HC-One Limited

Oaklands (Essex)

Inspection report

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28 February 2017

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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

The inspection was completed on 20, 21 and 28 February 2017 and was unannounced.

Oaklands (Essex) provides accommodation and personal care for up to 55 older people who may have care needs associated with living with dementia. There were 37 people living at the service at the time of our inspection. The service does not provide personal care.

The service is required to have a registered manager however there was no registered manager at the time of our inspection. 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.

Overall we found that the quality assurance systems and processes in place were not effectively robust to ensure the health, safety and well-being of people using the service and to drive improvements. The registered provider lacked oversight of the service and there was poor quality monitoring. Some of the concerns found at our previous inspection on 27 and 30 September 2016 continued to be areas of concern at this inspection.

Improvements were required to ensure the management of medicines was safe. Improvements were also required to ensure that all care records were accurate and reflected people's current care and support needs; and that any associated risks were clearly identified, monitored and mitigated.

Although staff were recruited safely upon completion of appropriate checks improvements were required to ensure the on-going monitoring to check staff's criminal histories had not changed. There were sufficient numbers of staff to meet people's care and support needs.

Improvements were required to ensure the registered provider learnt from safeguarding incidents. Staff received training regarding how to keep people safe from harm and abuse and were aware of how to report any concerns.

Staff had an understanding of the requirements of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards applications had been made where appropriate.

Generally people received sufficient amounts to eat and drink however we found sufficient action was not always being taken where people were at risk of malnutrition and dehydration.

People were supported to access healthcare services. However, where healthcare professionals were involved in people's care their guidance was not always followed.

People had mixed views about the caring attitude of staff. Whilst most interactions between staff and people were kind and caring, some were task focussed. People's privacy and dignity was respected.

Care plans and assessments did not always include sufficient information of how people's care and support needs were to be met. Activities required improvement to ensure people living with dementia were encouraged and supported in taking part in meaningful activities.

There was an effective system in place for complaints.

At this inspection we found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 including continued breaches from our last inspection. You can see what action we have told the provider to take at the back 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.

Medicines were not always managed safely.

Some care records contained contradictory information and did not always reflect people's current care and support needs and associated risks.

Staff were aware of their responsibility to safeguard people from abuse.

There were enough staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Improvements were required to ensure people maintained good health and were supported to access healthcare professionals and, where appropriate, guidance from external healthcare professionals is followed.

Care plans did not always contain sufficient information on how staff should support people with their nutritional needs.

Improvements were required to ensure monitoring charts such as food and fluid intake and repositioning charts were completed accurately.

Staff were able to demonstrate an understanding of the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not always caring.

Most interactions between staff and people who used the service were kind and caring, however some were task focussed.

People's privacy and dignity was respected.

Advocacy information was available to people.

Visitors were able to visit the service at any time.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Improvements were required to ensure care plans clearly recorded people's care and support needs.

There were systems in place to respond to complaints.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager.

The registered provider's quality assurance systems and processes did not ensure that they were able to assess, monitor and mitigate the risks relating to people's health, safety and welfare.

The registered provider was not meeting regulatory requirements.

People and staff felt supported by the manager and told us they were approachable.

Oaklands (Essex)

Detailed findings

Background to this inspection

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

This inspection took place on 20, 21 and 28 February 2017 and was unannounced.

The inspection team consisted of two inspectors, a pharmacist inspector, a specialised adviser for occupational therapy and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service including statutory notifications we had received from the service. Notifications are changes, events or incidents that the provider is legally obliged to send us. We reviewed safeguarding alerts and information received from a local authority. We also reviewed a Provider Information Return (PIR). A PIR 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 spent time observing care and used the Short Observational Framework for Inspection (SOFI). This is a specific way of observing care to help us understand the experiences of people who were unable to talk with us due to their complex care needs.

During our inspection we spoke with 18 people who used the service, six relatives, two health and social care professionals, six members of staff, the manager and the area director. We looked at a range of records including eight people's care plans and records, seven staff files, staff training records, staff rotas, arrangements for the management of medicines including reviewing 16 medication administration records, a sample of policies and procedures and quality assurance information.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection on the 27 and 30 September 2016 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service did not have effective systems in place to manage and mitigate risks to the health and safety of people using the service and for the safe management of medicines. In response, the registered provider shared with us on 24 November 2016 their action plan detailing their progress to meet regulatory requirements. At this inspection we found that the improvements they told us they would make had not all been implemented and sustained to an appropriate standard.

Although risks to people's individual safety and well-being were assessed and risk assessments were in place to minimise these, such as risks associated with mobility, personal care, choking, pressure area management and falls and nutrition, we found some risk assessments had not been updated, for example following a fall or loss of weight. We also found some risk assessments had not included all risk factors resulting people being placed with an incorrect risk rating. For example we saw that a Waterlow assessment completed for one person on 3 February 2017 had not taken into account all the person's health conditions, therefore the person had an incorrect risk rating. If this information had been included in the person's assessment this would have increased their overall risk rating score from 'low risk' to 'at risk' and would have ensured appropriate measures were in place to mitigate the risk. A Waterlow assessment is a tool to assess the risk to people of developing pressure sores.

Where people were at risk of development pressure ulcers, preventative measures were not always being followed. For example on one person's care plan it was recommended they should be repositioned every two hours. On reviewing their repositioning charts we found gaps where it had not always been recorded that they had been repositioned; for example we found no entries had been recorded on the chart from 19:05 on the 12 February 2017 to 08:10 on the 13 February 2017, from 19:12 on the 14 February 17 to 08:30 on the 15 February 2017. The last entry on the 15 February 2017 was at 14:30 and no further entries had been recorded until 08:14 on the 16 February 2017. Dates on some of the repositioning charts had also not been recorded. This meant we were not able to determine whether they had been repositioned thereby placing them at risk of developing pressure areas due to the lack of relieve. We could not be assured that risks to people were being effectively and safely managed.

Furthermore some care records contained contradictory information, for example in one person's care records it stated in their risk assessment that they were no longer able to mobilise and required the use of a wheelchair at all times for mobility. However this was not reflected in their mobility care plan and, in their safe environment care plan it was recorded that the person was mobile and required no aids or support from staff. This meant that there was a potential risk of the person receiving unsafe care as not all the information contained in the care records accurately reflected the person's current care and support needs.

During our inspection we looked at the systems in place for managing the administration of medicines. Although the records we looked at showed that administration was recorded clearly on people's medication administration charts (MARs), we noted on the morning of the first day of our inspection that there were two

omissions in the administration records as medicines were not available. We also found one person's medicine that should be administered once a week had been written up to be given daily. Although the person had received this weekly as prescribed, there was a high risk of the medicine being incorrectly administered due to inaccurate record keeping.

We also found that one person's MAR chart for the administration of insulin did not accurately reflect the current dose administered by the district nursing team. The label attached to the insulin pen also had the incorrect dose on it. This meant that the service's medicines records were not correct which could lead to inaccurate information being sent to other providers such as hospital staff should the person be admitted to hospital. We looked at the care records for this person and noted they had been discharged from hospital on the 13 February 2017. The service had faxed the person's GP and the district nursing team to advise they had been discharged from hospital. However we saw that the person did not receive their prescribed twice daily insulin on the 14 February 2017. There were no records to demonstrate that the service had taken any action on the 14 February 2017 to ensure the person received their medication. We raised a safeguard about this incident with the local safeguarding team. The service also raised a safeguard when we highlighted this to management.

On another person's MAR we found one medicine which was required to be administered once a week at a specified time, separately from breakfast and any other prescribed medicines. This was being signed for administration at the same time as other medicines. This demonstrated that people did not always receive their prescribed medication in line with the prescriber's instructions.

We also found that any handwritten additions or changes to the MAR charts had not always been checked by another member of staff in line with the registered provider's medication policy which states: 'In the event that the Home needs to introduce a new hand-written MAR chart, this should be created by a colleague with designated medicines management responsibilities and the new record should then be checked by a second colleague with designated medicines management responsibilities.'

Some people were receiving inhalers via devices to aid administration. There were two examples of these devices known as aerochambers with masks that were encrusted with medicine residue and did not seem to have been cleaned recently. We discussed this with the manager and area director who took immediate steps to ensure the aerochambers were cleaned on a regular basis.

Medicines were stored safely and securely, in locked medicine trolleys or cupboards within a secure treatment room. Medicines that required additional controls because of their potential for abuse (controlled drugs) were stored securely and checked regularly. However we found that the records in the Controlled Drug Register were not accurate as the wrong strength had been entered in the register and staff continued to sign against it when they were doing their daily checks. This showed that the systems in place for management of controlled drugs were not robust.

Protocols for the administration of 'as required' medicines were available. These protocols provide guidance as to when it is appropriate to administer medicines that are not required regularly such as analgesics, inhalers or sleeping tablets. We found that some of these protocols had exceeded their review date, one was not signed by the current GP responsible for that person's care and another had not been signed at all. Medicines that were applied as patches were recorded appropriately on separate charts; however we found that one chart had the incorrect strength of the medicine documented on the record.

Some people had documents in place to allow the administration of 'homely remedies'. Homely remedies are medicines used to treat minor ailments that can be purchased for use. These had been signed by the

care home manager but had not been authorised by the GP. We discussed this with the manager who informed us the GP would not authorise the use of these medicines and told us that they would be removing these documents from people's care plans.

There were photographs of people for identification purposes available as part of their medicines records. People's allergies were clearly recorded and their preferences on how they like to take their medicines. No one living at the service was administering their own medicines. Any discontinued or duplicate items were clearly marked by the staff. Medicines being applied topically such as creams and ointments had clear records in place so that staff knew where and how often these needed to be applied. If there was a choice of how much medicine to give, such as one or two tablets, the records clearly marked what had been administered.

Staff knew how to report a medicine incident and we saw evidence of incidents that had been reported to the local safeguarding team. Staff responsible for the administration of medicines told us that they received training in the administration of medicines and that their competency was checked regularly. The manager told us that four out of eight staff responsible for the administration of medicines had received medication training on the 7 February 2017 but was unable to locate the training certificates. We asked for these to be sent to us but at the time of writing this report these had not been received. We found records of competency checks on staff files but these had not been dated therefore it was unclear to determine when these had been completed. The manager informed us, and records showed that they had recently undertaken competency checks for three members of staff.

The manager was completing audits of medicine administration at the home and these records showed an improvement since we last inspected. However due to the nature of recent safeguards relating to medication and the issues we identified and the potential risks to people we could not be assured that the service was managing medicines safely to minimise risks or had robustly implemented the actions they told us they would be taking in their action plan from the last inspection.

Although staff had received manual handling training since our last inspection in September 2016, on the first and second days of this inspection we observed two occasions of poor practice when staff were supporting people to transfer from their armchairs to wheelchairs. We saw one person being assisted to stand fall back into their seat; this was because the instructions given to the person were not clear. This meant that people and staff were placed at risk of harm as there was potential risk of the person falling back into their chair and sustaining an injury. A number of safeguards had been raised by health and social care professionals relating to moving and handling and, although training records showed that staff had received 'safer handling people' training we were not assured that the service had systems in place to effectively embed and monitor this aspect of care. The manager told us that no regular on-going observations of staff practice were undertaken following staff training but they would take appropriate action if they were aware of any unsafe practice.

The above failings demonstrated a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we received information about the suitability of a member of staff working at the service. We checked the service's recruitment practices to ensure staff were safe to work with vulnerable adults. Overall we found these to be appropriate and records showed that relevant checks had been completed before staff were allowed to start work at the service. This included carrying out a disclosure and barring check (DBS) for new staff. However, there was no on-going monitoring or best practice procedures in place to check staff's criminal histories had not changed. We discussed the information we had received

with the registered provider who told us there were no additional measures in place for the on-going monitoring of staff. Upon discussion and information received following our inspection it was unclear whether, if we had not highlighted to the registered provider that they had overall responsibility to ensure people using the service were protected, they were going to investigate further. We could not be assured that the service had robust procedures and processes in place to ensure that people were protected.

Information shared with us prior to our inspection by the local safeguarding team showed that there had been 28 safeguards raised against the service since June 2016, of which five had been organisational safeguards. Of the 28 safeguards six had been fully substantiated, two partially substantiated and 12 were still being investigated. The general themes of the safeguards were around medication, neglect in care needs including pressure area care, lack of close observations and care with regard to repositioning / food and fluid recording, poor manual handling, staffing levels, end of life care, people being left unaccompanied and poor care planning. A number of these safeguarding themes had been identified by us at our last inspection. We found that improvements had not been made at this inspection. This demonstrated the service was not learning from safeguarding incidents thereby continuing to place people using the service at risk.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received training on safeguarding people. They were clear on the actions they would take if they suspected abuse and were aware they could contact external agencies such as the local authority or the Care Quality Commission (CQC) to report any concerns. Whistleblowing guidance was displayed at various points around the service. Records showed that the service had raised safeguarding alerts to the local authority; this included raising safeguards following concerns we had identified during our inspection.

People told us they felt safe living at the service. One relative told us, "We were thinking of moving [relative] but at the moment feel they are safe and that's what we want to feel." We observed one person locking their door when they left their room. A staff member told us the person was grateful for this as it gave them peace of mind that people cannot get into the room and take things away. We noted that several people had privacy gates installed at their doors; they told us that these had been put in place to prevent other people from entering their rooms. However, one relative told us, "[Name] can open the gates, it's not hard, they need a different gate system." On the first day of our inspection we observed two people opening the person's privacy gate and entering their room whilst they were asleep. We also observed staff failing to secure the privacy gates on two occasions.

We received mixed feedback from people regarding staffing levels. One person told us, "They don't have enough staff; you have to wait if you press the [call] bell." However they then went on to tell us that when they had fallen one night staff had attended quickly and stayed with them for a while as they were shaken. Another person said, "During the night I have to wait longer for them to come." One the first day of our inspection we pressed two call bells. On the first occasion a member of staff attended within one minute. However on pressing a second call bell no staff attended for 10 minutes. We observed during our inspection that call bells were not always accessible and therefore people had no means of calling for help. One person told us, "Staff don't give it to me and I can't get to it." Two people also told us they didn't have call bells and if they needed help they would go to their door and shout. Staff we spoke with felt there was enough staff and told us that if shifts were short staffed agency workers would be sourced. Our observations during the inspection were that generally there were sufficient staffing levels.

People were cared for in a safe environment and appropriate monitoring and maintenance of the premises

and equipment was on-going. There were up to date safety certificates in place for the premises and equipment. Records showed that the building had been well maintained and that repairs had been carried out swiftly. The service employed a maintenance person to carry out general maintenance and day to day repairs.

There were systems in place to keep people safe in the event of an emergency situation such as fire and personalised emergency evacuation plans (PEEPs) were in place for people. A PEEP provides guidance to staff and emergency services if people needed to be evacuated from the premises in the event of an emergency. Records showed that staff were trained in first aid and fire awareness and how to respond to emergencies.

Requires Improvement

Is the service effective?

Our findings

Some relatives told us that they felt that staff were not well trained. One said, "I don't think staff here understand dementia, they don't give people time to process what they're saying, or ask for things in a different way. I think they could have a better training programme." However, staff we spoke with felt their training had equipped them with the skills and knowledge to enable them to care for people using the service. One member of staff told us they had completed dementia training which had enabled them to support and communicate with people living with dementia more effectively.

We were provided with a copy of the registered provider's mandatory training matrix. This showed training was undertaken in areas such as safeguarding, moving and handling, health and safety and infection control. We asked the manager how they ensured training was embedded into day to day practice, for example through observations of staff practice. The manager advised, with the exception of some observations of staff member's competency to administer medication, they had not undertaken any observations of staff practice since they started managing the service. Staff records showed no evidence to demonstrate staff's practice had been observed. Issues identified during our inspection indicated that staff required more effective supervision and observations to improve their working practices.

Staff told us that they had not received supervision for some time and records showed that 19 out of 38 staff had not received supervision for over seven months, this included new staff. The registered provider's policy states staff should receive two supervisions per year. The manager showed us a yearly supervision planner they had developed to ensure staff received supervision in line with the policy. However we noted that the format of recent supervisions was to go through an action points list with staff on what was expected of them in their role as opposed to a 'two way' discussion. Supervisions and appraisals are important as they are a two-way feedback tool for the managers and staff to discuss work related issues, staff practice and training needs. The manager was unable to access the registered provider's electronic system to enable us to check whether any staff had received annual appraisals since our last inspection. We could not be assured that the competencies and knowledge of staff were being routinely assessed or checked to ensure they had the right skills and experience to support people using the service.

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

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty safeguards (DoLS). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff had received MCA and DoLS training and understood the importance of consent; they explained to us how they gained people's consent to their care and helped people to make choices on a day to day basis. Where required people's mental capacity had been assessed and any decisions were made in their best interests in the least restrictive way in line with legislation. Where people had been deprived of their liberty appropriate applications had been made to the local authority for a DoLS authorisation. In the provider's PIR it was stated two people had DoLS authorisations in place. We requested to see copies of these. The manager was unable to find the authorisations and subsequently informed us that the service was still waiting for the DoLS applications to be authorised. We noted from our last inspection that the previous manager had developed a DoLS information database but this had not been kept up to date therefore the manager was unable to easily access information regarding DoLS. Furthermore we noted that where people had bed rails these had not been considered as part of their DoLS application. We discussed this with the manager who took immediate action to address the inaccurate applications. The manager was aware that this information should have been included on the original DoLS applications.

We noted where people had Lasting Power of Attorneys (LPA) in place copies were kept securely in the administrator's office. A LPA is a legal document that enables people to appoint one or more people to make decisions on their behalf. There are two types of LPA; health and welfare and property and financial affairs, one or both of these can be chosen. This demonstrated that the service was aware of which decisions should involve the person's representative.

We observed a mixed lunchtime experience for people. There were dining rooms on both floors of the building and people could choose to eat in their own rooms if they preferred. Where people ate in their own rooms and required support to eat their meals we observed staff sitting with them. People were offered two meal options and these were plated up and shown to people to help them make their meal choice; people told us that the food was tasty and they enjoyed it. At our last inspection one relative told us how they constantly had to remind staff that their loved one was unable to use cutlery, preferred finger food and required encouragement to eat. We had also identified that there was no reference to 'finger food' in the person's care plan. At this inspection although we saw that the care plan had been updated to include finger food, we observed on the first day of our inspection that the person had been served beef and mushroom pie, mashed potato and broccoli. We observed the person trying to eat the food which they were finding difficult to eat. Their relative told us, "The problem with the food has got no better since last time." At this inspection we also observed one person who was dependent on staff to support them with eating waiting 15 minutes for this support as the member of staff was rushing around serving others before they could sit down with them.

We also observed on the first day of our inspection two people who were living with dementia pacing the corridors constantly. At lunchtime we saw one person being brought into the dining room and being told to sit down at a table. Although their meal was given to them immediately they took one mouthful before getting up and pacing the corridors. The other person was also observed being brought to the dining room but there was no chair available for them and whilst staff looked for a chair the person lost interest and left the dining room. Staff were not observed making any further attempts to encourage them to go back to the dining room or to provide them with any other food such as finger food which they could snack on whilst walking along the corridors. We spoke with two members of staff who told us they there were usually three people who spent their time walking the corridors. They told us that staff had tried everything to engage with them but nothing had helped. They went on to tell us that any form of intervention could cause aggressive behaviour. We could not be assured that staff were always effectively supporting and encouraging people with behaviours that may challenge and care records did not contain sufficient

guidance for staff on how to deal with people should they become anxious or distressed. During our inspection a relative told us they had been concerned about their loved one's hydration needs, they said, "Drinking has been an issue for some time. [Name] refuses drinks, we understand that, but they don't coax them. We've provided a beaker because it helps [loved one] to drink, but because of that it often just gets left there, there's an opened blackcurrant drink from last night too, it's still sitting in their room."

Although, throughout our inspection we observed people being offered drinks, biscuits and fruit throughout the day, we could not be assured that the service was effectively managing the nutritional and hydration needs of people who were at risk.

Systems were in place to monitor people's weight. Where people had lost weight care records showed that staff weighed people on a weekly basis. However, on reviewing people's care records who were at risk of malnutrition/dehydration we noted gaps and/or insufficient details had been recorded in some people's care records. For example it was recorded on one person's records that they were refusing food however food and fluid monitoring charts were not in place. We noted the person had lost 6.15kg over a four month period and could see no evidence to demonstrate advice had been sought from healthcare professionals. The eating and drinking plan for the person completed on 28 September 2016 stated, 'should it be noticed for [name] to be consistently losing weight, the senior on shift will make a referral to the appropriate community health team for further advice and instruction.' We discussed this with the manager and a senior carer. The senior carer told us the dietician had visited the service the previous week however there was no record on the professional visits log that the dietician had seen the person. It was therefore unclear whether the person had been seen by the dietician as the manager and senior carer were unable to provide this information. The service was unable to demonstrate they had sought appropriate timely advice following the person's weight loss.

The above failings demonstrated a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were generally supported to access healthcare services and professionals such as GPs, occupational therapists and the community nursing team. The outcome of appointments was recorded in people's care plans however this was not always consistent. One person told us that they were feeling progressively unwell but that staff looked after them well, involving other health and social care professionals when appropriate. They said, "I'm getting very breathless these days, but they'd notice if I was really unwell, they keep an eye on me." A health and social care professional told us, "They are proactive in contacting us for support; things are so much better now. I insist on speaking with the carers, they know the people I'm coming to see, sometimes more than the seniors."

Requires Improvement

Is the service caring?

Our findings

We received mixed feedback from people about staff. Comments included, "[Staff] are friendly, quite chatty really, I'm very lucky." And, "Overall I'm satisfied with them but I would like them to be a bit more friendly and chatty with me." And, "Some staff are very kind to me, others are not so good; the night staff treat me well."

We also received mixed feedback from relatives. One relative said, "Staff turnover is so quick, we don't get to know them really. That can't be good for people with dementia. A senior here was really wonderful but they went on maternity leave and are now only part-time; most of the staff aren't as good as them". Another relative said, "I think they're very kind, caring people, I always feel welcomed when I come and they understand that this is hard for me, seeing [name of person] like this."

During our inspection we observed most staff interacting well with people and showing empathy, engaging with people in a friendly, light-hearted manner, often stopping for a chat and a laugh with people. However we also saw some staff who were more task focussed and speaking to people in a clipped, disinterested manner, without any attempt to make more engaging, and stimulating conversation.

Staff were able to describe to us how they upheld people's privacy and dignity when providing personal care and support for example ensuring bedroom doors were closed. During our inspection we observed staff knocking on people's doors before entering and closing doors when providing personal care. We saw that people were dressed appropriately suitable for the time of year and people were supported to maintain their personal appearance so as to ensure their self-esteem and self-worth.

People were supported to maintain relationships with friends and families. Relatives visited throughout our inspection. One relative told us, "We can visit any time."

People's diverse needs were respected and recorded in their care plans. A regular religious service was held at the service for those people who wished to attend.

Where appropriate people had end of life care plans in place. The manager told us they were 'gold standard' trained and was in the process of improving people's ends of life care plans. The Gold Standards Framework is a model that enables good practice to be available to all people nearing the end of their lives. The manager demonstrated their passion and commitment to supporting people and their relatives before and after death. Records confirmed they had recently discussed improvements to end of life care plans with senior staff.

The service had information on local advocacy services. An advocate supports a person to have an independent voice and enables them to express their views when they are unable to do so for themselves.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to people's individual needs and preferences.

Although some people's care plans contained sufficient information and guidance for staff to enable them to provide personalised care that was consistent and responsive to people's needs, others did not. For example we found some care plans contained contradictory information or did not contain information which accurately reflected the care and support to be provided; examples of these have been highlighted in the 'Safe' section of this report. Furthermore not all care plans contained sufficient information and guidance for staff to follow. For example, for people living with dementia there was limited information in people's care plans on how staff should support people if they became anxious or distressed. This meant people's needs and preferences were not always being met.

We also noted that an occupational therapist (OT) had recommended for one person that they should have their feet raised due to cellulitis. The OT report had stated that the person would often take their feet off the raised stool but they should be encouraged to raise their feet by staff. Throughout our inspection we observed the person not to have their feet raised and not being encouraged by staff to do so. On many occasions we observed the footstool was placed some distance from the person which meant they had no means of raising their feet as they were unable to mobilise. We noted there was little information recorded in the person's daily log with regard to monitoring this aspect of their care and there was no information regarding the raising the person's legs in their care plan as specified in the OT assessment. This meant we could not be assured that staff were following advice and care planning of a health professional .

Prior to our inspection we had received information that there had been issues with delays in ordering individual hoist slings for people. On the first day of our inspection we asked the area director and manager whether these issues had been rectified and for confirmation that systems were now in place to ensure slings were received in a timely manner. We were assured systems were in place however later that day we found one person who had been assessed as requiring a toileting sling on 3 February 2017 and was still waiting for the sling to arrive. There were no guidelines in place for staff to follow until the sling arrived. We discussed this with the area director and manager who immediately arranged for the sling to be ordered. Although the sling arrived before the end of our inspection we could not be assured that effective systems had been implemented to ensure people received any necessary equipment to support their care needs in a timely way.

The above failings are a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The manager told us how they had implemented a system to ensure regular reviews of people's care and support needs and explained how important it was to work with families to ensure people received good quality care. During our inspection one person told us they had been contacted and invited to a review, they said, "That's a step in the right direction". Another relative said, "There's always an annual review of [loved one's] care but we can always speak with the manager if we had to."

The service employed two activity coordinators. A range of activities such as bingo, arts and crafts and music and singing were available. Information on weekly activities was displayed in the main communal area of the service. We spoke with one of the activity coordinators and asked what improvements had been made since our last inspection to encourage people living with dementia to participate in activities. They told us they were helping to collate information from families about the life people had led before using the service including their hobbies and interests and would use this information to help improve the delivery of activities for people. The activity coordinator told us they used sensory equipment to encourage people to engage in activities and gave people dedicated tasks to enable them to participate and enjoy activities. For example one person with problems with dexterity had been allocated the task of being 'chief taster' during a food activity. However, during our inspection we observed one person who was living with dementia and paced corridors all day. We discussed with a member of staff whether walking outside in the communal garden had been considered. We were informed the person was not taken to the garden as staff were concerned the person would refuse to come back into the building. There were no records to demonstrate that alternative activities such as walking in the garden or making a referral to the local health team for strategies had being considered for this person.

The activity coordinator told us that they had received lots of support and ideas for activities from the manager. This was confirmed by the manager who told us they were looking to make the service's environment more dementia friendly and had asked the activity coordinator to contact the registered provider's head office to take this forward.

Relatives told us they felt the activities programme was starting to improve. One relative told us they had been very grateful when the staff recently brought a small lamp for their loved one who often sat in the main reception area. They told us their loved one had complained that the main lighting was not helpful when they were reading or sewing, due to their poor eyesight. They said, "This little light has made things so much easier for [name of loved one] I'm grateful that they did that."

Overall although the activity coordinator clearly knew people well, we found that improvements were still required to ensure care records included clear information on how people's dementia affected their ability to participate and to be supported in taking part in activities and activities which interested them.

At our previous inspection we could not be assured that concerns and complaints were being recorded and appropriately responded to in line with the registered provider's policy. We found the service in breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that although improvements had been made and records showed that complaints had been responded to in line with the registered provider's policy, people repeatedly told us that, due to constant staff changes, they did not always know who to speak with regarding their concerns or potential complaints. Relatives told us that they could approach the manager and felt any concerns or complaints would be listened to and acted upon. One relative told us, "I would be able to share my concerns with [manager's name]." Another said, "At one time it was very poor and we were complaining every day, you shouldn't need to do that but we felt we had to as we were concerned. Since [name of manager] has come here things have improved. They are very approachable and I can go and see them with any concerns."

Since our last inspection we noted that care plans were more person centred. We saw that work had also been started to collate as much information as possible about people and the life they had led and what was important to them to enable staff to update care plans with as much information as possible. We did not note any adverse impact on people because of this lack of information but noted the service was working to improve this area of care planning.

Inadequate

Is the service well-led?

Our findings

There was no registered manager for the service. At our last inspection a 'turnaround manager' had been in post overseeing the day to day management of the service following the absence, and subsequent resignation of the registered manager. The 'turnaround manager' no longer worked for the registered provider and a manager from another of the registered provider's care homes had been seconded to manage the service from December 2016. The manager was supported by a deputy manager who started work at the service in January 2017. The registered provider was currently in the process of completing interviews for a new manager.

At our last inspection on 27 and 30 September 2016 we found that the provider's quality assurance systems were not effective or robust and there was a lack of managerial oversight of the service as a whole. This meant that the service was not effectively being run for the benefit of the people using the service. We asked the registered provider to send us an action plan which outlined the actions they would take to make the necessary improvements. In response, the registered provider shared with us on 24 November 2016 their action plan detailing their progress to meet regulatory requirements. At this inspection we found that the majority of the improvements had not been made and/or sustained to an appropriate standard. We found six breaches of regulations, three of which were continued breaches from our last inspection. This demonstrated that the registered provider had failed to take sufficient action in response to issues previously identified. Furthermore, at the time of our inspection the local authority's suspension of new placements to the service remained in place due to the local authority's concerns.

Although there were systems in place to monitor and assess the quality of the service being provided, we found that these were not robust and were not always being utilized to their full potential as they had not identified the areas of concern and breaches of regulatory requirements we had found during this inspection and at our previous inspection. We found care records continued to be inaccurate and/or incomplete; for example audits had failed to identify the omissions we found in the assessment and care planning of people's nutrition and hydration needs, pressure area care and ensuring people were referred to healthcare professionals when required. Also, although there were monitoring systems in place for safeguarding incidents, we could not be assured how the service learnt from these to ensure the service was safe and mitigate further reoccurrence. The manager told us that they were not fully aware, nor had a good understanding, of the registered provider's quality assurance systems. We noted that arrangements had been made for other managers within the registered provider's group to support the manager to understand these systems following our inspection. The manager went on to say that their focus had been on specific tasks they had been asked to complete by the registered provider.

The registered provider was unable to demonstrate how they effectively managed the performance and competency of staff to ensure improvements were made and sustained. For example, the registered provider's supervision policy stated that staff should receive two supervisions per year. Records showed that the majority of staff had not received formal supervision for over seven months; this included new members of staff. Furthermore no regular observations of staff practice were undertaken to check staff competencies. Since our last inspection three members of staff had been promoted to a senior role. The registered provider

was unable to demonstrate how the staff had been supported with the transition into their new roles. This meant that we could not be assured that the registered provider was effectively supporting staff and ensuring they had the skills, abilities and competencies to provide care that was safe, effective, caring and responsive to people's needs.

It was clear from our inspection that the registered provider lacked oversight of the service and that poor quality monitoring was an on-going contributory factor to the failure of the provider to make significant improvements and rectify regulatory breaches as identified at our previous inspection. Systems and processes in place to monitor the service to ensure people's safety and mitigate risks relating to their health, safety and welfare were ineffective.

The service remains in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that there had not been regular staff meetings since our last inspection. One member of staff said, "We've not had any for a while, staff tend not to say anything as feel that in the past nothing gets done. Since [name of manager] has been here we haven't had a meeting." Records showed to us confirmed that staff meetings had been held on 18 January 2017, 12 December 2016 and 8 November 2016. It was not clear how minutes from staff meetings were disseminated to all staff. We saw that the manager had developed a staff meeting planner for 2017 where specific topics such as skin care, nutrition and hydration would be discussed.

People we spoke with told us they were confused by the management structure of the service, particularly with the change of managers. A relative told us, "This home really went down after [registered manager's name] left, but now I think it's beginning to go up again." The manager confirmed to us that no surveys had been completed since our last inspection but they had scheduled monthly resident/relative meetings to discuss people's views on the quality of the service provided. The dates of these meetings were clearly displayed on a communal notice board. One relative said, "The resident's meetings are a bit better now, we have them monthly, and the manager listens. It's a two-way thing, the manager is very approachable, and they are better at walking around and checking up on things." The manager told us, "I am a nurse by profession and my vision is to make a difference in terms of the care here and create a happy environment, working closely with families and educating all the staff."

Staff told us that staff morale was improving and, although some were concerned about what was going to happen with the service, they felt supported by the manager. They told us the manager was approachable and had made some good improvements at the service.

Personal records were stored in a locked office when not in use. Up to date information and guidance was available to the manager and staff on the service's computer system that was password protected to ensure that information was kept safe.

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 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 (1) The care and treatment of service users must (a) be appropriate (b) meet their needs and (c) reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13((1) Service users must be protected from abuse and improper treatment in accordance with this regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Regulation 14(1) The nutritional and hydration needs of service users must be met

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18(2)(a) persons employed by the service provider in the provision of the regulated activity must receive such appropriate training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform

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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) Care and treatment must be provided in a safe way for service users Regulation 12(2)(a) assessing the risks to the health and safety of service users Regulation 12(2)(b) doing all that is reasonably practicable to mitigate any such risks Regulation 12(2)(g) the proper and safe management of medicines Regulation 12(2)(I) where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of service users.

The enforcement action we took:

Warning Notice for Regulation 12 Safe care and treatment

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(2)(a) assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services) Regulation 17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Regulation 17(2)(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of care and

treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

The enforcement action we took:

Warning Notice for Regulation 17 Good Governance