Veecare Ltd

Tralee Rest Home

Inspection report

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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

This inspection took place on 22 and 23 June 2016 and was unannounced.

Tralee Rest Home is registered to provide personal care and accommodation for up to 36 people. There were 25 people using the service during our inspection who were living with a range of care needs. These included diabetes and mobility support; and people were living with different stages of dementia.

Tralee Rest Home is a large detached and extended house situated in a residential area just outside Whitstable. The service had a large communal lounge available with comfortable seating and a TV for people and a separate, quieter lounge. There was a small dining room in which people could take their meals.

A registered manager was in post. A registered manager is a person who has registered with the care Quality Commission to manage the service. 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.

Tralee Rest Home was last inspected in December 2015, when it was rated as Requires Improvement overall, but safety of the service was rated as Inadequate. We found a number of breaches of Regulation at that inspection and issued requirement actions and warning notices. The provider sent us an action plan to tell us how they would address the breaches. This stated that all remedial actions would be completed by 30 March 2016.

At this inspection we found that although improvements had been made in some areas, other significant problems had emerged.

People had not consistently been protected against identified risks to their health, safety or well-being. This included risks associated with the control of infection, skin integrity and medicines. There was no robust system in place for raising safeguarding alerts with the local authority. We witnessed a safeguarding incident and made a referral to the local authority following our inspection.

Staffing levels had been increased following our last inspection but the competency of those on duty was not universally sufficient. Training and supervision had not been wholly effective in some areas and recruitment checks were incomplete.

Maintenance of the premises had improved but identified problems had not always been remedied promptly. Fire and equipment safety checks had been regularly carried out and there was a reciprocal arrangement with another home in the event of an emergency evacuation. The premises had clear signage to help people living with dementia to orientate themselves.

The principles of the Mental Capacity Act had not been followed with regard to obtaining consent, but Deprivation of Liberty Safeguards (DoLS) had been appropriately sought.

People's healthcare had not been properly considered when they had diabetes. Other people saw opticians, chiropodists and dentists on a regular basis. People were offered a choice of meals and appeared to enjoy them but food supplements had not been managed correctly.

Care plans were person-centred and detailed but they were not always an accurate reflection of the care people received. Information about people's life histories had been complied to give staff a sense of people's personalities and achievements. People engaged in a variety of group and individual activities.

Complaints had been managed effectively and people had keyworkers to support them if they wished to raise concerns.

The service was not well-led and quality assurance processes had failed to identify a range of issues highlighted by the inspection.

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

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

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines had not always been managed appropriately.

Equipment was not clean and sanitary.

Risks to people had not consistently been minimised.

There were not enough skilled and competent staff on duty to support people. Recruitment checks were incomplete.

Is the service effective?

Inadequate

The service was not effective.

People's rights had not consistently been protected by proper use of the Mental Capacity Act (MCA) 2005.

People's health care needs were not consistently met.

Nutrition advice had not always been followed accurately.

Staff training was not wholly effective in some areas.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some people's dignity was not respected by staff as they had made beds up over wet and stained mattresses.

People's health and well-being needs were sometimes overlooked.

Most staff delivered support with consideration and kindness.

Staff encouraged people to be independent when they were able.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Although care plans were written in a person-centred way; they were not always reflective of the actual care given.
People enjoyed a variety of activities in groups and one to one.

There was an effective complaints process in operation.

Is the service well-led?

Inadequate

The service was not well-led.

Not all concerns raised during the last inspection had been addressed and other significant issues had emerged.

The provider and manager had been reactive rather than proactive in addressing safety and quality problems.

Systems were in place to assess the quality and safety of the service but these had not been effective.

Staff said there was a good teamwork and open culture in the service and that the registered manager was supportive.

Tralee Rest 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 and 23 June 2016 and was unannounced. The inspection was carried out by two inspectors .Before our inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at any safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met with twelve of the people who lived at Tralee Rest Home. Not everyone was able to verbally share with us their experiences of life in the service. We therefore spent time observing their support and carried out a Short Observational Framework for Inspections (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with three people's relatives. We inspected the home, including the bathrooms and some people's bedrooms. We spoke with four of the care workers, kitchen staff, the registered manager and the provider.

We 'pathway tracked' eight of the people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home where possible and made observations of the support they were given. This allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed other records. These included three staff training and supervision records, three staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Inadequate

Is the service safe?

Our findings

Relatives told us that they felt their loved ones were safe. People appeared relaxed and comfortable around staff. One person remarked; "I'm quite alright here and nobody would harm me".

At our last inspection in December 2015, laundry facilities had not been operated properly and there was an odour throughout the service. At this inspection, a new hand wash sink had been fitted in the laundry and the flooring had been improved. Dirty and clean items were kept separately to avoid contamination. However, there continued to be a strong odour of urine on entering the premises and this was very noticeable in some bedrooms. The provider told us that
flooring had been replaced in some areas to try to remove the smell. We checked the mattresses in some bedrooms. In each of the rooms where we noticed overpowering odours, the mattresses were heavily stained with urine. One of them was a rubber mattress and the surface of it was soggy and had degraded. This person's bed had been made up over the mattress, so the sheets were damp with urine. Another person's mattress had faeces smeared on it and sheets also had brown stains on them. This was both unhygienic and undignified for people using those rooms. We brought this to the immediate attention of the provider and registered manager; who replaced the mattresses. The provider told us that he had not thought to look at the mattresses when trying to deal with the odours. An audit was introduced during the inspection so that mattresses would be checked regularly for cleanliness in future.

The failure to maintain clean equipment is a continued breach of Regulation 15 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Toilets and bathrooms were clean and bedrooms and communal areas appeared tidy and dust-free. Antibacterial hand wash and paper towels were available so staff, people and visitors could clean their hands appropriately. Staff used gloves and aprons when delivering personal care to prevent any cross contamination or spread of infection.

At our last inspection, medicines and creams had not always been managed safely. At this inspection, protocols had been introduced for medicines prescribed 'As and when needed' or 'PRN'. These were detailed and included other ways of dealing with conditions before resorting to PRN medicines. For example; when people had prescribed PRN laxatives, the protocol suggested trying fruit juice to resolve any constipation first. Assessments had been made about the risks of leaving prescribed creams in people's bedrooms; but these had not been followed in practice. Risk assessments showed that creams such as steroids and pain relieving gels should be stored in the medicines trolley. However, these were found in several bedrooms. In one person's bedroom there was a spray that had not been prescribed for them. This had belonged to a person who was now deceased. There was a risk that these items could be applied inappropriately by people living with dementia.

Records of creams applications were confused and showed that people had not always received their treatments as prescribed for them. Creams found in bedrooms did not consistently match the list of those prescribed; or those in use by staff. Some people had been prescribed pain relieving patches. These must be

applied in a different place on the body each time to avoid irritation occurring at the site of the patch. There were no records to show where the patches had been applied, so it was not possible to evidence that best practice had been followed to prevent people's skin from being effected.

During a medicines round conducted by the registered manager, she did not ensure people had swallowed their medicines before signing off the medicines administration record, (MAR). This was unsafe practice. Some of the photos on the MAR were clearly old and were no longer a good likeness of people. The purpose of these photos was to ensure that staff gave medicines to the right people. As there were several new and agency staff working, there was a risk that staff could be confused by the photos.

The unsafe management of medicines is a continued breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Controlled drugs (CDs) were stored correctly and signed off by two staff when they were given to people. The temperature of the medicines fridge had been recorded daily and MAR had been signed off on each occasion that medicines were given to people.

At our last inspection, there was no robust system in place for raising safeguarding alerts with the local authority. At this inspection, the situation had not improved. We observed one person threatening another with their fists. We checked the care plan of the person who had shown aggression and read a behaviour chart which recorded they had hit the same person during May 2016. No incident report or safeguarding alert had been raised about this. The registered manager told us that she had no knowledge of the incident until we brought the behaviour chart to her attention. We raised a safeguarding alert following the inspection.

Staff had completed charts to show when unexplained bruising or marks had been found on people. These were filed inside people's care records but there was no other information to show what actions had taken. In one instance we read about in January 2016, a safeguarding alert should have been made but had not been. This would have allowed the local authority to consider investigating and to ensure people were safe and protected.

The registered manager told us that she and staff had received extensive training about safeguarding following our last inspection. Staff were able to describe different types of abuse to us but systems for ensuring that any incidents were escalated had failed; leaving people at risk.

The failure to protect people from abuse is a continued breach of Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, actions to minimise identified risks to people had not been put into practice. At this inspection, assessments had been made about different risks to people; but actions designed to address them had not always been followed through. Some people's care plans recorded that they needed special air mattresses and cushions to help prevent pressure wounds. These should be set to people's weights to provide the best therapeutic effect. However, those we checked had all been set at the incorrect levels. For example; one person weighed 62.6kgs in May 2016 but their mattress was set to 30kgs and their cushion to 110kgs.They had had a recent skin wound. Another person weighed 47kgs in May 2016 but was sitting on a cushion set to 100kgs. The registered manager told us that it was the District Nurses' job to set the weights on this equipment but accepted that staff should have checked them. A new checklist was put in place during the inspection but people had not received the intended benefits of pressure-relieving equipment.

Actions to minimise identified risks to people had not always been carried out, which is a continued breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Other risks had been better managed. Where people were at risk of falling, assessments had been made about this; which contained guidance to staff about keeping people safe. For example; where people had poor eyesight, there were directions about how staff should walk with them to ensure they did not trip; which we saw staff did. Some people had been assessed as needing regular checks during the night and records showed that this had happened.

At our last inspection we reported that there were not enough staff to meet people's needs. At that time there were four care staff including a senior, on duty all day. At this inspection staffing levels had been increased by one in the mornings. Dependency tools had been revised to include dementia and behaviours that challenged; which meant these conditions were taken into account when deciding staffing needs. Staff told us that they were managing better with the extra staff member. Although staff were busy, they were able to make time to speak with people and to attend their needs promptly. Relatives said they generally felt there were sufficient staff to keep people safe. However, staff were not always competent when completing their duties. We observed incidences of poor practice when people were being helped to move around. One person was being assisted by two staff using a hoist. While the person was suspended in the air, the registered manager called one of the staff away to a telephone call. This left one, new staff member helping that person and they began to lower them into the chair too quickly. The registered manager left the medicines round that she was in the middle of completing to intervene. It was poor practice for the registered manager to have answered the telephone while carrying out a medicines round; as this requires full concentration and undivided attention. It was further poor practice to interrupt staff while they were hoisting a person to take a phone call. Another person was repositioned in their chair by staff putting their hands around the person's waist and pulling them backwards. This looked uncomfortable for the person; who grimaced during the manoeuvre.

The lack of competent staffing is a continued breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, staff recruitment documentation had not been adequately completed to list applicants' full work histories. At this inspection this had been put right and all files of new staff showed that any gaps in employment had been explained. However, at this inspection there were no current photos of staff held on files; which was important for identification purposes.

We recommend that a current photograph is retained on all staff files.

At our last inspection, maintenance of the premises had not been carried out to an acceptable standard and some equipment, such as toilet seats, needed to be replaced. At this inspection, a maintenance man had been employed and toilet seats and general maintenance had been carried out in most areas. However, one person was sitting alone in the quieter lounge, trying to watch a DVD. Every few minutes, the DVD would jump back to the beginning and was, in effect, playing on a short loop. This was causing the person to become frustrated and upset. The maintenance book recorded that a similar problem with the TV had been reported on 9 June 2016. There was also a report on the same date, of a curtain track requiring fixing in one bedroom, but neither job had been signed off as completed. We visited the bedroom and saw that there was nothing to prevent the curtains being pulled off one side of the track there.

We recommend that maintenance is carried out promptly, so that people's experience of the service is improved.

Equipment and utilities such as gas, water and electricity had been regularly safety-checked. Personalised emergency evacuation plans (PEEPS) had been completed for each person and detailed the number of staff and any equipment needed to assist them. Fire alarms were routinely tested and staff had received training in fire safety. Fire exits were marked and staff could describe escape routes to us. The service had a reciprocal arrangement with another local care home, so that people could be provided with continuity of care in the case of an emergency.

Inadequate

Is the service effective?

Our findings

At our last inspection we checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). This 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. At that inspection, capacity assessments were not specific about the different decisions for people to make and consent forms had not been signed by the appropriate person.

At this inspection, capacity assessments were now based on individual decisions and people's ability to make them. However, consent forms presented a confused picture about people's capacity to agree to certain aspects of their care. One person had signed consent for care and treatment, for medicines and the use of photos; but mental capacity assessments recorded that they were unable to express any views about their care. Another person had been assessed as lacking capacity to make most decisions relating to their care but had signed consent forms for vaccinations and medicines. Staff told us that this person was unable to make even simple decisions for themself. This demonstrated that the principles of the MCA had not been followed properly.

The failure to act in accordance with the MCA is a continued breach of Regulation 11(1) (2) (3) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People's health care needs had not been appropriately or consistently met. A number of people were living with diabetes; which could be controlled by tablets and diet. Care plans recorded, 'All staff to ensure X has a diabetic diet' or 'Staff to ensure X has as little sugar intake as possible'. There was no information within care files to tell staff which foods were suitable for people with diabetes, and staff gave us various responses to questions about this.

Food diaries for people with diabetes showed that they had regularly eaten four biscuits per day plus cake, meringue or pie and ice cream. Senior staff told us that people with diabetes would be given Rich Tea biscuits; which were lower in sugar. However, two people with diabetes were given chocolate biscuits by staff with their morning drinks. When we brought this to the attention of staff, they said they "Keep forgetting which people have diabetes".

We spoke with the cook on duty who initially told us that nobody had any sort of special diet. We asked this again on the second day of our inspection and this time the cook named some but not all of the people who required a diabetic diet. There was no list in the kitchen to remind cooks or staff about this. The cook was unable to provide us with clear information about how foods given to diabetic people differed from ordinary diets .Although the cook said desserts such as Angel Delight were sugar free versions, when we checked the store cupboard they were only full sugar items available. The cook said that cherry pie was bought in frozen and was not especially for diabetics and that meringue was not provided often. The cook had not had any training in catering for special diets. This meant that people were not consistently being provided with the

best options to keep them healthy.

People's health needs had not been consistently met; which is a continued breach of Regulation 9 (1) (a) (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Other aspects of people's health care had been addressed and a chiropodist visited during the inspection. People were seen in private to have their feet and nails treated. People had regular appointments with opticians and dentists to monitor and treat their eyes and teeth as necessary.

At our last inspection food and fluid charts had not always been adequately completed to ensure people were eating and drinking enough. At this inspection charts had improved and more detail had been included about people's intake. When people had lost weight, dietician advice had been sought. However, this had not always been accurately followed. For example; one person had been prescribed meal supplements at two per day in December 2015. Food and fluid charts recorded that these had only been given once on six days out of ten during May and June 2016. On one day no supplements were shown as given and on three other days three supplements per day were documented on the food charts. This person had lost 3.5kgs in total since March 2016. Their care plan stated that they should be weighed weekly if they lost more than 2kgs. In March alone they had lost 2.3kgs but were not weighed weekly following this loss. The dietician had not been contacted again at the time of our inspection; which meant this person remained at risk of malnutrition.

The failure to consistently meet nutritional needs is a continued breach of Regulation 14 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Most people appeared to enjoy their meals and one person told us, "I do like my food and there's always plenty". These were served hot and people were given choices. Hot and cold drinks were offered at intervals throughout the day and people had ice creams or lollies on one very warm day during our inspection.

At our last inspection we reported that training had sometimes been ineffective. At this inspection staff told us that they felt training had improved. A staff survey showed that most staff were satisfied with the way in which training had been delivered to them. Although training records documented that staff had received a range of training that was up-to-date, our observations showed that it remained ineffective in practice in some areas. For example; medicines administration was not always carried out safely, people were not consistently assisted to move in ways which met best practice guidelines and poor MCA understanding had led to consent being inappropriately sought. Some of these failings were by the registered manager; and provided a poor example for other staff. None of the staff had received training about nutrition and people with diabetes had been provided with foods that were not suitable. Supervisions had been carried out regularly and staff told us they were helpful; but they had not highlighted gaps in staff competency, so these could be addressed. New staff had completed detailed induction training which included job shadowing to help them experience the role before working independently. However, existing staff had not all received sufficient training to be in a position to guide new staff effectively.

The failure to ensure that the registered manager and staff were competent in putting their training into practice is a breach of Regulation 18 (2) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At our last inspection there had been no special adaptations to help people living with dementia to find their way around; such as picture signage. At this inspection, new and clear signs had been introduced to identify communal rooms. People had their names and a picture on their bedroom doors and toilet seats were

bright coloured to help people recognise them. A notice board to show the day, date and weather, however, showed the wrong details throughout the inspection. This was not helpful for people living with dementia who could become disorientated.

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 are called the Deprivation of Liberty Safeguards (DoLS).The registered manager had made applications for DoLS and received authorisations from the relevant authority.

Requires Improvement

Is the service caring?

Our findings

Relatives told us, "Staff are lovely-they're diamonds" and, "They are fabulous and do their best for everyone here". Visiting professionals commented that staff were "Very caring" and that they felt people were well looked after.

Although we observed that staff interacted well with people and often showed warmth towards them, there were areas in which people's care had not been provided to an appropriate standard. For example; some people's beds had been made up by care staff over wet or urine-stained mattresses. It was clear that these had not been cleaned for some time and their odour was offensive. It was not possible that staff could have missed this staining and moisture as it was very apparent. Senior staff told us that daily room checks were made and included people's beds and bedding. However, they could not explain how the soiled mattresses and sheets had been overlooked. It was not respectful of people's dignity or well-being for them to be sleeping in beds in this condition.

The failure to maintain appropriate standards of hygiene is a breach of Regulation 15 (2) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Some staff gave people living with diabetes foods that were not suitable for them. When asked, they said they kept forgetting who had diabetes. This showed a lack of caring about people's health. One person was observed for long periods on their own in the quieter lounge. Staff had put on a DVD but the TV was faulty and kept jumping and replaying the same short section of film. Staff we spoke with knew that this kept happening but still left the person watching it; and they became upset and frustrated. We asked staff to address the problem, but they were unable to do so and kept the DVD on and left the room. The person had nothing else available to entertain them and it demonstrated a disregard of their needs to leave them with only a broken DVD/TV for company.

At other times during the inspection, staff were kind and gentle with people. They took time to explain what was happening and showed great patience with people who were living with dementia and behaved in a repetitive way. Reassurance was offered and some staff went out of their way to provide comfort and encouragement when people became distressed or worried. One staff member in particular spoke with people in a clear and calming voice and used touch to guide and assure them. There was jovial banter between staff and people; which they seemed to enjoy. People appeared at ease around staff and comfortable in their company.

People were offered choices and most staff knew people's individual personalities and what pleased them. Staff and the registered manager knocked on people's bedroom doors and called out before entering; to allow them privacy. People were reminded to use the toilet in a discrete way and when a person had difficulty with their clothing which left them exposed, staff acted quickly and considerately to cover them and protect their dignity.

Where people were able to be independent, staff encouraged and allowed them to be. Care plans recorded

the things that people could do for themselves and we saw in practice that staff supported people while promoting their independence. For example; people fed themselves but staff were on hand to cut up food and prompt people to eat. Staff said that they tried to involve people in their own care as much as possible; but this was difficult for people living with dementia. Relatives said that they were kept informed about their loved ones progress and care and felt that they could ask questions if necessary.

There was no one receiving end of life care at the time of the inspection. However, records had been made about people's wishes, where known. Care files clearly noted if people had a Do Not Attempt Resuscitation order in place and this was also recorded in staff handovers. This helped to ensure that people's end of life choices were respected. Staff had not received any specific training about supporting people at the end of their lives and some said they felt this would be useful to them.

We recommend that the provider considers providing end of life care training to staff; to ensure people receive the best experience of care and support in their last days.

Requires Improvement

Is the service responsive?

Our findings

People's care plans had been written in a person-centred way. They documented details of people's needs and how their care should be delivered, but this had not always been carried out in line with the plans. For example; one person's care plan about personal hygiene recorded that staff should support them to, 'Maintain high levels of hygiene'. However, this person had been sleeping on a urine-stained mattress. The same person's care plan about continence contained conflicting information. One record stated that they were able to say when they needed the toilet, while another noted that they were doubly incontinent and, 'Unable to cope with toileting needs'. This created a confusing picture of the person's needs and may have contributed to their mattress becoming soiled; if staff were unsure about their level of continence and the care required.

Another person was witnessed showing aggression and had been physically violent in the previous month according to a behaviour chart. However, the monthly care plan evaluation about aggression recorded, 'No issues' and that they had been, 'Settled in behaviour'. This was misleading and did not raise staff awareness of this person's potential to be aggressive towards other people; so that they could act to protect them.

A person who was living with diabetes had been assessed as 'Low risk' for nutrition; even though they had lost 8.6kgs between January and May 2016. Although the GP had been made aware of the weight loss, the care plan information had not been updated to show the increased risk level for this person. There were a number of new and agency staff working in the service and it was crucial that they had up-to-date and accurate information about people's needs and the care and support to be provided.

The failure to ensure that care was delivered in line with care plans is a continued breach of Regulation 9 (1) (a) (b) (c) (3 (a) (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Detailed and sensitively prepared information had been produced about people's life histories. These included people's spiritual and/or religious beliefs and how they could be met. The activities coordinator had spent time and effort in creating these; with help from people's families. These records gave a clear picture of past events that were important to people and provided staff with a resource for learning about people's personalities and preferences.

The coordinator engaged people in a variety of activities during the inspection. These included singing and dancing; which people became involved with on different levels. Some people sat slightly apart from others but joined in the singing, while others got up and danced with staff. These sessions were light-hearted and fun and the coordinator did her best to include everyone in some way. One person said, "Isn't this lovely-you don't hear music like this anymore".

A programme of other activities was on display and included; puzzles, pampering, reminiscing, painting and brick building. Each person had an individual activities record that showed the things they liked to do and documented those events in which they had taken part. Some people preferred not to be included in group activities and the coordinator had one to one chats and time with them instead. Most people and relatives

we spoke with were satisfied with the programme on offer but one relative commented that their loved one was often bored. However, we did see that this person was given a meaningful task to carry out; which kept them busy and provided a period of distraction for them.

People had been allocated a keyworker and staff told us this gave them the opportunity to get to know people well. It also enabled them to try to deal with any concerns or worries people or their families might have. There were hospital 'passports' in people's care files that contained important information about people's needs and abilities. These could be passed to ambulance staff if people needed to be transferred to hospital; and helped to ensure people would receive appropriate care there.

There was a suitable complaints system in operation. All complaints had been logged and the outcome of investigations recorded; together with information about whether the complainant was satisfied. Relatives we spoke with said they knew how to make a complaint and felt able to approach the staff or manager with any concerns. Details about how to make a complaint were displayed and a relative old us that some flooring had been changed after they had complained that it smelt unpleasant. There was evidence that the provider had made changes in response to complaints.

Inadequate

Is the service well-led?

Our findings

The leadership of the service was neither adequate nor consistent. Following our last inspection we took enforcement action in the form of warning notices. At this inspection, we found that, despite assurances by the provider given in their action plan, not all the necessary improvements had been made. Where changes had been implemented to address breaches of Regulation, other areas of significant concern had arisen in their place. This showed that the service had been unable to sustain improvement. It was apparent that the provider and registered manager had been reactive in remedying some of the issues highlighted at the last inspection. Similarly, during this inspection the provider and registered manager acted immediately to replace mattresses, organise people's creams and amend air mattress settings, for example. However, it was not possible to tell how long these issues would have remained unchecked if they had not been brought to light by our inspection. There was little evidence to suggest that a proactive approach had been taken to identifying shortfalls in the quality and safety of the service.

The provider had however put in place a series of audits to give them oversight of how the service was running. The most recent of these had been carried out two weeks prior to this inspection. The audit process had picked up for example that, photos were missing from staff files, MAR photos were outdated and that food charts did not include supplements. None of these areas had been actioned following the provider audit and were highlighted again during this inspection. An earlier provider audit, carried out in April 2016, recommended that a diary was compiled to record people's dietary requirements. This had not happened at the time of our inspection and the lack of a single record of people's special diets had left them at risk of receiving unsuitable foods.

Medicines and creams were audited by the provider and the registered manager but neither process had identified that creams were not being managed safely or in line with prescriber's instructions. However, minutes of staff meetings in March and April 2016 recorded discussions about creams charts not being completed. An infection control audit on 17 May 2016 awarded a compliance rate of 91%. One of the audit questions asked if all mattresses were in a good state of repair and was scored as 'Fully met'. The mattresses we inspected were not suitable for use and had clearly been in a poor state for some time. This meant that checks made by the provider and registered manager had been ineffective, and the quality and safety of the service had suffered as a result.

The lack of a robust auditing process is a continued breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Feedback had been sought about people's experiences of the service. A survey of people had been carried out in May 2016 and analysis recorded that results were positive. However, the survey consisted of questions that were answered by rating experiences using a number scale. This would not be easy for people living with dementia to follow and it was clear from reading the survey returns that not all the replies were meaningful. A previous survey highlighted the need for a more 'Dementia-friendly' format, but this had not been produced and meant that results were not wholly reliable.

The failure to operate an effective process for seeking people's feedback is a breach of Regulation 17 (1) (2) (e) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At our last inspection statutory notifications had not been submitted to the CQC to tell us about incidents that we need to be aware of. It is a requirement of the manager's registration that these are submitted without delay. At this inspection we again identified safeguarding events which should have been notified but had not been.

The failure to submit statutory notifications appropriately is a continued breach of Regulation 18 (1) (2) (a) (b) of the Care Quality Commission (Registration) Regulations 2009.

The provider had displayed their current CQC rating in the entrance to the service. However, they had not included this information on the provider's website or details of the CQC's web address.

The failure to display a performance rating is a breach of Regulation 20A of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff had completed a 'Quality assurance' questionnaire recently and analysis of this showed staff were generally positive about the service. There was also a survey to gather staffs' views about training. The responses were positive and improvements had been made when staff raised any issues. For example, DVD training was now shown on a large screen rather than on a small computer to make visibility better for all.

Staff and the registered manager were open and cooperative with us. Staff said that they felt supported by the registered manager and that they worked well as a team. Relatives mainly said that the registered manager was approachable and helpful. Senior staff told us that everyone had worked hard to make the service better following the last inspection. However, they accepted that our findings showed that this had not been enough to make the necessary improvements.

The registered manager said that new meetings were being set up between the managers of each of the provider's services; so that good practice could be shared amongst them. The provider said that they wanted '"To make things right here" and that they would take whatever action was needed to make things better.

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 18 Registration Regulations 2009 Notifications of other incidents Statutory notifications had not always been made to the Commission in a timely way.

The enforcement action we took:

NoP positive conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's needs were not consistently met and person centred care planning was not always followed through into practice.

The enforcement action we took:

NoP positive conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of the Mental Capacity Act (MCA) 2005 had not been followed.

The enforcement action we took:

NoP positive condiions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely and actions to minimise identified risks to people had not always been carried through into practice.

The enforcement action we took:

NoP positive conditions

Regulated activity	Regulation

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 People had not been protected from abuse.

The enforcement action we took:

noP poisitve conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's need for proper nutrition had not always been met.

The enforcement action we took:

NoP positive conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Equipment was not appropriately hygienic or clean.

The enforcement action we took:

NoP positive conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance processes had not been sufficiently robust.

The enforcement action we took:

NoP positive conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider failed to display the location's CQC rating on their website.

The enforcement action we took:

NoPpositive conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of competent

staff on duty.
Training had not been effective in practice.

The enforcement action we took:

Nop posiotive conditions