Ivybank Health Care Limited

Ivy Bank Residential Care Home

Inspection report

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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

We undertook an unannounced inspection of this service on 7 March 2017.

Ivy Bank is providing residential and dementia care for up to 27 people. Residential accommodation is situated over two floors; there are 25 single rooms, with ensuite facilities, and one double room. A lift is situated near the dining area for people to access both floors. There is a shared lounge and dining area, and an additional smaller lounge on the ground floor. At the time of inspection there were 23 people living at the service.

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

The provider and registered manager had failed to ensure that the service was compliant with the regulations. After the previous inspection in February 2016, the provider sent us an action plan to address four breaches in the regulations. They told us they would be compliant by April 2016. At the time of this inspection the requirement notices had not been met, therefore there were four continued breaches of the regulations.

The registered provider and registered manager had failed to ensure that the checks and audits carried out by staff were effective; these had not identified the shortfalls found at this inspection.
Potential risks to people were identified; however there was a lack of control measures detailed in the moving and handling, and behaviour risk assessments to guide staff on how to safely manage the associated risks.

Accidents and incidents were recorded, however we could not confirm that appropriate action had been taken to investigate and look for patterns or trends, to prevent further occurrences.

The provider had made some improvements to the premises, and a maintenance and redecoration plan was in place. A recommendation was made with regard to seeking advice and guidance of how to design areas to be more dementia friendly.

Checks had been carried out regularly on the environment and equipment, however when there was a fault with a dial on a pressure relieving mattress the fault had been recorded but there was no record of the action taken. The systems to reduce the risk of fire were checked and staff had a clear understanding of what action to take in the event of a fire.

Medicines were not stored in line with current legalisation and there were no protocols to ensure that people received their 'as and when' required medicines when they needed them.

People were supported to access health care appointments and relevant health professionals were requested as required.

There were no mental capacity assessments in place and there was a lack of professional meetings to ensure that decisions were made in people's best interests.

Nutritional needs had been assessed but there was a lack of accurate monitoring of fluid charts to ensure people had enough to drink. The recommendations made by health care professionals with regard to the consistency of people's meals was not being followed.

Staff did not always uphold people's dignity, when supporting them to eat and drink. Staff treated people with kindness, encouraged their independence and gave them choices. Staff responded to people promptly when they needed help but there was a lack of interaction from staff during the morning. This improved in the afternoon when activities for some people were provided.

People's needs were assessed before they came to live at the service, however one person had been living at the service for over two weeks and their care plan had not been completed. People's care plans were not personalised to ensure they received care in line with their choices and preferences. Care plans were not always updated with current needs.

Although people's preferred hobbies and pastimes were recorded in their care plans, the activities were not structured around people's preferences. Relatives told us they were there was a lack of activities at the service.

There was a system in place to process complaints but this was not in a format accessible to people. There were mixed views from relatives, some thought there were no concerns, whilst others felt their concerns were not always acted on. We have made a recommendation about the management of complaints.

There was a lack of regular one to one meetings with staff and yearly appraisals so staff did not have an opportunity to discuss their performance, training, and development needs. Staff had received training in how to keep people safe and safeguarding procedures were in place to keep people safe from harm.

Relatives told us that there had been some changes in the staff team but there were sufficient staff on duty at all times to meet people's needs. Staff were recruited safely and there was a training programme in place to ensure that staff had the skills and competencies to carry out their roles.
People and relatives had been sent surveys to comment on the quality of the service, and positive feedback about the service had been received. However, these had not been summarised to show how the outcome would be used for the continuous improvement of the service.

Records were not always completed fully, such as the outcomes in the risk assessments, and the induction training records.

We found four continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and two additional breaches at this inspection. You can see what action we told the provider to take at the back of the full version of this 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 not always safe.

Risks to people were assessed but there was not always clear guidance in the care plans to make sure all staff knew what action to take to keep people as safe as possible.

Medicines were not being stored in line with current practice and there were no protocols to ensure people were receiving their 'as and when' required medicines when they needed them.

Checks on the environment had been carried out to make sure the premises were safe.

Staff understood the process of how to report and action allegations of abuse to protect people from harm.

People were supported by sufficient numbers of staff and recruitment procedures had been followed to ensure staff were safe to work at the service.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff understood that people should make their own decisions; however, there were no formal mental capacity assessments linked to
making specific decisions.

The programme of supervision was not up to date and staff had not received an annual appraisal.

Staff received sufficient training to ensure they had the skills and competencies to carry out their role.

Systems in place to monitor if people had enough to drink were not clear to show how staff encouraged people to drink enough to keep them healthy.

People were supported to maintain good health and had access

to health care professionals when needed

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always interact with people in a dignified manner.

People and their relatives told us that staff were polite and respectful.

Staff knew people well and knew how they preferred to be supported.

People and relatives told us that staff treated people with kindness and compassion.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not personalised and did not have the required information to ensure people received the care they needed.

There was a lack of meaningful activities to encourage people to maintain their hobbies and interests.

People and their relatives said they would be able to raise any concerns or complaints, however there were mixed views from relatives that their concerns were listened to, and acted on.

Is the service well-led?

Inadequate

The service was not well led.

The registered manager and provider had failed to comply with requirement notices issued at the previous inspection in February 2016. There were four continuous breaches in the regulations.

The provider and registered manager told CQC they would be compliant by April 2016 but the timescales had not been adhered to.

The checks and quality audits on the service had not identified the shortfalls at this inspection.

Records were not always accurate and completed fully.

Staff understood the visions and values of the service and told us the provider and registered manager were approachable, and very supportive.	

Ivy Bank 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.

We undertook an unannounced inspection of this service on 7 March 2017. Some people were not able to explain their experiences of living at the service to us due to their dementia. We therefore used the Short Observational Framework for Inspection which is a way of observing care to help us understand the experience of people who could not talk with us. The inspection was undertaken by two inspectors.

Before the inspection we reviewed the information we held about the service. A Provider Information Return (PIR) was submitted by the service before the inspection. 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 gathered and reviewed information about the service before the inspection, including notifications. A notification is information about important events, which the provider is required to tell us about by law.

We reviewed a range of records. These included five care plans and associated risk assessments, and environmental risk information. We looked at recruitment information for five staff, including one who was more recently appointed; their training and supervision records, in addition to the training record for the whole staff team. We viewed records of accidents/incidents, complaints and records of some equipment, servicing information and maintenance records. We also viewed policies and procedures, medicine records and quality monitoring audits undertaken by the registered manager and provider. We spoke with four people, five relatives, seven staff, the cook, registered manager, deputy manager, and provider. We also spoke with two health care professionals.

We last inspected this service on 29 February 2016, when there were four breaches in the regulations.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the service. One person said, "Yes I feel safe here, the home is safe". A relative said, "My relative is safe here, I have had no reason to doubt the staff".

At the last inspection in February 2016, the provider did not have sufficient guidance for staff to ensure that potential risks to people were identified and managed regarding moving and handling, risks to people's skin and their behaviour. The provider had failed to mitigate risks in relation to proper and safe management of medicines. Fire drills were not being carried out, there were no environmental risk assessments in place and water temperatures had not been recorded. After the inspection the provider sent us an action plan telling us how they were going to improve and told us they would be compliant by April 2016.

At this inspection we found that some improvements had been made, such as environmental risk assessments were in place, and fire drills had been carried out. However, the risks to people had not always been minimised, and there remained shortfalls in the safe management of medicines. Not all of the shortfalls identified had been actioned; therefore the provider remained in breach of the regulations.

Care plans to support people with their behaviour were not detailed to guide staff how to positively support people and reduce their anxiety. One person's plan stated 'I cannot always communicate how I feel pain or illness. All the staff to monitor my facial expressions and body language and I can hit out at times'. There was limited guidance to tell staff how to support the person and no further information as to any known triggers or strategies to minimise their future occurrence.

When people became distressed some staff responded calmly and helped the person to become calm. Talking to them about what they wanted and reassuring them. Other staff appeared unsure how to support people and had to call on other staff or the registered manager to help people calm or redirect them.

Another person could behave inappropriately towards other people and remove their clothes in communal areas. An incident form stated that staff had asked them not to do this as it was inappropriate in the lounge. This person was living with dementia and may not fully understand this instruction. There was no other information to guide staff how to safely manage this person's behaviour.

A moving and handling risk assessment stated, 'this person doesn't get out of bed very often when they do they are hoisted by two carers with a full body hoist'. There was no information to guide staff how to do this safely and what the size the sling should be. Another person's care plan said 'mobilising is very restricted due to arthritis, two carers required to assist to mobilise and transfer.' There was no further guidance to show staff how to do this safely and in line with the person's medical condition.

People's skin and pressure areas were not managed consistently. Risks to peoples' skin, such as the development of pressure ulcers, had been assessed; however there was no further guidance in the care plans to reduce the risks and ensure people's skin remained as healthy as possible. On 25/01/2017 a body chart had been completed for one person to identify they had developed a pressure area on their left side of

their bottom. There was no further information in the handover notes or care plan to show what action staff had taken to ensure this was treated and ongoing plans to reduce the risk of this happening again.

When people had fallen, accident forms had been completed but the action taken was not consistently recorded to show the care and treatment being provided. One person, who was prone to fall, had five falls in February. The registered manager told us that the staff should complete a body map detailing any injuries; record what treatment the person had received in the health care professional's form and daily notes in the care plan. In addition, if the person's needs changed to update the falls risk assessment. This process was not completed for any of the five falls as records were not completed to clearly show what action had been taken to make sure this person was as safe as possible.

The registered manager told us that action had been taken as the person had been referred to the fall clinic for assessment on 6/2/2017 and had since been seen by the physiotherapist. The person was a high risk of falls, and their falls risk assessment in the care plan had been reviewed on 9/2/2017. The falls risk referral was made on 6/2/2017 and the physiotherapist had been contacted on 10/2/2017 but there was no information how staff were to manage and reduce the risk of this person falling again. The person had fallen twice since the referral. Staff told us there were aware of monitoring and checking this person regularly but this had not prevented the continued incidents/accidents. There had been no further reviews to consider whether different actions could be taken to reduce the risk of this person falling.

Health care professionals had recommended that a person was to have their meals pureed. This was clearly recorded in the professional notes and in the person's care plan to reduce the risk of choking, but the eating and drinking check list recorded that the person never choked during or after a meal/drink. At lunch time this person was assisted to eat by one member of staff and the meal was mashed and not pureed. The staff member thought that this was the correct consistency for the person. Staff did not, therefore, have clear guidance to follow to ensure this person was supported to eat safely.

Environmental risk assessments were now in place and checks had been carried out regularly on the environment and equipment, however when issues arose there was no record of the action taken. For example, checks relating to pressure relieving mattresses, which reduce the risks of people's skin breaking down, had been checked daily to ensure they were on the correct setting for each person. If the setting is not correct this can reduce the effectiveness of the equipment. One mattress was recorded as having a loose dial every day since October 2016, the registered manager told us she had contacted the appropriate company and requested someone come to mend the dial. There was no record of this action on the checklist.

There were systems in place for the ordering, receipt, storage, administration, recording and disposal of medicines. However, records showed that staff were not bringing forward the stock of medicine each month to ensure that they were able to check the correct amount of medicines were given. The medicine room was over stocked with medicines that had been ordered each month but not returned. This included some medicines which had specific procedures to follow with regards to their storage. The medicine room floor required cleaning to reduce the risk of contamination.

Bottles and tubes of medicine had not always been dated when they were opened to ensure staff were aware that these items were only effective for a short period of time.

Medicine charts had not always been accurately completed, during the night of 5/3/2017 one person's medicines had not been signed for. The medicine was administered from a pod system and there was no medicine left in the pod for that day which indicated the person had taken them but there was no signature

on the record to confirm this.

Some people were prescribed medicines on an 'as and when' basis such as medicine to reduce their anxiety, and pain relief. There were no protocols in place to guide staff when people may exhibit negative behaviour or be in pain to indicate that they may need this medicine.
The provider had failed to mitigate risks in relation to proper and safe management of medicines, the premises and the health and safety of people. This was a continued breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff confirmed and records showed that the temperature of the fridge had been consistently taken and when it was out of range the fridge had been defrosted and was now within the required range. The record of the room temperature was not available; therefore the registered manager was unable to check that the medicines were being stored at the correct temperature in line with current legislation. The registered manager told us that this had been recorded regularly, but there were no records to confirm this. The registered manager also told us that they had arranged for a medicine audit from the local pharmacy to be carried out by the end of March 2017.

The provider and registered manager told us they were aware of the shortfalls in the risk assessments and were in the process of updating and changing the format of the care plans to address these issues. The registered manager had started to complete two care plans with detailed information to address these issues. The service had also being supported by the local mental health team to improve the behavioural risk assessments. At times, staff were observed supporting people positively with their behaviour but on other occasions staff requested assistance from senior staff or the registered manager to make sure people received the right support.

At this inspection the systems in place to reduce the risk of fire had improved. Regular checks had been made of the fire equipment and people had personal emergency evacuation plans which told staff what support people would need to leave the premises in the event of an emergency such as a fire. Fire drills were carried out on a regular basis. Water temperatures were monitored weekly by staff and three monthly by an external company, records were kept and temperatures were within the correct range to reduce the risk of scalding. Staff were provided with information about actions to take in an emergency and had emergency numbers to call if necessary.

The provider had made some improvements to the premises, such as replacing the cooker, and flooring. There was a maintenance plan in place and a plan of redecoration. The maintenance person was working later in the evening to ensure people were not disturbed during the day time. There were areas of the service which needed to be cleaned such as the carpet in the lounge. The registered manager told us that this carpet had been replaced since the previous inspection and was due to be steam cleaned.

Staff had completed training in relation to keeping people safe from abuse. They could tell us about different types of abuse and who they would speak to if they had any concerns. Staff understood they could talk to outside agencies such as the local authority or the Care Quality Commission if the service did not take action. There was a policy in place which gave staff guidance about prevention of abuse and what the service would do in the case of any allegations. The registered manager was aware of their safeguarding responsibilities and worked with the local authority to ensure people were protected.

Staffing levels were based on people's needs. A relative said, "There is always a member of staff around". There were sufficient staff on duty to ensure that people were supported. Some people chose to stay in their rooms and staff were allocated to different areas of the service to ensure they were nearby if people needed

them. In addition to care staff there was a cook and a domestic staff on duty. Relatives told us that there was enough staff on duty and people received the care they needed.

Since the previous inspection a number of staff had left the service including some senior staff. Health care professionals told us that they had concerns as experienced staff had left the service. The registered manager told us that they had recruited new staff to fill the gaps and the service was fully staffed. The staff rota showed that staffing levels were consistent and staff absences were covered. There were clear lines of accountability, with a senior member of staff on duty on each shift.

Recruitment checks were completed to make sure staff were honest, trustworthy and reliable to work with people. These checks included written references, proof of identity and a full employment history. Disclosure and Barring Service (DBS) criminal record checks had been completed before staff began working at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services. Staff had to complete a probation period to ensure they had the right qualities and skills to work at the service.

Requires Improvement

Is the service effective?

Our findings

People told us that the staff ensured they saw a doctor if they needed to. Relatives told us that they were kept informed of any health care changes in their relative's care.

Established staff had completed Mental Capacity Act 2005 (MCA) training and new staff were booked to attend the training in April. However, there was a lack of understanding of how to assess and apply the principles of the MCA.

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 decisions made on their behalf must be in their best interests and be 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). We checked whether the service was working within the principles of the MCA.

Some people were constantly supervised and/or had restrictions in place to keep them safe. In some cases, the registered manager had made applications to the local authority for a DoLS authorisation for these restrictions but these had not yet been authorised. However, the registered manager had not assessed people's capacity, before applying for the DoLS to check whether they had the capacity to consent to the restrictions In which case a DoLS application may not be needed. The registered manager told us that they were in the process of implementing a form to assess if people could make less complex decisions but these were not in place at the time of the inspection.

One person wanted to leave the premises and was standing by the front door with a member of staff telling them they wanted to go. The staff member called for a senior staff member to support them as they were not able to distract the person from wanting to leave the premises. The registered manager went to the door and calmed the person who came back into the lounge. There was no mental capacity assessment or DoLs authorisation in place for this person and the registered manager had not applied for one. There were no details in the care plan to guide staff how to safely deal with this situation effectively to ensure that the least restrictive options were in place.

Care plans recorded that relatives had consented for people to use bed rails, but there was no evidence to confirm how people had agreed to this and if it was in their best interests. Another person's care plan stated. 'I am unable to take my medicine whole. I can take them covertly (when medicines are administered in a disguised format, for example in food or in a drink, without the knowledge of the person receiving them) as agreed by my GP. I like it to be crushed then I like it to be added to some orange squash'. There was no evidence to confirm a best interest meeting had been held with health care professionals to show how, why

and when this decision had been made.

The provider had failed to assess people's mental capacity to make specific decisions and/or apply for authorisations to deprive people of their liberty in line with the Mental Capacity Act. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Before people received any care or treatment they were asked for their consent. We overhead staff supporting a person to get up and dressed, asking them if they could help them and give them choices about the clothes they wanted to wear.

At the last inspection in February 2016, there was a breach of regulations in relation to staff not receiving supervisions and appraisals. After the inspection the provider sent us an action plan telling us how they were going to improve and told us they would be compliant by April 2016. The shortfalls identified had not been actioned; therefore the provider remained in breach of the regulations.

Staff should have regular supervision meetings with a line manager so they can talk about any concerns or issues and their career development and training needs. Supervision also gives an opportunity for coaching and support. Some members of staff told us they had supervision but some staff did not have a recorded supervision for over 12 months and only three staff had an appraisal. Team meetings were occurring more frequently but these were generally used to give staff instructions and there was no evidence of staff being asked to give their views or suggestions.

The provider had failed to ensure that Staff were receiving regular supervision or an appraisal of their performance to identify any learning and development needs. This is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had recently had a number of staff leave and new staff had been employed. New staff members had an induction which included training in basic subjects and shadowing more experienced members of staff. They were also completing the care certificate, these are an identified set of standards that social care workers work through based on their competency.

Staff told us they felt confident in their roles and had access to training. Some staff had completed qualifications in specific areas such as palliative care or dementia, which they said helped them to meet the needs of the people they supported. Staff had the opportunity to undertake nationally recognised qualifications in health and social care and were encouraged to do so.

There was a tick list of tasks for staff members indicating if they were competent or had additional training needs. The registered manager told us that this was based on observations of staff's practice and was carried out by themselves and the deputy manager, but there were no records of the observations or feedback given to staff as a result. This was an area for improvement.

People told us that the staff supported them to maintain their health and to see the doctor when they needed to. Relatives told us that they were kept informed of their relative's health care needs. Care records showed that people regularly saw the chiropodist, dentist, optician and attended out patient's appointments when required. Referrals to health professionals were made when needed, for example, to speech and language therapists, the community mental health team and dieticians.

People had special equipment to support their skin and there were turning charts in people's rooms to reduce the risk of further pressure areas. Special equipment, such as cushions and mattresses were

provided to help prevent people developing pressure areas.

People were asked by the cook each day what they wanted to eat from the menu. However, not everyone had the capacity to make this decision. There were no pictures of meals or of the different food available to help them decide what they wanted to eat. Drinks were served after the meal and only orange squash was offered, people were not offered a choice. This was an area for improvement.

In the afternoon the cook sat and chatted to people, they brought people snacks and hot drinks of their choice when they wanted one. People enjoyed this social time. They were smiling and laughing with staff.

People enjoyed their food and were given choices. One person said, "There is lots of choice, I have cereal for breakfast, and have a choice at lunch time". "I have a special diet and the cook is really good and I get what I want". We observed the meal being served, which looked appetising..

Staff were very aware of people's likes and dislikes and told the cook was very familiar with people's different choices. People who had reduced appetites, or were at risk of losing weight, were offered foods that were fortified, with butter and cream, to provide them with extra calories. Health professionals, such as dieticians had been involved in the assessment of some people's nutritional needs and people were prescribed special shakes to supplement their diet.

Requires Improvement

Is the service caring?

Our findings

At times, staff were very kind and caring, however, sometimes we observed people's dignity was not always respected.

One person was left wearing a tabard over their clothes between breakfast and lunch despite not eating or drinking. When supporting people with their lunch staff offered to cut people's food for them, but did not wait for a response before starting to cut the meal. Some people needed support to eat their meals; staff put food into people's mouths without explaining what they were eating. They did not chat to people or interact with them at all throughout the meal.

People were supported to sit at the tables and wait for lunch which took over 15 minutes to be served. This resulted in people becoming anxious and asking for their meals. One person tried to leave the table twice until a staff member spoke quietly to them and reassured them the dinner was on its way.

People were not always spoken with in a respectful clear manner. Two members of staff, whose first language was not English, were supporting a person from the table to their chair. They were taller than the person who was bent over; they were not speaking with the person but spoke to each other in their own language. We discussed this with the registered manager who told us they were new staff and this would be discussed with them as soon as possible.

People's personal information was stored safely. However, we overheard a member of staff discussing a person's behaviour in the communal area which was not in a confidential manner.

People were not always treated with dignity and respect. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People and relatives thought the staff were kind and caring. One person said, "The staff here are all very nice". Relatives said, "The staff are just wonderful, they treat my relative with kindness, they are gentle and respectful". "The staff treat my relative with privacy and dignity. They always knock on the door, and pause before entering".

Experienced staff appeared to know people and their preferences well. Staff chatted to people and were heard laughing and joking. Relatives told us, "They know my loved one well and I know they care about them. My loved one went through a stage of being unwell, the staff encouraged them to get up and socialise rather than just stay in bed. I think that really helped them get better."

People were addressed by their chosen name and staff were seen offering some choices to people, such as what they wanted for dinner. However, when morning tea was served, people were just given their tea and were not given a choice if they wanted anything else. We also observed that some staff did not always greet people when they walked through communal areas.

People had an allocated key worker. Key workers were members of staff who took a key role in co-ordinating a person's care and support and promoted continuity of support between the staff team. The key worker system encouraged staff to have a greater knowledge, understanding and responsibility for the people they were key worker for.

Care plans had a brief outline of people's lives before they came to live at the service and staff knew people and their relative's well, so they were aware what was important to them.

People were able to choose where they wanted to spend time, in the communal areas or time in the privacy of their bedroom. They were also asked if they preferred a male or female member of staff to support them with their personal care. People's rooms were personalised with photographs, cuddly toys, ornaments and some had stencils on the walls.

Visitors were welcome in the service and there were no restrictions as to when they could call. Relatives told us they were made welcome when they visited, and offered refreshments.

Staff ensured people's privacy was maintained, by carrying out personal care discreetly in their rooms.

Staff told us how they made sure curtains and doors were shut, they spoke with people to let them know what tasks were to be carried out and how they covered people when they were supporting people with their personal care.

People's religious beliefs were supported. The service had developed links with local church groups and the local vicar visited the service on a regular basis. Advocacy services were available, but no one living at the service currently required this support. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in February 2016, there was a breach of regulations in relation to the lack of personalised care planning to ensure that people's preferences and choices of how they received their care were fully met. After the inspection the provider sent us an action plan telling us how they were going to improve and told us they would be compliant by April 2016. The shortfalls identified had not been actioned; therefore the provider remained in breach of the regulations.

Before people moved into the service a pre-admission assessment was completed to ensure that the service was able to meet people's individual needs and wishes. One person had moved into the service on 20/2/2017 and there was information from the hospital to identify what care this person needed. However, the care plan and risk assessments had not been completed to guide staff how to meet this person's needs. There was limited information about their personal care such as 'needs assistance with all personal care' and there were no details of what this person could do for themselves to maintain their independence.

Other plans lacked detail of how people preferred to receive their personal care, for example, one plan stated 'two carers to assist with personal care' but there were no details of how this person preferred to be supported, what they could achieve for themselves or what their preferences and choices were. There was, therefore, a risk that people were not receiving consistent safe care that was responsive to their needs. One relative told us staff knew their relative well and supported them to have their preferences and choices, however these details were not always reflected in the care plans.

Some staff had a good knowledge of people's needs but less experienced staff did not. One person who was living with dementia would wander into other people's rooms; some staff observed them and intervened if they tried to enter bedrooms, but when other staff were in the lounge area they did not notice until it was pointed out to them by an inspector.

Staff described to us what people were able to do for themselves and how they met their needs in the ways they preferred, but this was not fully detailed or recorded in the care plans. The records of people's personal history varied, some were very brief therefore staff did not always have full
details of what was important to people.

One person's care plan stated they could not hold a conversation, and on occasions could be anxious, agitated, tearful and shout. The plan stated 'I can also become worried if no one talks to me when they are supporting me with everyday needs". This person's first language was not English, but there were no clear guidelines of how to communicate with them effectively. Staff told us that the person could understand English and they knew the person well but this information was not recorded in their care plan. At lunch time a member of staff was supporting them but there we did not observe any conversation.

One person was living with epilepsy and there was generic information in their care plan about the condition, however, there was no further guidance for staff about how or what they should do if the person had a seizure. Health care professionals told us that they could not be sure their advice was acted on as

there was a lack of details in the care plans to show how people's needs were being met.

Although care plans had been reviewed they were not always updated with people's current needs. For example, one plan was contradictory saying the person was to be hoisted by two staff for transfers when the person was being cared for in bed. Staff told us they used slide sheets to support the person to move in bed but this was not recorded in the care plan.

During the afternoon staff sat with some people at the table chatting and colouring pictures, but no other activities had been planned for people who were not able to do this. Some people stayed sitting in their chairs or in their rooms. People were not routinely asked if they wanted to go on outings. One relative said, "We were told people go out and about, and have lots to do but that isn't what we see. People rarely go out and the activities are few and far between."

There were no dedicated hours for an activity co-ordinator. The registered manager told us that they were in the process of recruiting an activities co-ordinator but meanwhile staff were supporting people with activities. There were, on occasions, people who visited the service to provide entertainment, such as 'music for health' and sport activities. Although people's preferred hobbies and pastimes were recorded in their care plans, but the activities were not structured around people's preferences.

At the last inspection in February 2016 the registered manager told us that they would review the format of the care plans and would introduce a new format to ensure the plans were person centred, however, only two care plans had been started at the time of the inspection.

The care plans were not person centred to ensure that people's preferences and choices of how they received their care were fully met. People were not involved in regular activities of their choice. This was a continued breach of Regulation 9(3) (b) and 9(3)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Relatives told us they were involved in their relatives care. One relative told us how they had discussed their loved ones care plan in all areas of care including their dietary needs. A relative said, "When the care plan needs updating I am invited to attend the review".

A staff member said , "We really do care about people, it is amazing to see how people respond. One person was really agitated and angry when they came here. We worked with the local mental health team and had their medication reviewed, it has made such a difference to them and us. They are very happy now and you can really see their sense of humour." The person could be seen taking part in activities, they were engaged, joking with staff and their peers.

Some relatives told us that the care staff were responsive to their relative's needs, whilst others felt that some staff, whose first language was not English, were not as responsive as they could be. They were concerned that their relatives, living with dementia, would not be able to understand what they were saying to them. We observed that some staff did speak over people in their own language whilst supporting them with their care. People seemed to accept this practice as the staff also spoke with them in English. We told the registered manager who said they would address this and speak with the staff concerned.

There was always a member of staff in the lounge to respond to people's needs, but people sat in their armchairs with little interaction from staff. The television was on, but muted, and there was music playing in the background. To the side of the lounge there was a small table where staff completed care plans and took telephone calls. This did, at times, contribute to increased noise levels in the lounge where most of the

people in the service relaxed. Poor design of areas can impair memory, reasoning, learning and cause stress to people living with dementia. When staff were sitting in one area of the lounge they could not see what was happening in the other section. During the morning a person asked to sit where they could see the television in the lounge, the staff moved a chair for them which then partially blocked a passage way. Some people who were living with dementia became confused when they could not pass through.

It is recommended that the provider reviews the design of the communal areas in line with current guidance. Detailed advice on dementia friendly design can be obtained from the Dementia Services Development Centre at the University of Stirling at http://dementia.stir.ac.uk

There were mixed views from relatives about complaints, One relative told us that they had no reason to complain and had never felt 'cross' about anything in the service. Other relatives told us although staff were kind, they sometimes felt that their concerns were listened to, and not always acted on. They said, "We sometimes have to raise things a number of times before they are addressed. It can be frustrating, especially when people agree with you that things need to change but when you next visit they remain the same. Things have improved lately and I hope that continues."

There was a complaints policy in place but this was kept in a folder in the office and was not in a format accessible to people or on display in the premises. The registered manager and provider told us that people and their relatives were encouraged to complain or raise any issues. However, we were aware that a relative had raised concerns recently but these had not been recorded. There was no evidence to confirm if the person who raised the concern was happy with the outcome.

We recommend that the service seek advice and guidance from a reputable source, about the management of and learning from complaints.

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Staff felt confident to pass complaints they received to the registered manager and action would be taken if needed. There were positive compliments from the families of people who were no longer at the service. They said, "Thank you for all the support over the last couple of years, I have always felt welcome and supported." and "Thank you for the love and compassion each of you showed my relative."

Inadequate

Is the service well-led?

Our findings

At the previous inspection in February 2016 there was a breach of regulation related to a failure to identify shortfalls in the service through regular effective auditing. After the inspection the provider sent us an action plan telling us how they were going to improve and told us they would be compliant by April 2016. They also made a commitment during the previous inspection to address all the shortfalls identified during the inspection, to make sure that people received a good, safe service at all times. The shortfalls identified had not been actioned; therefore the provider remained in breach of the regulations. At this inspection this had not improved, although audits had been completed by the registered manager they had not identified the issues we found at inspection. A tick chart of the documents reviewed was completed monthly but there were no records of issues identified or actions taken.

Accidents and incidents were recorded but not analysed to look for patterns and trends. The recording of the incidents was not accurate to show that appropriate care and treatment was provided and what actions should be taken to reduce the risk of further events. One person had fallen a number of times. These incidents had not been analysed to look for any themes, for example, the time and place they occurred. This could help make changes to prevent further falls.

There continued to be a lack of staff supervision, medicines were not managed safely and there was a large amount of medicine stock held. Staff were not given the guidance required to minimise the risks to people and care plans did not have the detail needed for people to have consistent, safe support.

Relatives and professionals were asked for their views on the service but the information received was not analysed and people were not made aware of the results. There was no formal feedback sought from people who used the service. This was an area for improvement at the previous inspection and had not been addressed. Relatives told us that they had not attended any relatives meetings to give their views.

Records were not always completed fully, one person did not have a completed care plan although they moved into the service two weeks before. there were gaps in the medicine records, and a lack of recording when people had accidents/incidents in daily notes and health care professional records.

The provider had not ensured that they were compliant with the fundamental standards and all of the regulations. The action plan the provider sent to CQC after the previous inspection in January 2016 stated that they were compliant with these regulations in April and May 2016. However, at the time of this inspection there remained four breaches and a further two breaches of regulations were found.

The provider had failed to take appropriate action to mitigate risks and improve the quality and safety of the service and records were not always accurate or completed. This was a continued breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Relatives told us that the registered manager was approachable and was knowledgeable about the service. One relative told us they would recommend the service.

Staff told us that the management team were very supportive and worked with the staff to provide the service. One staff member, "I love my job and feel very supported by the management. I can tell them what I think and they do listen."

The provider and registered manager told us that they were in the process of implementing new care plans and there was an action plan to address these issues, however the actions taken were in the early stages. Two care plans were in the process of being reformatted and mental capacity assessments were being implemented (although there was no evidence of this at the time of the inspection.) They told us that the staff were to have person centred care planning training and they were being supported by the local specialist nurse to improve their practice.

The registered manager told us that they had a number of new staff recruited since the previous inspection and they were working with the team to ensure they were aware of their roles and responsibilities. Staff understood the visions and values of the service, they told us they wanted to support people to be as independent as they could and to treat them how they would want to be treated themselves.

The service was a member of The Enabling Research in Care Homes (ENRICH) initiative and Research Ready Care Home Network Research Ready Care Home Network which aims to improve the consistency of support for research outside the National Health Service. The registered manager had information about dementia and provided relatives with a book of top tips for carers and families of people living with dementia.

Services that provide health and social care to people are required to inform us of important events that happen in the service. The registered manager had informed us of events in a timely way and had taken appropriate action following any incidents.

At the time of the inspection the rating from the previous inspection was not displayed. The provider emailed CQC the day after the inspection to confirm the rating was now displayed in the hallway.

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	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to assess people's mental capacity to make specific decisions and/or apply for authorisations to deprive people of their liberty in line with the Mental Capacity Act.

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 This was a continued breach of Regulation 9. The care plans were not person centred to ensure that people's preferences and choices of how they received their care were fully met. People were not involved in regular activities of their choice.

The enforcement action we took:

A Warning Notice was served as this was a continued breach of Regulation 9

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment This was a continued breach of Regulation 12. The provider had not taken steps to mitigate risks in relation to proper and safe management of medicines, the premises and the health and safety of people.

The enforcement action we took:

A Warning Notice was served as this was a continued breach of Regulation 12

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance This was a continued breach of Regulation 17. The registered person had failed to identify the shortfalls at the service through regular effective auditing. Records were not always completed or accurate.

The enforcement action we took:

A Warning Notice was served as this was a continued breach of Regulation 17.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing This was a continued breach of Regulation 18.

Staff were not receiving regular supervision or an appraisal of their performance to identify any learning and development needs.

The enforcement action we took:

A Warning Notice was served as this was a continued breach of Regulation 18.