

The building was designed to enable people to mobilise independently. Two floors were available although at the time of our visit, everyone was living on the ground floor. A passenger lift was available to the upper floor and access to the gardens was available. Attention had been paid to ensuring that people could be

orientated within the building with appropriate signs on areas such as the lounge and toilets. Consideration had also been paid to the internal decoration of the building. Adaptations such as contrasting handrails and doors were in place to assist people living with dementia.

Requires Improvement

# Is the service caring?

## Our findings

People told us "I am happy with the care I receive", "There could be no better place, staff look after us well" and that "Staff are very good to us." They also told us "They have my best interests at heart."

At the last inspection in August 2017, we found that the registered provider did not always provide a consistently caring approach to the people they supported. This was because of the deficiencies in areas of the support which led to significant risks to the safety of people, the overall management of the service, staff skills and the level of person centred care given. There were also concerns in how the service had responded to relatives whose relations had experienced injury while using the service.

The manager and registered provider had recognised where improvements were required and had put plans in place to address them. While further improvements were required to be made, the manager had introduced systems to address ongoing areas of development in order to provide a caring approach to the people they supported.

The manager, who had come to work at Curzon house since our last visit, stated that they considered the staff team to have caring and committed qualities and were dedicated to providing a good standard of support to people. They considered the staff team needed their skills and knowledge to be expanded and this combined with their personal quality would ensure an effective and caring approach to the people they supported.

People had their personal care needs attended to by staff in a way which promoted their privacy and dignity. Staff gave us practical examples of how the privacy and dignity of people was promoted. This was seen throughout our visit and through the observations of care practice. Staff were mindful of promoting people's privacy through knocking on bedrooms doors and awaiting an invitation to enter. Staff spoke to people in a friendly manner providing as much assistance to people as possible and providing them with the information they needed. When people needed support with mobility, for instance, people were supported in a helpful and unhurried manner. People were given the opportunity to mobilise at their own pace with appropriate and patient staff support.

At our last visit we had observed that people who required assistance with eating had been supported by staff in a task orientated manner. This had been addressed and staff now fully understood people's needs and provided a more meaningful and valued experience at mealtimes.

While staff were observed to have caring qualities in their approach to supporting people and while the manager had identified the areas of development following our last visit; further improvements are required in areas such as medication, nutrition and risk assessments before a good rating for the question, whether the service was caring, could be awarded.

People had the opportunity to maintain family contact and people were able to receive visitors in the privacy of their own bedrooms. We saw visiting relatives being offered a drink and provided with invitations

to attend forthcoming internal activity events. People permanently residing at Curzon House were also able to introduce personal items into the service such as, furniture, photographs and ornaments. One person stated that the staff team had made efforts to preserve an item of sentimental value to them to reflect the wishes and emotional needs. An inventory of people's personal items was maintained when people were admitted and this was added to as people bought new personal items or clothing. This enabled the service to demonstrate that the correct clothing, for example, would return to their owner after being laundered.

Compliments were received by the service. These took the form of letters and cards thanking staff for the care and support they had provided. These were on display for staff to refer to.

Requires Improvement

# Is the service responsive?

## Our findings

People told us 'activities are good here' and 'we can always get involved with things going on here'. People commented that 'the activities staff organises everything and they are very good'. One person told us that they considered staff were very good and responded quickly if they needed help and did not have to wait for support. This view was echoed by relatives we spoke with.

Our last visit in August 2017 found that care and care plans were not person centred. This was a breach of regulation17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as the registered provider had failed to ensure that personalised records were held in respect of each person.

Person-centred care can be considered as an approach which sees the people receiving support as equal partners in planning, developing and monitoring care to make sure it meets their needs. We found that improvements had been made to the care that people received and it now was more personal and tailored to their needs. However, records did not always reflect this.

Ongoing concerns in relation to care planning had been identified by the new manager when they came to manage the service. A new care planning format was being developed. This involved an electronic care planning system which linked key aspects of people's lives into one format, covering areas such as nutrition, medication, accidents and risk assessments. We spoke with the person who was designing the system and we saw that the proposed care planning system offered the opportunity for person centred care to be introduced. The new system enabled staff to instantly record any changes in the needs of people and enabled the manager and management team to be aware of those changes that required an immediate response. The system was still in development and it was anticipated that it would be introduced in March 2018.

Care plans were available for all people who were using the service at the time of our visits. Despite the proposed introduction of a new system, the existing care plans still did not meet the needs of the people supported and had not been reviewed since our last visit. Care plans still made reference to people having "mixed dementia" with no explanation as to how this presented itself, how staff could assist or how this would impact on a person's daily life. In addition, some people had health needs which had not been reflected in care plans. Two people had issues with their skin viability (that is ensuring that their skin was not broken or vulnerable). There was no accompanying care plan to outline how skin integrity would be promoted for these individuals. There was no body map in place for one person for staff to refer to the application of creams to prevent further deterioration.

Another person had been provided with a pad to alleviate pressure on their ear. No care plan had been devised around this. Another person had been identified as being at risk from choking. While this had been included in the care plan, there was no further information on how this could be prevented. Another person had been identified as being at risk from developing a pressure ulcer and received input from district nurses as a result. There was no reference in the care plan to this.

Other aspects of care plans showed that they were limited and basic. Reference was made to people's emotional needs yet there was no information in people's care plans about the support people needed. General terms about people's behaviours were included in care plans but these did not specify exactly what the implications were for the person and how staff could best support them during times of distress.

We looked at how the health of people was promoted through the care planning process. All people were registered with a GP and records outlined the ongoing treatment for conditions with health professionals. Communication provided from hospitals had indicated the need for some people's skin integrity to be maintained, yet no care plans or instructions were in place for staff to follow. While people had access to health services, this meant that aftercare within the service was not meeting the needs of people and instructions were not being followed through.

This was a repeated breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Our last visit in August 2017 found that there was no effective activities programme in place. We reported this as a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The activities co-ordinator was absent and no alternative provision had been made to cover this absence and provide meaningful activities.

At this visit found that a full activities programme had been restored. Details of activities on offer were on display in the building. We spoke with the activities co-ordinator and they told us about the work they did to establish the social history of people and their preferred interests. Records were maintained about people's participation in activities and their enjoyment of them. Activities included in- house daily events, as well as trips out and the marking of key dates and events throughout the year. We spent time observing one daily activity in the main lounge. A magazine had been produced outlining key events on that day in the world and points to stimulate discussion relevant to people's lives in the past. This stimulated debate, memories for people and shared stories prompted by the contents of the magazine. People told us that there were 'plenty of things to do'.

A complaints procedure was in place outlining the timescales in wish any concerns would be investigated. Records of any complaints demonstrated that any concerns received were investigated and the findings made known to those making the complaint. We had received concerns since our last visit to the service and these reflected the findings that we made at that time. Concerns received were included within our planning of this inspection.

Inadequate

# Is the service well-led?

## Our findings

People gave us positive account of the care they received rather than commenting specifically on the way the service was run. People told us that they felt safe living there and that the staff were kind and responsive to their needs.

Our findings from the previous inspection demonstrated non-compliance with the regulations. During our last comprehensive inspection of the service in August 2017 we found the registered provider did not have effective systems and arrangements for the management and oversight of the service to ensure the quality and safety of people's care. This was breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. As a result we rated this key question inadequate and placed the service into special measures.

At this inspection we found some further improvements were required to address concerns that had only been partially actioned by the manager and the registered provider. The registered provider remains in breach of regulations.

One relative told us that despite the shortcomings identified at our last visit, the service had made improvements and were 'going in the right direction'. We found that although ways to improve the service had been identified, these new systems were not fully embedded. People were still placed at risk of harm through deficiencies in medication recording, risk assessments and gaps in care planning, for example, as well as inconsistency in maintaining people's nutrition and hydration.

The manager considered that the identified deficiencies in care planning during our last visit served as an audit and that improvements were needed. As a result, no care plan auditing took place. This meant that in the intervening time before the improved care planning system was implemented, people were at risk of not having their needs met to a satisfactory manner. The findings of this visit confirmed that there was a lack of person centred planning and as a result people were at risk of not receiving appropriate care.

Medication audits were in place but they were not robust. These had not been effective as they did not identify issues with the medication management highlighted during this inspection. These have been described in the Safe domain.

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

Since our last visit, a new manager had come to work at Curzon House. This person has started the application process to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The manager had devised their own action plan of improvements and how the service could better support people.

Our last inspection concluded that there was not sufficient oversight at registered provider level and as a result deficiencies in the service had not been identified and as a result people were at risk of receiving inappropriate care. There had been some improvement. A representative from the registered provider now visited the service on a weekly basis and sometimes more frequently. This was confirmed by the manager and the staff team. We were provided with evidence which outlined that oversight of the service was now taking place at registered provider level. An action plan had been devised and progress was discussed at registered provider level to effect improvements. Visits by the representative enabled the progress within the service to be discussed and evaluated.

Assistive technology had also been introduced, however, while this had been purchased, it had not been installed until the new manager had come to work at the service. Despite assurances from the registered provider of its introduction, there had been a delay in implementing this and as a result, people were still at risk of serious harm during that time. The introduction of assistive technology had eventually had had a positive outcome for people who used the service with no falls being recorded for January 2018. The manager had identified those systems that they wished to be brought within their scope such as the analysis of accidents and incidents and the introduction of a new care planning system. The manager had analysed patterns of accidents and incidents and had identified ways of determining patterns of accidents with a view to minimise future re-occurrence.

Staff confirmed that they attended staff meetings. The manager sought to run the service in a transparent manner with consultation with the staff team, relatives, people who used the service and other stakeholders. Staff commented that the manager was approachable and supportive and in particular commented that the manager had a strong presence within the service. They told us that the manager was 'hands-on' and was involved in the day to day support of individuals. They told us that they felt the service had improved since the manager had come to work there.

Our records evidenced that the registered provider notified us about those incidents which adversely affected the wellbeing of people who used the service. This meant that the registered provider was meeting registration requirements.

By law, a registered provider is required to put on display the most recent ratings for the service. This is designed to provide transparent information about the quality of care provided. The rating for our last visit had been put on prominent display. The rating had also been displayed on the registered provider's website.