R Sons (Homes) Limited

Church Farm Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 30 and 31 August 2017, and was unannounced.

Church Farm residential care home provides accommodation and personal care for up to 40 people. At the time of this inspection, there were 37 people using the service, some of whom were living with dementia.

There was a registered manager in post. 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.

At our previous inspection in 2015, we rated the service as 'good' overall. During this inspection in 2017 we found the registered provider to be in breach of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009.

We took enforcement action to impose conditions on the providers registration. We asked them to advise us what action is being taken to improve the quality of the service in relation to the assessment and monitoring of risk and staff competency. This will include the implementation of quality and monitoring audits, how the quality assurance system is identifying issues, and what action has or is being taken to mitigate any shortfalls. This condition continues on a monthly basis, whereby the provider informs us of actions which have or are being taken to mitigate identified risks. We decided to impose these conditions on the providers registration because people may be exposed to the risk of harm.

The registered provider did not have sufficient oversight of the service's operations. Quality assurance systems and audits were not in place to monitor the service provided to people, and as a result shortfalls in the safety and quality of the service were missed. The provider had not undertaken regular checks to ensure the quality of care or to drive improvement. Additionally, the registered manager had not notified us of serious injuries which had occurred in the service, which is required by law.

Records relating to MCA and DoLS were not clear. Mental capacity assessments were not completed without delay where a person was regularly refusing medicines.

Two people living in the service did not have a care plan which meant that staff did not have clear and accurate guidance on how to care for and their needs. This put people and the staff delivering their care at risk. Some information was not documented fully in care plans.

Risk assessments were not in place for two people who had complex health needs. Risk assessments in relation to nutrition and moving and handling were not always completed accurately, and there were no risk assessments for people who were at risk of choking.

Clear and accurate records were not being kept of medicines administered by staff. This meant we could not be sure people were always given their prescribed medicines.

Infection prevention and control procedures were ineffective and we found that hygiene in the service was poor.

A risk assessment for legionella was in place. However, cold water temperatures had not been taken, despite the service having been advised to do this in November 2016.

We could not be assured that suitably competent and skilled staff were deployed to ensure that people's care and treatment needs were met. Staff's competence in risk assessing and administration of medicines was not being checked by the management team.

People's food and fluid intake was not always monitored effectively.

There was an activity co-ordinator in the service. However, the provision of activity was not meeting the individual and specialist needs of all people using the service.

Staff were observed to be kind and caring, but the staffing level arrangements in the service meant that staff did not always have time to spend with people in a meaningful way to meet their social and emotional needs.

People had access to a range of healthcare professionals. However, we found that one person was not referred for specialist advice in a timely manner. Risks were not accurately assessed, which meant there was a risk that people may not be referred to other professionals when needed.

Staff were aware of their responsibilities in relation to safeguarding people, were aware of the types of abuse they may come across, and had received training in this area. Appropriate recruitment checks had been carried out on new staff, to ensure they were of good character and suitable to work with people in the service.

There was a complaints procedure available in the service for people and relatives to raise concerns.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will 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?

Inadequate

The service was not safe.

Risk assessments were not completed accurately. Two people with complex health needs had no risk assessments in place.

Risks relating to the water system were not being monitored fully.

Clear and accurate records were not being kept of medicines administered by staff. This meant we could not be sure people were always given their prescribed medicines.

Infection prevention and control systems were not in place, resulting in poor hygiene and cleanliness in the service.

Staffing level arrangements were being reviewed to ensure they met the needs of people at all times.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Records relating to MCA were not clear and did not maximise the people's ability to have control over their lives or the care they received. It was not always clear why DoLS applications had been made.

People's food and fluid intake was not always monitored effectively.

Not all staff had received training relevant to their role. Staff competency was not checked in risk assessing and medicines.

People had access to healthcare support.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not routinely involved in the planning of their care.

People were supported to see their relatives and friends.

Peoples' privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Two people using the service did not have a care plan in place. Some information was lacking in detail.

Activities were provided by the activity co-ordinator. However, this was not at a level which would meet the individual and specialist needs of all people using the service.

There was a complaints process in place. People and their relatives felt able to complain if they had concerns they wanted to raise.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not ensured that the service was operating effectively to ensure that people were receiving safe and effective care at all times.

There were no procedures in place to monitor the quality of the service.

The registered manager had not checked staffs work to ensure they were competent to carry out their roles. This relates to the assessment of risk and medicines.

The service had not notified us of serious injuries that had occurred in the service.

Church Farm Residential Care 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.

The inspection took place on 30 and 31 August 2017, was unannounced and undertaken by two inspectors 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, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service: what the service does well and improvements they plan to make. We also reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also spoke with local safeguarding and quality teams.

During the inspection we spoke with eight people living at the service, four relatives, and one health professional. We spoke with the registered provider, registered manager, deputy manager, assistant manager, and five members of care and catering staff. We also observed the interactions between staff and people. Following the inspection we spoke with the local infection control team, and quality assurance team.

To help us assess how people's care needs were being met we reviewed eight people's care records and other information, including risk assessments and medicines records. We reviewed three staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

Inadequate

Is the service safe?

Our findings

We found that people living in the service were at risk of harm because risks had not been accurately assessed or mitigated and in some cases, no risk assessments had been implemented.

We found that two people had no care plans or risk assessments in place. One person had been living in the service for five days, and had been assessed by a social worker prior to coming to live in the service. The assessment showed that they had complex health needs and were at risk of malnutrition. Daily records were in place, but staff were not consistently recording what the person had eaten. There were no risk assessments in relation to their risk of malnutrition, pressure ulcers or moving and handling. This meant that staff did not have up to date information or guidance on how to care for the person safely and monitor risks.

Another person had been living in the service for three weeks and also had complex health needs, but no risk assessments had been completed. The person was identified as being at risk of falls, and their daily records showed that they had fallen several times since living at the service. The person had been admitted to hospital on one occasion as a result of a fall, however, no care plan or risk assessments had been completed since. Control measures to reduce the risk of falls, (such as a pressure mat which alerts staff when the person stands up) had not been put in place at the point of admission, despite knowing the person had a history of falls. Additionally, another person had fallen three times in May 2017. Whilst the service had implemented control measures to minimise injury, they had not sought specialist advice until August 2017. This meant that people did not receive the care they required in a timely manner.

Where people had care plans and risk assessments in place, these were not always accurately completed. The service was using the MUST (Malnutrition Universal Screening Tool) to assess people's risk of becoming malnourished. However, the assessments were not being completed correctly. In three care records, we found that the MUST only recorded how much the person weighed which meant the assessed level of need was not known. Two of these people were already known to be at risk of malnutrition. The third was already seen to be losing weight over a period of four months; their nutrition plan recorded them as '0', meaning 'little or no risk'.

A full completion of a MUST will identify what action needs to be taken, for example, weighing a person weekly, maintaining and monitoring food intake, or referral to a dietician. This meant the risks to these people were not being adequately assessed.

Moving and handling risks assessments were not completed accurately. These assessments identify the most effective techniques to move or transfer a person safely. We found that the staff member responsible for reviewing risk assessments was not assessing these correctly. For example, one person was scored as 'at risk' for moving and handling, but when we spoke with staff about the person's needs, they said the person should have been scored as 'high risk' in certain areas due to their complex needs. The registered manager also agreed that this was not accurate. Another person had been scored as 'high risk', but not all areas of the assessment had been scored, for example, the person's ability to co-operate. This meant that guidance for staff was not accurate putting both their safety, and the safety of the person being moved at risk.

We found that one person had suffered an injury from a bed rail that was in place to prevent them from falling from their bed. The person had trapped their leg in the rail resulting in a wound. The daily records did not explain how the incident had occurred. We asked the registered manager who told us that they caught their leg in the rail, and then implemented bed rail 'bumpers' (a soft covering secured around the rail) to avoid a recurrence. However, when we checked the person's bed we found this was not in place. Staff had placed a duvet over the top of the rail which would not be effective or safe to use to prevent injury. There was not a bed rail risk assessment in place for this person, so the risk of harm had not been identified.

We were advised that two people had thickened fluids prescribed, which indicated they were at risk of choking. However, there were no risk assessments in relation to choking. This information is needed to provide guidance to staff on how to minimise the risks associated with choking, such as positioning safely when people are eating or drinking. Staff had no guidance on action they should take if a person were to choke, or guidance on how to prevent this.

Infection control procedures were not effective. For example, we found dust and debris under chairs. We also found that toileting equipment such as commodes and toilet seats were not sanitised thoroughly and some needed to be replaced due to rust and plastic coverings which had split. Bed sheets needed to be replaced as some had holes in them and were threadbare. We brought our concerns to the attention of the registered manager. We also contacted the local infection control team who visited promptly following our inspection.

We reviewed the systems in place for managing people's medicines and found that these systems did not consistently ensure people received their medicines safely. For example, one person's MAR showed two medicines which they had been prescribed, but there were no instructions written on either to say how many times a day the medicine should be given or what dosage. Staff had highlighted the times of the day they needed to have the medicine, but this was not sufficient to ensure the person received the medicines as prescribed.

We found that there were gaps on the MAR charts of two people where staff had not consistently signed to say if people had received their medicines. We also found that where people had refused their medicines there was no explanation written as to why they refused it, or what action had been taken as a result. One person was routinely refusing their medicines, one of which was an anti-biotic. This had been refused over a period of five days, but the MAR did not explain what action was being taken in respect of this.

A staff signature list, which is used to identify staff member's initials when they sign a MAR chart and to verify medicines are being administered by staff trained to do so, was not kept in the treatment room or with the MAR charts. We were therefore unable to determine from the records whether the codes used on the charts were staff initials or codes to denote medicines administered or not. This meant there was no way to accurately audit the medicines systems, and whether people had received their medicines as prescribed.

Where people were prescribed 'as and when' (PRN) medicines, appropriate guidance was not in place to instruct staff on the intended purpose of these medicines and when they should be administered. This presented a risk that they could be used inappropriately.

Some people were prescribed topical applications, such as creams. However, there were no body maps or detailed information on where to apply these or why it was being used. This information is important as it ensures that creams are applied correctly and at appropriate intervals. We checked three topical application charts and found they were not being signed by staff as having been applied. This meant we could not be certain that people were receiving their topical medicines as prescribed.

Where people were receiving medicines in the form of an adhesive patch, there was guidance to say where the patch should be applied, but not where the patch was applied on each occasion so it could be rotated. Ensuring the patch is rotated reduces the risk of skin sensitivity. We also found that some patches which were a controlled drug were applied by only one member of staff rather than two. This is important due to the possible misuse of these types of medicines.

We also found that daily temperatures had not been taken where the medicine trolley was stored. There was a fridge in place for temperature sensitive medicines, however, temperatures were not being taken to ensure they were within the correct temperature range. This meant the effectiveness of medicines could be compromised. Additionally, the administration of medicines did not finish until 10:45am. We found that staff were not documenting the time that certain medicines were given on the MAR. This meant that they had no way of monitoring that there was a correct interval of time before the next dose was given.

The service had informed us that they had recently tested positive for legionella bacteria in their hot water system. The service were advised that it was not a strain of legionella which would cause fatalities, but needed to be eradicated as the results indicated that the water system was providing the ideal environment for legionella growth. They subsequently took action to cleanse the system, which was then re-tested by a water company showing that legionella had not been detected.

In November 2016, environmental health services visited the home to check health and safety in relation to legionella. They sent a letter outlining a number of issues found which required attention to ensure they were legally compliant. One of these requirements included taking the temperatures of the cold water supply. We checked the services records and found that hot water temperatures were being taken, however, cold water temperatures had not been taken despite being advised to do this.

We concluded risks associated with people's care and support were not safely managed, and this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had ensured that hoists and other equipment used to assist people had been serviced to ensure their continued safe use. Personal evacuation plans were in place which outlined the support people would need in an emergency situation.

We received feedback from people and relatives regarding the staffing levels. One person said, I can't walk at all so the staff are very good to me. It depends who is on and what is going on whether or not staff are always round to assist there are a lot of us [people]." Another said, "I have got my buzzer, they [staff] may not come straight away you only have to wait a few minutes, if they have got another person they are seeing to you have to wait your turn". A relative said, "[Relative] says there aren't enough staff and that they are always really busy, and they assist as promptly as they can." A staff member told us, "I think the ratio [of staffing] is correct, but in practice it's not enough, we need more staff in the afternoons."

We observed staff to be available in the main lounge throughout the day, however, there was no formal system in place to calculate staffing level arrangements, to ensure they were adequate to meet people's needs. The registered manager told us they helped staff to provide care whenever needed but this had impacted on their time in undertaking management tasks. The registered manager told us that they were trying to recruit new staff to increase staffing levels across the day. Following the inspection they informed us that they were adding an extra staff member from an agency on the morning and afternoon shifts to support in the interim whilst permanent staff were recruited. They also planned to implement a dependency tool to calculate more effectively the staffing levels required.

Staff had received safeguarding training and were able to identify different types of abuse and what action they needed to take if they suspected someone was being abused. One staff member said, "I couldn't take any one being abused, I'd report it to deputy manager, or the manager, or I'd whistle-blow, whatever it took." Another said, "people can experience verbal abuse, physical abuse, or financial. I'd tell the head of shift, or I would contact CQC if I was concerned."

Appropriate recruitment checks had been carried out on new staff, to ensure they were of good character and suitable to work with people in the service.

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 decision made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty.

We checked whether the service was working within the principles of the MCA, and found that this needed to be improved. For example, we found that one person had been assessed as not having capacity, but it was not clear what decision was being made in relation to the need for a capacity assessment. Another person had been assessed as lacking capacity but it was not clear which decisions they were unable to make. Their record stated, "Although [person] lacks capacity to make their own decisions, [person] is able to make decisions around their food likes and dislikes." It went on to say that the person's family visited daily, and that they would make 'day to day' decisions on their behalf. The family did not hold any legal authority to make decisions on the person's behalf, and in addition it was indicated that the person was still able to make some decisions. This approach did not maximise the person's ability to have control over their life or the care they received.

We found that one person was routinely refusing to take their medicines. The registered manager told us that there was confusion over the person's capacity to make the associated decision. The registered manager said they had spoken with the person who they felt understood the consequences of not taking their medicines, and believed that they had capacity to make the decision. However, there was no documentation in place or capacity assessment completed to show that this had been assessed appropriately. We explained the importance of ascertaining the person's capacity before going forward and documenting this thoroughly along with the support given and the rationale for any decisions taken.

DoLS applications had been made for people living in the service. Some detailed why they had been applied for, however, others did not. For example, a DoLS application had been made for one person, whose record said they 'needed lots of care and had dementia'. It did not detail the specific reasons for the DoLS, how they were being deprived of their liberty and if this had been considered as the least restrictive option. This level of information is important to ensure people are only deprived of their liberty when absolutely necessary. We were not assured that the management team fully understood their responsibilities in relation to this.

Staff had a mixed understanding of the principles of MCA and DoLS. They understood why they needed to gain consent from people to provide care, but were not knowledgeable about what DoLS meant in practice.

This knowledge would enable staff to recognise when to take action, for example if a person's needs changed, or if a person moved into the service who needed support in this area. It would also safeguard against a person being unlawfully deprived of their liberty. One staff member said, "I know [MCA] is about not making decisions for people, we always ask first, but I've not had any training in this area." Another said, "I don't know what DoLS means, I don't know much about MCA." We also observed during lunchtime that staff did not ask people for consent, prior to placing a clothes protector on them.

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

The registered manager told us that four staff had completed dementia care coach training and the registered manager held a degree in dementia studies. However, four staff we spoke with told us they had not received training in MCA/DoLS, dementia awareness or in relation to behaviours which challenge, which would provide staff with knowledge of how best to support people living with dementia.

We could not be assured that suitably competent and skilled staff were deployed to ensure that people's care and treatment needs were met. For example, the staff member responsible for completing risk assessments had not been completing these accurately and this area of their work was not being checked by a senior member of staff to ensure they were competent to carry out their role effectively. The registered manager confirmed they had not received training in assessing risk.

Staff received training in moving and handling, safeguarding, first aid and medicines. However, staff administering medicines had only received online training and there were no practical assessments to support the learning gained, such as annual competency assessments.

People and relatives commented on the care that staff provided. One person said, "What they [staff] are good at here is mostly looking after you, doing things for you, if you are struggling to get out of the chair there is always one that will help me." A relative said, "They [people] are all looked after very well. Anything that needs doing they just do it so you have to have the skills and know the people to do that." Another said, "From what I have seen the staff seem qualified enough in how they treat [relative]. Very humane and they call [relative] by name and a little touch, a pat, which is important."

For staff working in the service who did not have formal qualifications in care, they were expected to complete the Care Certificate, which is a set of standards that care workers are assessed on to ensure they are providing good quality care, and standards that should be covered as part of induction training of new care workers. However, staff views about the induction varied. One staff member said, "I only shadowed for one day. I didn't feel quite ready to work alone, but I'm ok now. The staff here are really good so they helped me." Another said, "The induction was good, covered absolutely everything, and I shadowed for a good amount of time." We advised the registered manager to review their procedures for staff induction to ensure this was adequate to meet staff needs.

Supervisions and appraisals provide staff with the opportunity to discuss how they are working, receive feedback on their practice and identify any training needs. The registered manager told us that they tried to ensure staff were offered formal supervision on a regular basis, but some had fallen behind and they were planning to arrange sessions to ensure all staff were up to date. One staff member told us, "I have regular supervision, I find them useful and I'm asked my views." Another said, "I had supervision about six weeks ago. I'm asked questions about how I am getting on, we can discuss training needs."

Where people required assistance, they were supported to eat and drink. However, food charts were not

consistently completed where people were at risk of weight loss. Therefore staff were not able to monitor if people's fluid intake was adequate to support their needs. Staff completed a daily record where they circled if the person had eaten well or not. This did not provide an account of what the person had eaten and we found in several cases that this had not been completed. Therefore the detail around how much people had eaten was not recorded accurately. This information is particularly important when people are at risk of malnutrition.

We asked people their views on the food. One person told us, "If you want anything to eat you can get it, I had egg, bacon and tomato for breakfast it was lovely." Another said, "The food is good, breakfast is excellent, beans or egg on toast. My favourite is cheese on toast every night I have that." A third said, "Sometimes if it's something I don't want they [staff] will get me something else."

We observed the lunchtime meal which was served in the main dining area. Appropriate music was playing softly in the background, and we saw some people singing along to songs they recognised.

People were assisted to the tables where required, and a choice of squash was offered to drink. Staff were available throughout the meal, supporting people where needed. People who needed support to eat their meal were assisted by staff in a dignified way. A sweet trolley came round after lunch for people to choose from. The atmosphere was relaxed and staff interacted with people in a positive manner. Drinks were offered throughout the day, and there was a sweet stall for people to use with different jars of traditional sweets available. We saw two people happily sharing their sweets after lunch.

Records showed that people had access to healthcare services and received on-going healthcare support. This included health and social care professionals, dieticians, physiotherapists, podiatrists, and mental health. However, in one case we found that a person had been experiencing falls. Whilst the service had implemented control measures to minimise injury, they had failed to refer the person for specialist input in a timely manner. This meant that there was a risk that people may not receive the care they require in a timely manner which could be detrimental to their health and wellbeing. Additionally, where risks to people were not always being accurately assessed, there was a risk that specialist advice may not be sought promptly as risks may not be identified accurately or promptly.

People commented on the provision of healthcare support. One person said, "I had my feet done yesterday and the optician has visited." Another said, "The GP comes every Friday if you need to be seen." A third said, "I had a cough and I couldn't get rid of it, the doctor came the next and gave me some medicine." A relative told us, "We had an incident when [relative] was unwell, the staff let me know straight away one of the carers called an ambulance which took [relative] to hospital. The doctor has been called two or three times when they [staff] have decided to get the doctor." A health professional told us, "Staff generally call us in appropriately when needed, but usually they have done some first aid before we arrive. I have found that staff follow any advice given, they know people well, and are always available to assist."

Requires Improvement

Is the service caring?

Our findings

The provider needed to develop their approach to ensure that it was consistent in delivering care in a way that supported a positive and person centred culture. While we observed that individual staff were kind and caring towards people, the provider's systems and processes did not always ensure that people were cared for safely. For example, poor risk management placed people at risk of harm. Additionally, we could not be assured that people's views had been consistently listened to in relation to how they preferred their care to be delivered. The detail in some care plans reflected individual preferences and wishes, but there was no evidence that people were consulted about their care.

The registered manager told us that people were not generally involved in creating their care plans, but planned to improve this. They also confirmed that there were no 'resident' meetings held in the service at present which would provide an opportunity for people to give their views on the care and support they receive, and any other aspect of the service they may wish to comment on. This meant that people's views were not routinely sought about the care they received or any changes they may wish to make in the service.

People and relatives gave us their views on the approach of the staff. One person said, "The staff are really caring, I am a huggy person, I like a hug." Another said, "You couldn't get any better anywhere, especially if you are a bit down they [staff] bring you right up, they listen to you if they think something is upsetting you." A relative told us, "Everyone acknowledges you. Bearing in mind it is an old building with bits added on, rather spread eagled you might say, they [staff] never give you the impression it's too much trouble, there is a calmness, they do their best to make it a home for them [people]."

Staff respected people's privacy and dignity. For example, a staff member was asking a person if they wanted the toilet before lunch. The person was struggling to hear them, but the staff member was trying to maintain their privacy by speaking quietly. The staff member then re-phrased the question in a more dignified manner and said, "Would you like to go to the powder room." We also observed that when staff were speaking about people in the service they did so in a hushed voice so others nearby were not able to hear. Staff were seen to knock on doors before entering people's rooms. When we approached one person's room, we were asked by staff to come back later as the person was receiving personal care and they liked to take their time.

Care plans made reference to the importance of maintaining people's independence. One care plan said, "Remember to always ask [person] if they would like to do their own personal care", and "Always encourage [person] to do things for themselves".

We observed that positive and caring relationships had been developed between staff and people. Many of the staff had worked in the service for a long period of time and therefore knew people well. We saw people readily ask for assistance from staff who reassured them, and used touch appropriately. For example, we saw staff holding people's hands to reassure them, and rubbing the back of another person who was not feeling well. One staff member said, "We [staff] know people well. There is one person I sing to when they are

being hoisted because they get scared. They love rhymes, so we [staff] sing to them and they join in and forget they are on a hoist."

Requires Improvement

Is the service responsive?

Our findings

We found that two people did not have a care plan in place. Each had a 'health' folder in place which showed who had been involved in their care to date, and the assessment which was carried out by a social care professional, outlining the complexity of their needs. No other information had been compiled to feed into specific areas of risk, such as malnutrition and falls. This was not sufficient for staff to have clear and accurate guidance on how to care for and meet the person's needs. This put people and the staff delivering their care at risk, and meant people did not always receive individualised care

Where there were care plans in place, some details were not comprehensive. For example, one person was having milkshakes to assist with their weight loss. Though we found the person was receiving these, their nutrition care plan made no reference to this. The care plan stated to encourage food 'little and often', however, their daily records were not consistently completed by staff to show what food the person was offered and how much they had eaten. Therefore records were not accurately or consistently completed to monitor people's progress. Additionally, the registered manager confirmed that people were not routinely involved in the development or review of their care plans.

Staff told us they did not think they could always be responsive to people's needs. One staff member said, "We need more time in the evenings. Some people have dementia, and this affects them more in the evening, we need to keep an eye on the 'sundowners' later in the day to make sure they are safe." (Sundowning is a symptom of Alzheimer's disease and other forms of dementia, where confusion and agitation may get worse in the late afternoon and evening)." Another said, "A lot of people want to go to bed at the same time. The impact of this is that someone has to wait which isn't fair. We don't have time to sit and chat with people, and just have fun."

All of the above constitutes a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people did have care plans in place, these outlined the support people needed in relation to personal care, how they mobilised, communication, mental health, continence, activity, skin integrity and nutrition. We also found there were 'About Me' summaries at the front of people's records which gave a good overview of people's needs, which included their likes and dislikes, personal care, and social activity preferences.

The service benefitted from an activity co-ordinator who had been in post for six months. They told us that they knew people well, and demonstrated this by telling us about people's life histories and jobs they had been employed in when they were younger. We saw that 'memory frames' had been created and displayed in people's rooms. Family members had brought in photos of their relatives in their younger days, and the activity co-ordinator had created the memory frame, which showed the person in their youth, sometimes dressed in war time uniforms.

Outside entertainers came into the service monthly and provided singing and dancing and themed parties, such as afternoon tea. There was not an activity schedule in the service for day to day events so people

could see what activities were taking place and when. The activity co-ordinator told us they were aiming to devise a schedule which people will give their views on, and display it in the communal areas.

We observed an activity taking place in the morning. Music was playing and several people were joining in with tambourines and other musical instruments. On both afternoons we did not see any activity taking place. We observed that the activity co-ordinator was at times assisting care staff, and this impacted on their time to provide activity.

We asked people their views on the activity provision. One person said, "There is bingo on a Tuesday, there isn't anything else to do, I do get bored, we had someone come and sing one day and we do have party days which I enjoy." Another said, "Nothing goes on in here, I wish there was something I could do but there isn't." A third said, "I like to have a go at anything but they [staff] seem to be so busy lately with caring they haven't had time to do much in the way of activities. My family come and we play cards sometimes." A relative said, "In the afternoons is a bit boring for [relative] there is not enough going on, [relative] has got a good mind still and is switched on."

The activity co-ordinator had spoken to people about their preferences for activity and was hoping to provide more structure for people. However, we were concerned this was not meeting the individual or specialist needs of people, for example, those with dementia. We were also concerned that people who did not wish to leave their rooms, or who were cared for in bed, were not receiving 'one to one' activity time. Improvements were required to prevent social isolation. This is particularly important where people are developing, or living with dementia. Additionally, the activity co-ordinator was working Monday to Friday, 8:00am-2:00pm. It was unclear how the service would promote activity and engagement outside of these times, and was an area which required further consideration to ensure it was meeting the individual and specialist needs of all people.

The service had a complaints procedure in place should people or relatives want to raise concerns. We saw that the service had recently received a complaint from a relative, and showed us a letter they had written in response to this. We asked people if they knew how to complain. One person said, "I would speak to [registered manager] but I have no complaints." Another said, "If ever there is a problem you speak to [registered manager] that's the rules." A relative said, "I would contact the manager if not the deputy, but I have never had an occasion or the need where I have had to."

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post who was supported by a deputy manager, assistant manager and admin manager. The registered provider visited the service twice a month. During the inspection the registered manager was open and transparent about how the service was run, and their failure to recognise obvious risks to people's safety. This included inaccurate risk assessments, poor infection control, documentation and record keeping. The registered manager had been in post for over five years and held qualifications in dementia studies and education and training.

There were no quality assurance systems in place to continually monitor the service provided to ensure people received safe and effective care. There were no quality assurance audits being carried out routinely with regard to checking documentation, for example, care plans, daily records, or MAR charts. As a result the management team were unable to demonstrate how they monitored the quality of the service to make sure the overall management of the service was safe and effective. The lack of any formal monitoring or auditing meant that issues relating to people's care and treatment were missed and risks of potential harm were not being mitigated as far as possible.

We looked at accident and incident reporting. Information had been documented, but was not always completed fully, for example, the time of the day a person fell, which could be used to identify trends. Many of the incidents did not include actions that had been taken, or lessons learned. The information documented was not being monitored or used as an opportunity to identify themes and recurring trends thereby limiting future occurrences. One person injured their leg on equipment which could have been identified as a potential risk if this had been assessed by staff. We found that following the injury suitable preventative measures had not been put in place to reduce a recurrence.

Shortfalls in record keeping relating to care plans, risk assessments, and MAR charts had not been identified by the management team. No checks were being undertaken to ensure records were accurate and complete.

Risks in relation to the water system were also not being monitored fully despite clear guidance form environmental health in November 2016. Given the service had recently been advised that the water system was providing the idea environment for legionella growth, this had not prompted the management team to ensure robust checks were in place as they had not been monitoring the cold water temperatures. Therefore preventative measures were not being carried out in line with health and safety guidelines.

Work that staff had completed was not being checked by the management team to ensure they were competent to carry out their roles. The registered manager told us they simply 'trusted' staff to do their work rather than check the quality of it. There were no assessments to support the learning gained at the service, for example, medicines and assessment of risk, to ensure staff were competent. This resulted in errors where we found inaccurate and poorly completed risk assessments and medicine records. The services Statement of Purpose says; "All members of staff are required to attend training in dementia care, and MCA DoLS". No staff had received recent training in these areas, so were not aware of their responsibilities in relation to this.

Staff told us that staff meetings were not held regularly in the service and that communication needed to improve. One staff member told us, "I think [registered manager] is good, but communication definitely needs to improve. We [staff] work well as a team, but important information is not always passed on." Another said, "A communication book would be good, as things get missed. I've raised this a few times with [registered manager] but nothing has happened. I do wish they would listen more." A third said, "[Registered manager] is approachable, but I think they need to listen to us [staff] more. I don't feel valued in my job."

The provider and registered manager had failed to recognise potential harm to people using the service, and their non-compliance with regulatory requirements. All of the above constitutes a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to and following the inspection we reviewed the information we held about serious incidents within the service. We found that the registered manager had not always completed appropriate notifications about incidents that had taken place. A statutory notification is a notice informing CQC of significant events and is required by law. During the inspection we became aware of incidents, such as serious injuries, that had not been reported to CQC as required by law.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The service had issued surveys in July 2017 where people and relatives were asked for their feedback in relation to their care. 11 people had returned these, but had not yet been reviewed fully by the management team. Feedback was mainly positive, however, people wanted more to do in the afternoons. One person commented, "I'd like more to do in the afternoons", and "Be nice to go out for the day." Relative feedback was also mainly positive, however, some relatives commented that the building was 'tatty and not clean'.

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager had not informed us of serious incidents which had occurred in the service. 18 (1) 2 (a) (ii)

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 The service did not have appropriate arrangements in place for obtaining and acting in accordance with people's consent in line with MCA 2005 DoLS safeguards. 11 (1) (3)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Staff did not have accurate and up to date information on people's needs to refer to. 9 (1) (a) (b) (c) (3) (a) (b) (d)

The enforcement action we took:

Notice of Proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Risks were not always identified and managed so as to ensure people's safety and wellbeing. Clear and accurate records were not being kept of medicines administered by staff. This meant we could not be sure people were always given their prescribed medicines. Infection control systems were not in place. 12 (1) (2) (a) (b) (g) (h)

The enforcement action we took:

Notice of Proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The service did not have systems in place to monitor the quality and safety of the service. 17 (1) (2) (a) (b) (c) (e)

The enforcement action we took:

Notice of proposal