Care Quality Commission

De Vere Care Limited

Chantry House Residential and Nursing Home

Inspection report

Chantry House
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Ratings

Overall rating for this service	Requires Improvement

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

Chantry 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.

Chantry House accommodates 24 people in one adapted building. At the time of our inspection they were supporting 22 people. The service is divided into three units with a secure garden.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risks were not managed effectively. For some risks, such as the use of bed rails, risk assessments had not taken place. Where risk assessments had been carried out, actions identified to mitigate the risk were in not always followed.

Staff training was not up to date. Some staff training had not been refreshed since 2015 despite the service policy being that it should be updated yearly. We are aware that the provider has now planned training dates for staff to catch up.

Environmental checks did not ensure that the service was safe. On the day of our inspection a fire exit was obstructed. We also found areas that needed repair and additional cleaning.

Oral medicines were managed safely and people received these as prescribed. However, due to a lack of adequate recording we could not be sure that people were receiving topical medicine as prescribed.

The manager used a dependency assessment tool to assess the number of staff required. People and staff had mixed views as to whether there were sufficient staff.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice. Applications for authorisation to deprive people of their liberty under the Mental Capacity Act 2005 were not always made when necessary. Where authorisations had been received, conditions on the authorisation were not met.

Decoration within the service was tired and worn. The provider had obtained a quote for the service to be re-decorated. However, this was not supported by an action plan which showed how the new decoration would meet people's needs and be carried out in way to cause least disruption to those living in the service.

People gave us mixed views about the quality of the food. People were offered a choice of food to meet their individual taste and dietary requirements.

People's dignity was not always respected. Linen was worn and shabby and personal items were stored and on display in people's bedrooms. People's confidential information was not being stored in a way which ensured it was secure.

People were not involved in their care planning. Sufficient regard had not been given to ensuring that people with fluctuating capacity were able to take part in planning their care and support. There were minimal activities. People were not supported to follow their hobbies and interests.

Audits by the manger and provider had not identified all of the concerns identified at our inspection. Where concerns had been identified actions had not been taken to remedy concerns. Feedback from staff was not always acted upon to ensure people received high quality care. A recent survey of relatives and residents had provided individual feedback to people but not been analysed to identify any trends.

Some of these issues constituted breaches in the legal requirements of the law. There were four breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of the full version of the report.

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 consistently safe.

Risks were not managed promptly, safely or effectively.

Effective investigation of incidents was not carried out.

Topical medicine was not applied consistently.

The service was not managed and cleaned to minimise the risk of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The service did not adhere to the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards (DoLS). Where conditions under the DoLS had been put on the authorisation these had not been enacted.

Staff had not received up to date training.

Some areas of the service required re-decoration.

People were supported to access other healthcare professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Information about people was not stored securely.

Bed linen and towels were discoloured, ragged and frayed.

Staff knew people and spoke about them in a caring manner.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not involved in their care planning.

People were not supported to follow their individual interests and remain socially engaged.

Not everybody knew how to complain or had confidence that a complaint would be dealt with effectively.

The service had received compliments about end of life care.

Is the service well-led?

Inadequate

The service was not consistently well-led.

Audits by the manager or provider did not always identify concerns. Where concerns were identified prompt action was not taken.

Feedback from staff was not always listened to and acted upon.

There was lack of high level leadership and support for improvements at the service.

Care Quality Commission

Chantry House Residential and Nursing 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 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.

This was a comprehensive inspection which took place on 5 and 6 September 2018. The inspection was unannounced and carried out by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at information we held about the service including notifications they had made to us about important events. We also reviewed all other information sent to us from other stakeholders for example the local authority and members of the public.

The provider was not requested to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During our inspection visit we spoke with the manager, three care staff and the chef. We spoke with five people living in the service and three relatives. People living in the service were not always able to discuss their care in detail with us. We observed interactions between people and care staff. We reviewed three people's care records, policies and procedures and records relating to the management of the service, training records and the recruitment records of three care staff. We also spoke with a visiting advocate.

Following the inspection we requested information from the provider.

Requires Improvement

Is the service safe?

Our findings

We received mixed views from people we spoke with as to whether they felt safe living in the service. One person said, "Yes I feel safe six out of 10." Another person said, "No I do not feel safe here."

During our inspection visit there was an incident while we were inspecting which necessitated a safeguarding referral to the local authority. The manager was aware of the process to make a safeguarding referral and has confirmed to us that the appropriate referral had been made.

On the day of our inspection staff were not up to date with safeguarding training. Information we were supplied with showed that of 55 staff, 10 had received appropriate training. The majority of staff had received safeguarding training in either 2015 and 2016. We spoke with the manager who advised us that safeguarding training had been arranged for September 2018. We are aware that safeguarding training had taken place since our inspection visit. Staff we spoke with were not able to describe what constituted a safeguarding incident. For example one member of staff said, "If you see something untoward you go to your manager." However, they were not able to explain this further in relation to safeguarding issues. Not keeping staff up to date with safeguarding training may mean that they do not recognise a safeguarding concern when it arises which would put a person or member of staff at risk.

Risk were not always managed effectively with appropriate actions put in place to mitigate any identified risks. For example, one person had been identified as at high risk of pressure ulcers. Their care plan recorded that they should be supported to change position two hourly. Records confirmed that this was taking place at night. However, there was no record of when this person was re-positioned during the day. At the staff handover staff discussed that this person had a recurrent moisture lesion to their sacrum. Failure to follow the care plan and re-position the person regularly may have resulted in the recurrence of the moisture lesion. We spoke with the manager who confirmed that about this who said they would ensure that the person was re-positioned throughout the day.

Where bed rails were in place no risk assessment had been carried out to ensure that this was the safest most appropriate and least restrictive option for the person. Guidance from the Medicines and Health Produces Regulatory Authority states that where bed rails and bed safety equipment are prescribed, issued or used, it is essential that any risks are balanced against the anticipated benefits to the user. This had not been done. Weekly checks were recorded as carried out on the bed rails. This was a tick box type form and there was no guidance for the person carrying out the checks as to what they were checking against. For example, the measurement of gaps between the bed rails and the mattress.

Environmental checks did not ensure that the service was safe and prompt action was not always taken when concerns were identified. On our initial walk around the service we noticed that a fire exit was partially obstructed by equipment. The manager told us that this had also been identified by the local authority when they had visited some days earlier but that they had not had the time to get the exit cleared. We noted that the exit had been cleared by the end of the first day of our inspection. Only 24 of the 55 had up to date fire safety training.

Oral medicines were administered by the registered nurse on duty. The registered nurses also audited the medicines regularly to ensure the correct amounts were in stock. There were safe systems for ordering, receipt, storage and disposal of medicines. Where people required their medicines to be administered when required (PRN) there were protocols in place to ensure this was done appropriately.

However, we found that this was not the case for topical medicines. The information for staff was not sufficiently specific to ensure consistent application. For example, one person's medicines chart for cream directed that a thin layer be applied to the affected area. There was no guidance as to when the cream would be required or which area to apply it to. Records showed that some members of care staff had applied the cream in the morning and others had applied it in the evening. There was no record of where the cream had been applied.

Thorough investigations did not always take place when an incident occurred. We saw a report of an incident where a person had not taken their medicines but hidden them. These had been found by a member of care staff and a report had been made. However, there was no record of any investigation into the incident or actions taken, for example guidance for staff when administering medicines to that person or action taken regarding the member of staff administering the medicine. We asked the registered manager about the incident. They were unable to tell us what action had been taken.

Infection control and cleaning audits were carried out but these were not effective in ensuring the service was clean and managed the risk of infection. Infection control audits on 27 June 2018, 27 July 2018 and 27 August 2018 had recorded that all high and low surfaces were free from dust and cobwebs and that curtains and blinds were free from stains, dust and cobwebs. During our inspection we saw cobwebs and spiders in two bathrooms, the communal lounge and one person's bedroom. There was a build up of dirt on the roof blind in the reception area. In a bathroom on the ground floor there were tiles missing from the wall. This meant that the wall could not be cleaned effectively and exposed masonry could harbour infection. We pointed this out to the manager who told us they would get the maintenance staff to repair the tiles. They had been replaced by the end of our inspection. The bathrooms also had wooden shelves adjacent to the sink. These were old and the varnish had worn away. This could mean that cleaning was ineffective and the shelves harboured infection.

The above paragraphs demonstrate breaches of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There were risk assessments in place relative to people's manual handling needs. These were detailed and contained information for staff on size and type of sling people needed and how the sling should be used.

People had mixed views as to whether there were sufficient staff on duty to support them safely.
One person told us, "There are not enough staff here especially at night." However, when asked about staffing another person said they thought there were enough. Staff we spoke with also had mixed views with one member of staff saying that sometimes people had to wait for their care due to staffing levels but another saying staffing was fine. During our inspection we observed that staff were available to respond promptly to people's needs. The manager told us, and records confirmed, that the service used a dependency assessment tool to determine staffing levels. The manager also confirmed that the required number of staff had been on duty for the past month, falling below on one occasion due to short notice sickness.

Recruitment procedures continued to ensure that staff were suitable to work with the service client group. These included checks with the disclosure and barring service (DBS) which checks if applicants have a

criminal record or if they are barred from working with vulnerable people.

Equipment being used such as hoists which was being used to support people to transfer had been serviced regularly.

Requires Improvement

Is the service effective?

Our findings

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. The service had made applications for DoLS authorisations for 21 people living in the service. Three people had DoLS authorisations in place. One person had two conditions on the DoLs authorisation. One of these conditions was not being met. The condition was for the service to give consideration to the person paying privately for a support worker to take them out as they enjoyed one to one contact. We discussed the condition with the manager and asked them why there was no record of this being carried out. They told us that the person's social worker had said this was something for the social worker to arrange, they also told us that it had not been done as they considered that the service should provide the support and the person should not have to pay for the one to one support. We discussed the position with the social worker and as a result it was clear that the manager was not ensuring that the condition on the authorisation was being met.

One person was staying in the service on respite care. We asked the manager if the person was able to leave the service. They told us that the person would not be safe if they left the service and they would not allow the person to leave on their own. Exit from the service was by an electric door opened by a token. The person living in the service did not have access to a token. The service had not made an application to the appropriate authority to ensure that restrictions on this person's liberty had been appropriately authorised. Since the inspection visit the manager confirmed that an application to deprive this person of their liberty had been made to the appropriate authority.

Every room in the service had a sensor which alerted staff if a person moved about in their bedroom. This was built into the fabric of the building and could be turned on and off by a switch in the corridor outside the room. The manager told us that all but one person had this method of monitoring turned on at night. There was no reference to this in any care plans we looked at. The manager told us that consent to this form of monitoring was part of people's consent to receiving care and support. This type of monitoring should be considered on an individual basis as to whether a person needed the monitoring for their safety. The service had used a blanket approach to the use of this sensor.

During our inspection we were concerned that the manager and staff did not have an understanding of the MCA. People should be involved in decisions about their care and support as far as they are able. When we

spoke with the manager they said, "Everybody in a nursing home has to have a DoLS". This is wrong, people need a DoLS application under the MCA if their liberty is being restricted. The manager did not understand that this should be considered for each individual and the reasons for the restriction appropriately evidenced. One person's care plan recorded, for three consecutive reviews of care, that they were unable to attend the review due to fluctuating mental health. There was no record of what had been done to support the person to be involved in reviews and decisions about their care and support. Where decisions had been taken in a person's best interest, for example to give medicines covertly, these had not always been appropriately evidenced with the full name and designation of the person involved in the decision making process.

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

After our inspection visit we spoke with the local authority about the manager and staff understanding of the MCA and DoLS. They told us that they identified concerns in mid July 2018 and training had been offered. We are aware that training had taken place since our inspection.

When staff began working at the service they received an induction. This consisted of reading policies and procedures, training in particular activities such as moving and handling and shadowing more experienced staff. Staff told us they felt supported by the manager. One member of care staff said, "I get very good support. We have supervisions and you can speak about anything." Nursing staff told us they were supported to keep their professional qualifications up to date and attend courses outside of the service.

Staff training was not up to date. Some staff had not received updated safeguarding training, food hygiene training or infection control training since 2015. The service policy was that this training should be updated annually. Lack of current training could mean that staff are not providing care and support in line with current best practise and standards. The manager told us that they had plans in place to provide staff with up to date training in these areas and has sent us a schedule of when this will be taking place.

The staff team worked together to ensure people received consistent care. Handover meetings were held between shifts to ensure the staff coming on duty were up to date with people's needs.

People were supported to access care and support services. Records demonstrated that people received regular visits from healthcare professionals such as the optician. One person's record demonstrated that they had been supported to attend a routine bowel screening appointment.

The service had a secure garden. This meant that people could go out into the garden when they wished. We observed one person enjoying sweeping up the leaves. Staff told us that they had asked to do this when they had first came to live in the service.

The decoration in the service was tired with chipped paint and worn surfaces. A corner of the dining area was used to place the medicines trolley when medicines were being administered. This was relatively dark. A desk lamp placed on a shelf over where the trolley was located was missing a shade. This gave the dining room a dark and dingy feel. The manager told us that they had spoken with the provider about redecorating the service and estimates for redecoration were being obtained.

People gave us mixed views about the quality of the food. One person said, "Very good, eight out of 10." However, another person said, "Not enough food and I do not like it very much." During our inspection we observed staff encouraging a person to eat their breakfast. The person said they did not like what was being offered to them and staff went through a range of choices for them to choose from. We saw that the person

agreed to eat some breakfast after receiving a lot of encouragement.

We spoke with the chef. They told us they spoke with people every day to see if they liked their food. They displayed a good knowledge of people's food preferences giving us an example of one person who liked a beetroot sandwich. They also told us that people did not have to have what was on the menu but could have an alternative such as an omelette if they requested it.

Some care plans contained details of people's specific dietary requirements for example the texture they required their food to be. Care plans also showed that people had been referred to dieticians and speech and language therapist where required. Where necessary people's food and fluid intake was monitored to ensure it was sufficient. Where people required support with their meal this was provided by staff.

Requires Improvement

Is the service caring?

Our findings

Information about people was not always stored securely. People's care plans were kept in the three communal areas. In one unit the care plans were stored in a walk in cupboard which the manager told us was kept locked. However, on three occasions we found the cupboard was unlocked. In the other two units the care plans were stored in small cupboards. One of these cupboards had a lock but we found it was unlocked throughout the day. The other cupboard did not have a lock. This meant that all of the care plans could be accessed by people who did not have a right to read them.

People's dignity was not respected because linen such as towels and sheets had been allowed to deteriorate into a very poor state. We looked at the towels available which were in the cupboard in the laundry. The manager told us these were used by people on a daily basis. All of the towels we looked at were faded, very thin and many had ragged frayed edges. Bed linen was thin and discoloured. Pillows and spare cushions were also stored in the cupboard. Pillows were lumpy from washing and the cushion had a hole in the internal lining. We asked the manager if they would like to use this linen. They replied that they could see several that they personally would not use. They also told us that they had had a meeting with the provider and had been promised new linen but nothing had happened. Some new towels arrived on the second day of our inspection.

Items of a personal nature such as incontinence pads were stored in people's bedrooms. In two rooms we saw four boxes were stacked against the wall in full view. In another room the housekeeping 'wet floor' sign had been stored in a person's bathroom. People's dignity was not respected with items of this nature on full display.

During our inspection we observed caring and compassionate interactions between people and staff. One person told us, "Staff know me as a person. They ask me what I want." We saw one person being supported to move between a chair and a wheelchair. Staff carried out this procedure with compassion explaining to the person at each stage what they were doing and what they needed the person to do. We observed the staff handover and saw that staff spoke about people in a caring manner. They showed an understanding and knowledge of people's preferences and how they liked their care delivered.

We observed staff supporting people to express their views on a one to one level. For example where they wanted to sit or what they wanted to eat. At a relative and residents meeting, minutes showed that relatives had been encouraged to bring in items to personalise people's bedrooms.

Requires Improvement

Is the service responsive?

Our findings

Nobody we spoke with had a knowledge of their care plan or could recall being involved in their care planning. One person said, "No, I do not know what my care plan is. I have not seen my care plan." Another person said, "No, I am not involved with my care planning."

Care plans did not demonstrate that people had been involved in planning or reviewing their care and support. Two care plans contained the phrase, "[Person] would be unable to attend a review due to fluctuating mental capacity." There was no explanation of the person's mental capacity or exploration of how the review could be structured to enable the person to be involved. For example, if the person may be able to participate at different times of the day.

Care plans did not always contain sufficient detail as to what support people needed. For example, one person's care plan stated, 'I am unable to participate in my care due to my fluctuating mental capacity'. It did not record how the person liked their care delivered for example, if the person preferred a bath or a shower for how staff could encourage the person to be involved with their personal care. Another person's care plan recorded that to maintain their skin integrity they should sit in a chair two to three times a week. There was no guidance for staff as to which days they should sit in a chair or if the person required a particular type of chair.

People told us that they were not supported to follow their interests and take part in activities. One person said, "There are no activities going on here. We are all bored." Another person said activities were, "Ad hoc, we sometimes do jigsaw puzzles. Otherwise no there are no activities." For another person they and their advocate had identified that they would enjoy visits into the community and one to one activities and this would benefit their well being. We spoke with the manager and they were aware of the person's wishes, although they did say that sometimes the person refused to participate in activities. We spoke with the person's advocate who told us they had asked the service if it could be facilitated but had had no success. From January to July 2018 records showed that the person had been supported to access the community on four occasions. On two occasions carer notes from the trip demonstrated how much the person had enjoyed the excursion.

For another person who was nursed in bed their care plan stated that they preferred one to one activities as they were not able to leave their bedroom. We checked their care records for four days prior to our inspection. There was no record of any one to one engagement during this time. All records were for carers attending to carry out tasks such as providing personal care. The care plan for the person also recorded that the person required glasses. When we visited them in their bedroom they did not have their glasses on and we could not see them available. The bedroom had some photographs on the wall but these were at the far end of the bedroom and could not easily be seen by the person in bed. Records showed that the person regularly exhibited challenging behaviour such as shouting and that care staff had considered physical factors such as comfort and food and drink. Care staff had not considered, and the care plan did not direct staff to consider social engagement.

People who were nursed in bed or were not mobile did not have call bells to hand. We asked the manager why people did not have call bells in reach. They told us that if staff did not think people were able to use their call bells they would not be given them. There was no risk assessment or rational in people's care plans for not giving them a call bell.

Where people lived with a condition such as diabetes care plans did not contain information on how the condition was managed. This could mean that conditions such as diabetes which cause a number of different health issues, for example eye and foot conditions, were not managed effectively.

The above paragraphs demonstrate breaches of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The manager told us that there was a complaints policy in place but that they had not had any complaints this year. The complaints policy was displayed in the entrance to the service. However, this area was not accessible to people living in the service. People we spoke with did not know how to complain and were not confident that any complaint would be dealt with to their satisfaction. One person said, "No my relatives do not complain and they are not encouraged to complain nor do they feel safe to complain." Another person said, "No I do not feel safe to complain." A third person told us they had made a complaint but it was dealt with badly and they would not complain again.

There was a folder in the main office which contained details of people's end of life wishes. The manager told us that they spoke with people and their relatives soon after they moved into the service about their wishes for end of life care. The service had received compliments with regard to end of life care. One compliment read, '[Person] was very lucky to have such attentive care in her final days and I do thank you all for her care.'

Inadequate

Is the service well-led?

Our findings

The provider registered to provide care at Chantry House in October 2017. Since that date there had been no registered manager in place. The current manager was the deputy manager when the provider took over 2017. They were and had been appointed as the manager in October 2017. They told us that they would be applying to register to manage the service.

Staff gave us mixed views about the management of the service. One member of care staff said they enjoyed working in the service because of the good team work. However, another member of staff said that the senior management [the provider] was "Not particularly interested." Although they were complimentary about the manager.

The organisational systems in place to monitor the quality of the service at Chantry House were not effective. These systems had failed to identify the areas of concern identified at this inspection. This included concerns with infection control, staff training, medicines, MCA and DoLS, and people's social engagement. In addition, where internal audits had identified issues these had not been addressed in a timely way. For example, a care plan audit on 6 August 2018 had identified one person who had been assessed as at high risk of developing pressure ulcers did not have a skin integrity care plan. Another person's care plan contained two care plans regarding their continence needs. These contained different information. Neither of these concerns with the care plans had been addressed. We asked the manager who was responsible for checking these audits. They told us that before they became the manager they had checked the audits but since becoming manager they had not checked the audits which were carried out by the care and nursing staff.

During our inspection we asked the manager what audits were carried out by the provider. They told us that they were not aware of any formal audits carried out by the provider. They said that the nominated individual had recently visited the service and walked around. We asked the nominated individual what process they had in place to ensure the quality of service at Chantry House. They have sent us one audit completed on the day they visited the service. The audit shows that one care plan was looked at, although the service audit form gave space for three. No explanation was given for only inspecting one care plan. Other areas identified on the form to be audited had been left blank, including medicines, staff files, safeguarding and DoLS. The provider also sent us one additional audit dated the same as the above. This was entitled Head Office audit. Again, staff files, medicines and DoLS were not checked. The auditing system was not used in a proactive way when new issues had arisen and the provider's own governance and quality monitoring systems were not effective at providing checks of the service and the manager's work.

The above paragraphs demonstrate breaches of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There was a lack of management presence at the home. Basic shortfalls had not been identified and addressed. The manager had been overseeing another service owned by the same provider which was larger and there were known issues at that home, the local authority had been involved with that service

recently. Staff training had been allowed to lapse. Given the issues we found, we were not confident that the provider was appropriately supporting the manager. Since the inspection visit the provider has told us 'Moving forward, [Manager] will be conducting monthly audits. There would also be a monthly audit conducted by myself, so that we can provide a better support system for [manager] and to ensure all systems have a pragmatic and realistic objectives to ensure we are compliant with all Regulatory departments.' They have also told us they will put other support in place for the manager.

We were also aware that the provider had identified that the service required re-decorating and updating. However, there was no plan in place to ensure that this met the needs of people living in the service and followed current guidance, for example colour coding of communal areas for people living with dementia. Neither was there any plan as to how people would be involved in choosing the decorations or how re-decoration would be carried out in the least disruptive way to those living in the service.

The service had carried out a survey of residents and relatives in August 2018. The results of the survey had not been analysed to give an overall picture but individual responses had been provided. These had been recorded as a hand written note on the original survey form. For example, a relative had been spoken with regarding their comment about food.

Resident's meetings and staff meetings were held but staff feedback was not always acted upon. There had been two resident's meetings this year where issues such as the menu had been addressed. Staff meetings had been held in March and July 2018. At the March meeting staff had raised a concern regarding the quality of the linen. A member of staff told us they had also raised this as a concern earlier in the year. The manager told us that they had raised this with the provider but nothing had happened. Some new linen was delivered on the second day of our inspection.

There were examples of institutionalised practice. Some people's bedrooms contained little personalisation. Communal spaces were also not personal to the people who lived at the service. There was no focus on trying to support the people at the service to live as a community. Some practices were for the benefit of staff not the people at the service. For example, one person had continence products on display in their bedroom.

The service had recently worked with the local authority. The local authority had identified areas for improvement during a visit and the manager has attended a training session since this inspection visit.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans did not reflect people's individual health needs. People were not supported to live meaningful lives. Audits were not effective in identifying concerns and where these were identified action was not taken to address these.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People had not given consent to their care and support. DoLS applications were not made appropriately. Conditions imposed on DoLS had not been met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments had not been carried out with regard to the use of bed rails. Topical medicine to be applied 'as required' was not managed appropriately. Everything reasonable possible was not done to mitigate risk.

Regulated activity	Regulation

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Audits were not effective in identifying concerns and where these were identified action was not taken to address these.