Ravenswood Care Home Limited

Ravenswood Care Home

Inspection report

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Date of inspection visit:
22 February 2017
24 March 2017

Date of publication:
13 June 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 22 February and 24 March 2017and was unannounced. Ravenswood Care Home is a residential home for up to 55 older people. There were 52 people living at the service at the time of the inspection. People who used the service were older people and may have had physical and/or mental health needs.

At our previous inspection in October 2016, we found there were concerns about staffing levels and there was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. It was also identified that audits were not always being carried out. We asked the provider to tell us how they were going to make the required improvements.

There was a Registered Manager in post 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.

At this inspection we identified multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. One of these breaches was an on-going breach identified in the last inspection in relation to staffing levels. There was also a breach a breach of Care Quality Commission (Registration) Regulations 2009.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

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

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

For adult social care services the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

There were not always enough staff available to keep people safe and meet people's needs. Communal areas were often left unattended which left people at risk of harm to their health, safety and wellbeing.

Plans were not always in place to support people if they became agitated. Staff were also not trained to support people effectively who were experiencing periods of agitation.

Plans were also not in place for people who needed support with their skin integrity and we could not be sure that people were receiving the level of support required to look after their pressure sores.

Risk assessments and detailed plans were not always in place to prevent people from falling and if people had fallen, action was not always taken to support people from falling again and some people had continued to experience falls.

We could not be sure that people were receiving their topical medicines as prescribed. Some risks to people's safety had not been taken into consideration, such as access to some medicines.

Effective systems were not in place to protect people from the risk of abuse. Potential abuse was not always reported to the local authority as required.

Equipment was not always fit for purpose and unsafe equipment was accessible for people to use.

Staff training was not always effective. For example, we saw staff use unsafe methods to support people to move.

The principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were not always followed as required by law.

People were not always supported to have food and drinks that were appropriate for their needs and there were mixed reviews about the food.

The environment was not always dignified. Some areas of the home had unpleasant odours and bathrooms were not always welcoming and tidy to promote dignified care.

Staff were sometimes not respectful and responsive to people's needs. However, we did see some caring interactions between staff and people.

Care plans were not always personalised and did not always contain accurate and up to date information about people and their care preferences. This put some people at risk of not having their needs met or not having their preferences catered for as there was limited information available for staff.

Complaints were documented and responded to and people generally felt able to complain about their care however feedback was not always acted upon.

Audits of accidents and incidents or care plans had not been taking place so omissions in care had not been identified. Medicine audits were in place however these had not identified concerns relating to topical medicines.

The registered manager had not always submitted notifications to us which they are required to do so by law.

Although people who could partake in activities independently were observed carrying out their hobbies on the day of inspection, most people watched TV for the day.

On the days of the inspection, the staff did not have time to support people to participate in activities that were meaningful to them or therapeutic.

Safe recruitment practices were in place and staff had appropriate checks prior to starting work to ensure they were suitable to work with people who use the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not always enough staff to meet people's needs and keep people safe.

Risks were not always assessed and action was not always taken following an accident or incident occurring.

Alleged abuse was not always reported to the local safeguarding authority as required.

Oral medicines were managed safely. However, we could not be sure people were having topical medicines and they were not stored safely and people were at risk of harm because of this.

Safe recruitment practices were followed to ensure staff were working with people who used the service were fit and of good character.

Is the service effective?

Inadequate

The service was not consistently effective.

Staff had not been trained sufficiently to support people effectively.

The principles of the Mental Capacity Act 2005 were not always being followed. DoLS referrals were not always made in an appropriate timescale and staff were not always aware of the MCA and DoLS.

People were not always given food appropriate to their needs and there were mixed opinions about the quality of the food.

Advice from health professionals was not always followed.

Is the service caring?

Requires Improvement

The service was not always caring.

The environment was not always dignified.

People were not always treated with respect and staff did not always engage with people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always have personalised care plans or their preferences reviewed. This placed people at risk of receiving unsuitable care.

People were not consistently supported to undertake activities due to staffing levels.

The service had a complaints policy, and people knew how to complain, however feedback was not always acted upon.

Is the service well-led?

Inadequate

The service was not well-led.

Action had not always been taken to rectify issues when people had experienced behaviour that challenges.

There was a lack of oversight regarding accidents and incidents.

There were no effective quality monitoring systems in place to ensure care files were fit for purpose and documents were not always regularly reviewed and updated.

People, relatives and staff generally felt supported by the manager and they had confidence in them.

Ravenswood 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.

This inspection took place on 22 February and 24 March 2017 and was unannounced. The inspection was carried out by three inspectors who were accompanied by 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.

We looked at information we held about the service including statutory notifications submitted. Statutory notifications include information about important events which the provider is required to send us by law.

We spoke with five people who used the service, seven relatives, six members of staff that supported people, the registered manager, the deputy manager and three visiting health care professionals that had contact with the people who used the service. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed the care plans and other care records for eleven people who used the service and the medicine records for eleven people. We also looked at management records such as quality audits. We looked at recruitment files and training records for four members of staff.

Inadequate

Is the service safe?

Our findings

At our last inspection, we found that there were not always enough staff to support people effectively and to keep people safe. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made.

People told us that they did not always receive the support they needed when they needed it. One person said, "Staffing is sometimes a bit short." Comments from relatives included; "Sometimes they come quickly sometimes they don't" and, "We really like the staff but they're run off their feet." Records from a recent meeting held with people who used the service showed they had reported concerns about staffing. Comments from people documented in the records of this meeting included; 'New residents keep coming but there are not any new staff. The staff are rushed off their feet' and, 'We need more carers.' Most staff also told us they felt there were not enough staff. One member of staff we asked if they felt there was enough staff and they answered, "No. Truthfully, no. The manager is recruiting. The manager is trying" and they went on to say, "We have to take staff from others floors to help us, which leaves them short." Another member of staff said, "There are four night staff on but that's not enough to reposition people throughout the night." Other comments from staff included; "Buzzers aren't always responded to [during the night]", "We could push for more staff and it would be a lot better paced" and, "I think we need more staff." We observed occasions when people had to wait a long time for support. For example, one person asked to be supported to the toilet and staff told them they would help them soon, but 40 minutes later and staff had still not been to support the person after they had told they would return soon. One member of staff we spoke with said, "People are not getting to the toilet when they need to." The registered manager told us they had started to recruit more staff, but progress with recruitment had been very slow. They also explained that they were working shifts as a carer due to staffing shortages. The said, "I am plugging the dam". This meant action to address staffing shortages had not been effective and the manager's ability to manage the service was being affected.

The registered manager was unable to show us how they assessed how many staff were required based on the number of people, their individual levels of need, staff competencies and the layout of the building. Some of the training records which tracked what training the entire staff group had received were not up to date so it would not have always been possible to ensure the right mix of skilled staff were working. When we asked a senior member of staff about this, they said, "I don't know how the registered manager decided how many staff are needed." The building had three main communal areas and some people chose to stay in their rooms. We were told that one of the communal lounges was sometimes closed due to insufficient staffing levels. We asked a member of staff about this and they said, "One of the lounges was shut the other day due to sicknesses and we couldn't get cover, there were only five members of staff on." This meant staffing levels were not being regularly assessed and the layout of the building had not always been taken into consideration.

We observed occasions when communal areas had no staff present however some people's care records showed they needed staff to be present at all times due to their risk of falling or their risk of agitation and

aggression. One member of staff told us, "We are managing people's behaviour but staffing levels can make that difficult." We observed one person in a communal lounge holding their walking stick in the air, shouting at other people who used the service. However there were no staff present to immediately respond to this behaviour. The person did not injure anyone and calmed down without assistance from staff however there was the risk that the situation could have escalated if staff were not aware of it occurring. We observed another person shout 'get off me' and another person was standing over them. Again, no staff were present in the communal room at the time, however they did enter the room shortly after the person shouted. There were also documents for staff to complete to record where people were periodically throughout the day to ensure staff knew people's whereabouts to protect them. However we saw that these checks were not always recorded, therefore we were unable to determine if these checks were completed as planned. We could not be sure that people were being protected by sufficient numbers of staff who were able to respond quickly if they were not always present in areas where incidents could occur.

The above evidence shows staff were not always available to meet people's needs in a timely manner and keep people safe. This was a continued breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the risk of harm to people's health, safety and wellbeing and not always been adequately assessed and planned for to promote people's safety. Some people needed support from staff to help maintain their skin integrity however we found that there were not always plans in place for staff to follow. For example one person who had pressure sores needed to be periodically repositioned according to the advice from other health professionals involved with the person's skin integrity care. This is so that they were not sitting or lying in one place for too long, which could damage their skin further. The records showed that the person was not being repositioned in line with the guidance. This meant we could not be sure the person was being supported to improve their skin integrity in line with guidance. Another person had a pressure sore however their care plan had not been updated since the sore had developed so there was no detail as to what staff should be doing to support the person with their skin integrity. When we asked a member of staff about how frequently the person should be repositioned, they were unable to provide a definite answer and it differed to the advice from the health professional. Some people who had pressure sores also required creams to be applied to their skin in order to protect it. However, there were not always Medication Administration Records (MARs) available to show that cream was being applied by the staff in line with the prescription. When we asked a member of staff about the MARs they told us that staff were not completing them as they were in a drawer in the office for updating but they had been there for some time. This meant we could not be sure that people were receiving the appropriate level of support to help maintain their skin integrity or to help improve sores if they had developed and could not be sure they were receiving their creams as prescribed.

We found that people were not consistently protected from the risk of harm through accessing medicinal creams. Topical creams were kept in people's unlocked bedrooms. Some people who used the service had dementia and there was a risk that they could access and ingest some of these topical medicines or apply them to areas that it was not prescribed for. There were no risk assessments in place to determine if it was safe or not for each person to have access to their topical creams. This meant some people were at risk of harm as they could access their topical cream.

People who were at risk of choking were not always provided with food appropriate to their needs which put them at risk. For example, one person needed a soft diet; however staff were giving them food that put them at risk of choking and we saw that the person had had episodes of choking. We saw evidence that the person was given cake and biscuits on multiple occasions which put the person at risk of choking. The person's care plan did not mention that they needed a specialist diet and when we asked a member of staff

about the type of diet the person required, they said they thought they were on a soft diet but needed to check. The Speech and Language Therapist (SaLT) was contacted whilst we were present and they said the person needed a soft diet and should not be given biscuits and cake but could have bread with crusts cut off. We saw another example of a member of staff supporting a person to eat a meal of solid food and they stated to a colleague, "I think [Person's name] needs to be on a soft chew diet" to which the colleague responded, "I do too" however the person was still being supported to eat solid food. This meant there was a risk to people's health, safety and well being as staff were not always aware and plans were not always in place to protect people and people had experienced choking episodes.

There were not always sufficient plans in place to inform staff of how to support people who could become aggressive or agitated and how to de-escalate the situation. One member of staff told us, "[Person's name] has been violent towards everybody" and they went on to state that they felt some people's behaviour that challenged was impacting upon other people and staff. Permanent staff were able to tell us how they managed this person's behaviours in a consistent manner. However, any new or temporary staff would not have access to the plans needed to protect this person and others from any harm as a result of their behaviours that challenged.

We found that when risk management plans were in place, they were not always followed by the staff to keep people safe. For example, one person's care plan stated they needed constant supervision from staff during the afternoon. However, when we asked a member of staff about this they told us, "[Person's name} doesn't need to be watched all the time." Staff were also not always available to provide this supervision as we saw this person was left unsupervised on multiple occasions during the afternoon of our inspection. Another person's care records stated they needed, 'staff to be aware of [person's name] whereabouts at all times'. However we observed this person being left unattended for a prolonged period of time with no staff present. This meant people did not always receive the support they needed from staff to keep them safe and staff were not always aware of what was required.

We found that action was not always taken in response to safety incidents to prevent further incidents from occurring. For example, one person's care records stated the person had put themselves onto the floor in an uncontrolled manner whilst being supported by staff. However no action had been taken to address why the person had done this and what staff should do to reduce the risk of this happening again. Another person's plan recorded that they became aggressive in the afternoon; therefore they required increased supervision at that time. However, this person's care records showed incidents of aggression were at all times of the day which showed the risks of aggression in the morning had not been assessed and planned for and other people living at the service were coming to harm as a result of this person's behaviour. This meant that the likelihood of an incident occurring again had not always been reduced and staff would not always have sufficient information available to them in order to respond appropriately to an incident, which could put people at risk.

We found that the risk of harm and injury through falling was not managed safely and effectively. Some people were at risk of falling; however some plans and risk assessments in place lacked the detail to guide staff in how people should be supported to prevent them from falling and to keep them safe after a fall. For people that had fallen, there was sometimes no action documented as to how the likelihood of future falls occurring were reduced so people had continued to experience falls. For some falls action had been documented and this included staff to observe people for a period of 24 hours following a fall to ensure their safety. However, these observations did not always last for a 24 hour period as planned. For example, one person who had fallen had continued to experience further falls, sometimes within the 24 hour observation period. This meant staff were not following the plans in place to monitor people's safety post falls. This meant people were at risk of developing symptoms following a fall and this may not have been identified by

staff. Risk assessments that were in place had not always been updated following a person falling. For example, one person had fallen six times in one month; however their falls risk assessment and mobility care plan had not been reviewed or updated to reflect their change of need at the time of their falls. We also saw that when risk assessment and plans were in place for falls, these were not always being followed. For example, one person should always have their walking frame close to them to reduce their risk of falling. However we observed that their frame was not always close to them. This meant they could have started to mobilise without the use of their frame and potentially fallen. This showed that effective systems were not in place to protect people from the risk of falling.

Some people needed extra support to help them mobilise. We saw staff did not always follow safe moving and handling guidance to support people to move. For example we saw a person being assisted from a sitting down to a standing position by two members of staff. One of the members of staff helped the person by putting their hand under the person's arm. This is not an appropriate technique as it can cause injury to the person however on this occasion the person did not come to harm. We also saw people being wheeled on a wheelchair without their feet being on footplates. If a person's feet are not on the foot plates, this puts them at risk of having their feet trapped under the wheelchair or knocked whilst being moved. We also saw staff moving a person in a wheelchair without due care and attention and knock the person into the side of the chair. These unsafe practices placed people and staff at risk of injury.

Some equipment that was accessible to people living at the service was unsafe. We observed a commode that had a rubber foot missing which meant it could move more easily and slip when someone tried to use it. A frame that was positioned over a toilet to assist people to sit and stand and a walking frame had screws missing which left them unstable, placing people at risk of injury and falls. There were some walking frames that had rubber feet which had been worn down to the metal frame, so the frame could become slippery, rather than supportive. This meant that equipment was not always safe or fit for purpose which placed people at risk of harm to their health, safety and wellbeing. We made the registered manager aware of the unsafe equipment and action was then taken to either remove or fix the equipment.

The above evidence shows that systems were not in place to ensure people consistently received safe care and support. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people were not protected from the risk of abuse and neglect. All incidents of alleged abuse must be reported to the local safeguarding authority. There were some documented incidents of alleged abuse which had not been reported and which the registered manager told us they had not been aware of. As the incidents had not been reported, we could not be sure that appropriate action was taken to keep people safe from future incidents. Staff we spoke with were able to identify some signs of symptoms of potential abuse and they knew how to report it. However the incidents had not been recognised as potential abuse by the staff. Therefore, incidents had continued to occur as action was not taken to report and respond to these incidents to protect people from further harm.

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

People told us they had their prescribed oral medicines when they needed them. Documentation relating to people's oral medicines showed that staff had recorded when these medicines had been given. There were one page profiles for staff with the person's photo on and details of their allergies. We observed staff administering medicines and they were kind and encouraging to people. People were not rushed and were given their medicines at their own pace. Some medicines are applied or taken as and when required, these

are called 'PRN medicines'. We observed staff offering people their PRN medicines and we saw this was sometimes refused and the staff respected this. We checked the storage, documentation and the stock levels of some people's oral medicines. They were stored safely and the stock levels matched the documentation. The room where these medicines were kept was checked to ensure it was below the recommended maximum temperature. This meant people's oral medicines were managed safely.

The service followed safe recruitment practices. Staff files we viewed included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure staff were suitable to work with people who used the service.

Inadequate

Is the service effective?

Our findings

Staff told us and records confirmed that they had not been trained to know how to manage people's behaviours that may challenge. One member of staff we spoke with said, "[Person's name] can be very aggressive. It's hard as we're not trained to handle people like that. We don't know what to do" and they went on to say, "People should be able to live here and not worry but because of some people's behaviour they do." This meant that people in the home were being affected by people with behaviour that challenges and staff were not always trained to react appropriately. If staff are not trained appropriately it could lead to situations escalating and people becoming more distressed or coming to harm. This meant staff were not suitably skilled to meet this person's needs and people were at risk of harm because of this.

Records showed that training was not always up to date and our conversations with staff identified gaps in their knowledge and skills. For example, one staff member told us they did not know enough about how to gain people's consent to care or how to act in their best interests if they were unable to consent. They said, "We've told the manager we need more training. We're told if things are not right but there's no training." Another staff member told us they felt most of the training was online and that they did not learn as effectively from a computer and preferred hands-on learning. This showed that the staffs' individual learning needs were not always met. One professional we spoke with said, "There are a lot of training issues." Another professional we spoke with said, "Staff would benefit from formal pressure care training." We saw that training had not always been effective or was out of date. For example, we observed moving and handling techniques that were not always safe or appropriate. Records relating to moving and handling training showed that some staff had not had their training refreshed recently. One member of staff had undertaken the training but had not scored well on the knowledge check. There was no evidence present to suggest that steps had been taken to improve their knowledge of moving and handling techniques as a result of this. This showed that effective systems were not in place to ensure staff were suitably skilled to meet people's care needs.

The above constitutes a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Mental capacity assessments were being carried out, however these were often not reviewed to identify if people's capacity to make decisions had changed. This meant that if a person's ability to make their own decisions had changed, then staff would not necessarily know as people had not always had their needs reviewed.

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). Some DoLS referrals had been made, however some referrals were not made in a timely manner and as a result people were being potentially unlawfully restricted at the service. For example, one person had lived in the service for period of 61 days. They had restrictions placed upon them that ensured their safety, for example if they started to walk around the home during the night, they were restricted to a particular area of the home. However, the service had not made a DoLS referral for this person and the person was not able to consent to this restriction. This meant the person had been potentially unlawfully restricted for a significant period of time. Training records showed that some staff had undertaken MCA and DoLS training but staff were not always able to tell us about the MCA or DoLS or which people had a DoLS in place. One staff member told us, "The residents mental capacity changes so much, there should be more training." This meant that the requirements of the MCA and DoLS were not consistently followed and at least one person was being potentially unlawfully deprived of their liberty at the time of our inspection.

This was an additional breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Appropriate referrals had not always been made to other health professionals, or when health professionals had been involved their advice was not always being followed. For example, one person should wear special boots in order to help protect their skin integrity and prevent pressure sores, however one professional we spoke with told us, "[Person's name] hasn't got their boots on today but they should wear them all the time" and went on to say, "We [the health professionals] couldn't get any answers about how the sore had developed." The details of the boots they required were not reflected in their care plan, even when it had been reviewed. The advice from a SaLT had not been followed as one person was at risk of choking however they were still being given food that could cause them to choke. This meant that although some health professionals were involved in people's care, their advice was not always being followed which put people at risk of becoming or unwell, or not getting better.

People were not always appropriately supported to maintain their food and fluid intake. Some people were on food and fluid monitoring charts where staff recorded how much and what they ate and drank. However, these charts did not identify a target for each person and the amounts were not added together to check how much a person had consumed each day. Therefore it was not always possible to determine if people were having an amount appropriate to their needs. There were mixed opinions about the food. One person told us, "It's not bad, you get a choice" and we overheard another person say, "This isn't very appetising." A person we spoke with told us about their meal. They said, "I've eaten warmer ice cream" and went on to say, "I need to eat it quickly before it gets colder. It's horrible." We observed a staff member checking whether someone had liked their food, as they had left most of their meal. The person shook their head that they had not enjoyed the food. The member of staff offered the person the alternative meal on the menu which they accepted. This meant people were at risk of losing weight or becoming unhealthy if they did not maintain their nutritional intake and some people did not always enjoy the food.

Requires Improvement

Is the service caring?

Our findings

Some people told us that staff did not always have the time to interact with them. One person we spoke with said, "It would be nice if they chat to us" and, "The staff could make a better effort to make me feel wanted." Another person told us they felt staff were not consistently caring. They said, "Some very good, some very bad, depends on who it is." We saw examples where staff did not treat people with dignity. For example, we saw a member of staff ask a colleague in front of the person sitting in the dining room, "Do they need taking to the toilet?" to which the colleague responded, "Just ask them." We saw another member of staff who entered a dining room and said, "Who needs taking to the toilet?" in front of multiple people. We also observed during lunch time that staff would sometimes place plates of food in front of people without explaining what the food was.

We saw that staff did not always deliver care in a caring and respectful manner. For example, one person's care records showed they enjoyed colouring. Their care plan also recorded that they could get agitated if their colouring book was moved away from them. We observed this person participate in some colouring, then they moved their colouring book to one side for a rest. A staff member then took their colouring book and gave it to another person to finish off. This showed staff did not follow this person's care plan and they didn't respect that the colouring was the person's uncompleted work. We later saw this person become agitated and a member of staff asked if they would like do some colouring to which they responded yes. The member of staff walked away as they were called to support another person, so the person did not get their colouring book as requested. We also observed a member of staff support a person to have a drink however they just tipped the drink into the person's mouth without explaining what they were doing or what the drink was first; this is not respectful or dignified. We also overheard staff talking about applying for other jobs in a communal area of the home where people could have heard them. This meant staff did not always have the time to ensure people's needs were met in a timely and caring manner.

The environment within the home was not always dignified. Certain areas of the home had unpleasant odours. Some of the cushions people were sitting on had not been cleaned. When we asked the registered manager about this they explained that night staff should clean things as necessary however it was evident that this had not always been done. The placemats being used in one of the dining rooms were dirty on the under-side, however they were being stacked on top of one another so the dirty side would touch the top side that people would put their plates on. Bathrooms that were in use were sometimes cluttered. For example one bathroom had a broken fan and walking stick in the corner as well as stored mobility equipment. Two bathrooms also contained bags of animal wood shavings. It was explained to us that this was used to clean up any spillages; however having this on display in an area where people were having personal care was not dignified. People's clothes had also been left in bathrooms and corridors. This showed a lack of respect for people's personal property. Some people had sensors by their beds so that if they got out of bed, staff would be able to go and help them so they didn't fall over. Some of the mats were taped to the floor with yellow hazard tape, which is not a dignified or discreet way of ensuring the mats did not become a trip hazard.

There was both a written and pictorial menu for people to use when they were choosing their meals, however the food being served did not match the menus, so people did not always have the correct information when choosing food. The kitchen staff explained that there had been a recent staffing change and menus had not yet been updated. We were also told that some areas of the home (such as communal lounges) are not always open for people to spend time in, due to staffing issues so people could not always choose where to spend their time. This meant people were not always supported to make choices effectively and their choices were not always respected.

There was a display board in each lounge area which told people the day and date. However this had not been updated for six days. Some people with dementia need support to be able to know the date and this may have caused them confusion. We observed three people mention to staff that they were cold in a communal area, however the radiator was not switched on for them. This meant that staff did always ensure people were comfortable.

The above evidence shows that people were not consistently treated with dignity and respect. This was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people and relatives told us that they felt the staff were caring and we did also see some examples when staff were kind and encouraging to people. One person told us, "The staff are lovely." Another person we spoke with said, "So far so good, I get help from the staff." A relative we spoke with said, "The staff seem very friendly. There's a nice atmosphere." One member of staff we spoke with told us, "The staff that are here do care." The member of staff who was administering medicines was kind and did not rush people when taking their medicines. We heard the member of staff say, "I've got your tablets, will you take them for me?" and the staff member had a nice approach. We also saw staff support a person to eat their lunch and this was done with patience.

We observed that staff respected people's privacy. We saw staff knock on people's doors before entering and when people had a visit from a health professional people were supported to have their appointments in a private area. Visitors were also able to come at any time and they told us there were no restrictions on visiting hours. Relatives told us that they were made to feel very welcome by staff and that they would be offered tea and coffee whilst they were there, some relatives also stayed to eat with their loved one. We observed that staff knew the regular visitors by name.

Requires Improvement

Is the service responsive?

Our findings

There was not always evidence that people had always been involved in planning their care. Some people's care records showed that they had been asked about their care preferences. However, this information was not regularly reviewed to ensure people's preferences were still current. For example, one person's care records showed their care preferences had been recorded in 2014, therefore we could not be assured that they were still current. Some people's care plans were not personalised and did not give staff details as to how to support individuals. For example, one person had a plan in place to support them with their behaviour that challenged but the plan was generic. For instance, it referred to the need to support the person with any diabetic needs; however the person did not have diabetes so the support plan was not appropriate for that person. Another person had a plan in place as they would wake during the night and would appear to be looking for something. However no detail was included how staff should support this person at this time. Care planning documentation was also often not reviewed for long periods of time, so it would not be known if people's preferences had changed. This meant that there was a risk that people were not receiving care that reflected their individual needs.

People and relatives we spoke with told us there was a programme of activities. However, on the day of our inspection the activities coordinator was on annual leave. One person we spoke with said, "After breakfast we're all sent in here and we go to sleep." Most people spent their day in the communal lounges watching television. We observed that people who were able to do activities independently, such as knitting and colouring had the opportunity to do so. Other people who needed support to participate in their hobbies, did not receive this support on the days of our inspection. The registered manager explained that there was a plan to have another member of staff working on activities however that member of staff was currently working as a carer. They also said that due to staffing levels, the staff did not have time to engage people in activities. Some people also enjoyed being able to touch and fiddle with certain objects and we saw that some people had a 'fiddle muff'. This is a piece of material with multiple different objects attached that a person can fiddle with. One relative we spoke with said that their loved one was calmed and occupied with having these objects available to them and told us that the activities coordinator had worked with their loved one to ascertain what they liked to do and what would suit their needs. However, we observed that one person had their fiddle muff placed onto them without their consent which caused them to became agitated and hit out. The staff member had tried to support the person with objects that were meaningful to them however they did not try to engage with the individual effectively. The staff member then spent some time encouraging the person to accept their fiddle muff. Once the fiddle muff was placed onto the person, the staff member walked away to support another person who used the service and the person was not supported to use their fiddle muff therapeutically. This meant that when there were staffing shortages, people were not always able to partake in activities that were meaningful to them or therapeutic.

There were meetings held with people to discuss their care. We saw the notes from these meetings; however, people's feedback during these meetings had not yet been fully acted upon. For example, a request from people for a menu change had been acted upon but the concerns people raised about staffing shortages had not. None of the people or relatives that we spoke with said that they had needed to make a

complaint. One relative we spoke with told us they would be 'very happy' to raise it with the registered manager if needed. A person we spoke with said, "So far no complaints." We saw that when complaints had been made they had been recorded and written responses sent in line with their policy. This meant that although people were sometimes asked for their feedback about the care, timely action was not always taken in response to this to improve people's care experiences.

Inadequate

Is the service well-led?

Our findings

There was a continuing breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 since our last inspection in October 2016 and action taken had not been effective in ensuring the service was fully staffed. Also, additional breaches of the regulations of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified during this inspection which meant the quality and safety of care in the home had deteriorated.

Effective systems were not in place to ensure risks to people were assessed and managed to promote their safety. For example, we found that a number of incidents of alleged abuse had not been reported to the local safeguarding authority as they had not been reported to the registered manager. When we asked the registered manager about these allegations they confirmed, "They haven't been reported to me." Care notes had also not been audited in order to identify any incidents. When people had fallen there was no analysis of any patterns or trends to try and determine why falls had occurred or if something could be done to reduce the likelihood of people falling again. There was no monitoring system in place to ensure people received the safety checks they required after falling. For example, care records did not always show that the provider's policy to monitor people's safety through regular checks for a 24 hour period after falling had been completed. Food and fluid charts were also not audited to identify whether people were consuming food appropriate to their needs or consuming enough to promote their wellbeing. This meant that risks were not being monitored and action was not always taken to promote the health, safety and welfare of people. This lack of analysis and oversight may have contributed to why people had continued to experience some falls or incidents within the home.

There was no evidence of audits of care notes and care documentation and therefore omissions in care and care planning had not always been identified. For example, one person experienced periods of physical aggression and the plan in place to guide staff had not been reviewed for six months, despite the person continuing to experience behaviour that challenges. This meant the person, and other people living in the home, had continued to experience periods of agitation or distress and action had not been taken to review what worked for the person in order to reduce the episodes of aggression. Some people had food and fluid charts in place so that they could be monitored, however these were not always totalled or audited so it was not known whether people were eating and drinking their recommended daily amounts. It was not always clear what the purpose of the charts were as it was unknown why they had been implemented for some people due to no targets being noted and no audits taking place. This meant they could be at risk of losing weight if the amounts they were consuming were not enough and this was not being checked. When we asked the registered manager about the lack of audits, they said, "I know I've slipped with paperwork." The registered manager went on to explain that they and the deputy should be carrying out audits but they haven't been able to do them, due to staffing shortages. Care plan documentation was often not reviewed in a timely manner. For example, one same person also had their mental capacity assessed however this had not been reviewed or updated for 17 months. This meant people's needs may have changed but this was not always being reviewed or identified.

We found that systems to monitor safety and quality were not effective. For example, checks on equipment had not always been effective as damaged equipment was still being used or available for people to access when it was not safe for them to. When we asked the registered manager about this they said, "I know it's my responsibility to check." This meant that checks in place had not been fit for purpose and this could have put people at risk of injuring themselves. The registered manager told us that they carried out night visits to the home to monitor the night staff. However, there was no evidence that these had been carried out so we were unable to see the outcome of these checks, whether any actions required had been identified and we could not be assured that they had been completed.

Staff had not always received the training necessary to effectively support people, which left people and staff at risk. One person we spoke with said, "I don't think that those over the staff keep enough of an eye on them." Although it had been identified that staff were not able to support a person effectively with behaviour that challenged, no action had been taken to train staff to support people who did experience periods of agitation. When looking at training records we saw that some staff had not been added to the overall training matrix the registered manager used to have an oversight of when staff needed refresher training. Therefore staff did not always receive the necessary training as the registered manager did not have complete oversight. We did not see any evidence of staff competencies being checked so we could not be sure the registered manager was ensuring staff were using the correct techniques when supporting people. This left people and staff's health, safety and wellbeing at risk. This meant that the systems the registered manager and provider had in place to ensure staff were suitably skilled to meet people's needs were not effective.

We saw one example of a medicines audit however it was not dated so we could not be sure when it was carried out. The audit noted that photos used to identify people were sometimes missing from the medicines paperwork and we saw that photos had now been put in place. However, the audit had not looked at the way in which the application of topical creams was being recorded and how they were being stored and whether it was appropriate for people with certain needs to have access to them in their own room or communal areas. This meant the medicines audit had not identified potential safety concerns relating to medicines management.

When we asked the provider about how they were ensuring the registered manager was doing all they needed to run the home effectively and make improvements they were unable to tell us how they monitored this. Feedback had also not always been acted upon by the provider as people and relatives had fed back about staffing being an issue but these had not been improved. We also provided feedback at the end of the first day of our inspection to the provider and the registered manager regarding the cleanliness of the home. We found on our next visit to the home that limited progress had been made to rectify this and bathrooms were still cluttered and some equipment being used by people was still dirty. This meant timely action had not always been taken to rectify issues.

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

The registered manager is required to submit notifications to the CQC about certain incidents within the home, for example, serious injuries that had occurred at the service and incidents of alleged abuse. However, we found that these were not always being submitted as required.

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