Sovereign (George Potter) Limited

George Potter House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 13 and 14 June 2017 and was unannounced on the first day; the provider knew we would be returning on the second day.

We last carried out an unannounced inspection of this service on 10 May 2016. Breaches of legal requirements were found regarding the assessment and management of risks, cleanliness of the premises, person-centred care, dignity and respect, complaints and good governance. After the comprehensive inspection the provider wrote to us to say what they would do to meet legal requirements in relation to these breaches. On 13 December 2016 we carried out an unannounced focused inspection, where we found the provider was now meeting these requirements.

George Potter House is a care home that provides nursing care for up to 69 older people. At the time of our inspection there were 47 people using the service. The ground floor is called Primrose Unit and has a large kitchen and dining area, garden, courtyard and lounge which serves as an activities room. The first floor of the building, called Rainbow Unit, provides care to people living with dementia, and contains a lounge, dining room and sensory room.

The service had a registered manager. 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.

We found that the provider had taken steps to improve the overall quality of the premises; this included replacing carpets and furniture, decorating communal areas and refurbishing bathrooms and toilets. However, areas of the building remained dirty and we saw some hazards such as trailing wires and unsafe filing cabinets. The provider carried out regular checks of some areas of safety such as electricity, gas and window restrictors and had evacuation plans in place in the event of an emergency. There were also regular checks of their fire safety systems.

We saw many instances of good and respectful interactions between people and staff, but we also saw examples of poor care. This included people not being seen to promptly when they needed support to be changed, and people did not always receive showers or oral care in line with their care plans. Some people complained of being handled roughly by staff, and some people told us they were put to bed too early. We saw some examples of poor infection control practice. The provider had measures in place to assess people's capacity and demonstrate how they were working in people's best interests, but these were not always applied effectively.

There were measures in place to assess and mitigate risks to people. People were assessed by the provider for their risk of pressure sores. However, measures were not always followed to prevent these, which included pressure relieving mattresses being placed on the wrong setting for the person's weight and

turning charts not being correctly completed. We also found that staff carried out weekly audits of whether existing pressure sores were healing but did not always record appropriate measurements of wounds which would help to measure if this was taking place.

The provider carried out assessments of people's nutritional needs and monitored people's weights. However, dietitian referrals were not always followed up, and although many people received suitable support to eat, some people did not. We found that food and fluid charts for two people contained misleading information about what people had actually eaten.

The provider had measures that ensured staff were suitable for their roles, which included providing regular training and supervision and carrying out suitable pre-employment checks. However, we found that staffing levels were frequently far below what the provider told us were required; some people and relatives told us the service was short-staffed and that care workers were often rushed or unable to see to people's needs promptly. Three people who used the service and two relatives said that staff did not have the time to talk to people, and three people felt they were not treated with dignity by care workers.

There was a programme of activities for people, which included activities in people's rooms for those who were unable to participate. The activities programme of gardening and music was carried out in partnership with local schoolchildren.

Medicines were safely managed by staff with the correct training to do so, and regular checks took place of people's medicines to ensure these were given correctly.

Managers had systems in place to monitor staff training, supervisions and meetings, and there was a detailed action plan for responding to the points raised at the previous comprehensive inspection. Audits were scheduled regularly of the service, but did not always detect areas of concern.

We have made a recommendation about how the provider ensures measures for obtaining consent to care are used effectively. We found breaches of regulations regarding safe care and treatment, person-centred care, nutrition and hydration, dignity and respect, staffing and good governance.

We issued warning notices against the provider with regards to person centred care, nutrition and hydration, staffing and safe care and treatment. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe in all respects.

There were measures in place to assess and mitigate risks to people, however we found that equipment and repositioning charts were not suitably used to protect people from the risk of pressure sores.

There were measures to check the suitability of staff, but staffing levels were frequently below what the provider determined were necessary to safely meet people's needs.

Checks of the building were carried out, however we identified a number of concerns relating to the safety and cleanliness of the building.

Medicines were correctly managed and checked by staff and audited regularly.

Is the service effective?

Requires Improvement

Aspects of the service were not effective.

People did not always receive adequate support to eat and drink. Although people's nutritional needs were assessed records did not always accurately reflect people's intake of food and fluids.

The provider had measures in place to assess people's capacity and demonstrate how they were working in people's best interests, but these were not always applied effectively.

Staff received adequate training and supervision to carry out their roles which was monitored effectively by managers.

Is the service caring?

Requires Improvement

Aspects of the service were not caring.

We saw examples of poor practice with regards to personal care, and sometimes care workers were not aware that people needed support. Some people complained of rough handling by care workers.

People we spoke with were involved in their care plans and told us their views were recorded. Care plans contained information about people's life histories and preferences.

We had mixed comments from people about whether they were treated with dignity, and some people told us that staff did not have time to speak with them.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive.

People's needs were assessed and detailed care plans were in place for all areas of people's lives. However, we found that they were not always followed, and people did not always receive appropriate support to bath or shower.

There was a weekly activities programme in place. The provider had measures in place for responding to and investigating complaints.

Is the service well-led?

Requires Improvement

Aspects of the service were not well led.

People who used the service and staff were very complimentary about the registered manager. The provider had systems of audit in place and a rolling action plan to improve the service; these were effective, but not sufficiently comprehensive to identify areas of concern.

Key documents such as records of care, nutrition and repositioning charts were not checked in a way which would have highlighted serious problems.

Managers held regular meetings with staff teams to promote good practice. There were systems in place for consulting with people who used the service and their relatives.

George Potter House

Detailed findings

Background to this inspection

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

The inspection took place on 13 and 14 June 2017 and was unannounced on the first day. We told the provider we would be returning on the second day. The inspection was carried out by a single inspector with the support of a specialist professional advisor in nursing and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to carrying out this inspection we reviewed information held by the Care Quality Commission on significant incidents that the provider is required by law to tell us about.

In carrying out this inspection we looked at records of care and support relating to four people who used the service and at records of medicines relating to four people. We spoke with eight people who used the service and three of their relatives and 13 members of staff. This included the registered manager, deputy manager, eight care workers, an activities co-ordinator, a domestic assistant and a registered nurse. We carried out observations of care and support and of the building. We also looked at records relating to the management of the service, including records of training, supervision, audits, complaints, incidents and accidents. We also looked at the personnel files of four staff members.

Requires Improvement

Is the service safe?

Our findings

The provider was not always taking steps to protect people from the risk of pressure ulcers. Staff carried out assessments of people's skin integrity using the Waterlow scale. The Waterlow score (or Waterlow scale) gives an estimated risk for the development of a pressure sore in a person. We saw that in most cases there was a care plan and risk assessment for maintaining skin integrity where people had a high risk of developing pressure ulcers. However, in one case a person had a high score and had a care plan in place but the provider had not carried out a risk assessment.

Where risk assessments were in place, skin integrity checks were being carried out in line with these. In two cases, we saw that people had pressure sores, and although staff told us these were healing, there was not photographic evidence or measurements to support this, although these were identified on body charts and dated. When photographs were taken of wounds, there was not always use of objects of scale in order to assess the size of the wound. One person had been referred to a Tissue Viability Nurse (TVN) for further action regarding a necrotic wound. This had taken place on 19 May but had not been followed up by staff at the time of the inspection.

For two people, we saw that pressure area care mattresses were not set at the appropriate setting for the person's weight. Where people's care plans stated they required regular repositioning the provider had turning charts in place, however we saw significant gaps in these. For example, one person's chart showed no entries at all for a 59 hour period. Another person's chart also had no entries for three days. On two charts staff were regularly failing to write the day's date, so it was not clear what periods were covered by the records, but these did not contain sufficient entries to indicate the person was regularly repositioned. These charts did not appear to have been checked by a manager or a senior member of staff.

The provider carried out a weekly audit of people's skin integrity needs, including recording whether pressure sores were present and healing, whether they had been seen by the GP or a TVN and whether a care plan and turning charts were in place. However, audits did not record whether turning charts were appropriately completed. The registered manager told us that she checked the mattress setting records on a daily basis to ensure that they had been completed. We looked at pressure care audits dated 12, 20 and 26 June; each of these stated they covered Primrose and Rainbow units, but referred only to people who lived on the Primrose Unit. This meant that audits were not sufficiently thorough or effective to monitor the measures in place to manage the risks of pressure ulcers developing or worsening.

We also found that some aspects of the premises were not safe. the upstairs dining room, we found a filing cabinet which was full of confidential information and left unlocked with one drawer open. It was of a type that did not have an automatic locking system, which meant that opening another drawer could have caused it to tip over. This cabinet had a dinner plate on top of it, which was covered in a thick layer of green mould. The inside of the cabinet was soiled, as a cup containing a soft drink had fallen into it and had dried. There was also an unlocked cabinet in this room which contained thickeners and nutritional drinks; the provider told us that these items were not to be stored in this cupboard, but the shelves were labelled for these items. The provider arranged for these items to be removed by the second day of our inspection. Arts

and crafts items were left out for an unsupervised activity; we observed a resident walking around with a pair of scissors unchallenged by staff.

People told us that the provider had made improvements to the cleanliness of the premises. Comments included, "It is very clean and has a feel good feeling about it" and "The rooms and areas are usually very clean. The new toilets are lovely and well kept." The provider had replaced the old, worn carpets with wipe clean flooring which was also non slip. Chairs had been replaced with easier to clean vinyl chairs, which were an improvement on the worn, stained furniture which had been in place beforehand. However, we saw that some of these chairs had not been wiped, and found crumbs and litter under some chair cushions. There was also a large seating area in the ground floor which was covered with what appeared to be a urine stain. This cushion was present at our last comprehensive inspection in May 2016.

This constituted a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Three people who used the service and two relatives expressed concern about the levels of staffing. Comments included, "There are not nearly enough of them and it is the same at night too", "They are stretched but you see the same ones" and "It would be nice if there were enough staff to take him out, they are nice enough though." One person told us "There is…a permanent need for more staff on every shift."

Most staff we spoke with also stated they did not feel there were enough staff to meet people's needs. Comments included, "There's not enough staff at present but there are a lot of empty rooms. Ordinarily we have enough…we are managing", "Sometimes there's enough, sometimes it's difficult if two or three people phone in sick. The manager tries her best for there to be enough staff", "We need more carers, the work is getting harder for us" and "We have enough staff on the rota but the carers call in sick."

The provider used a dependency tool to assess how many staff were required in the service. People's dependency levels were assessed using a scale which included their personal care, mobility, behaviour needs, continence and communication, which was reviewed monthly for the whole service.

We looked at three weeks of rotas during the period of May to June 2017. During this time, the provider's own dependency tool stated that there should be three registered nurses and nine healthcare assistants (HCAs) on duty during the day, although the provider told us that the reduced occupancy in the service meant they considered two nurses to be appropriate, which was not reflected in the dependency tool. The provider told us that there were usually five HCAs on duty in the Primrose unit, and four in the rainbow unit.

We found that in the Primrose unit, there were usually two nurses on duty during the day, and one on duty during the night. However, levels of HCAs (including senior carers) were frequently below what the provider told us. For example, out of the 21 days we looked at, there were seven mornings where four HCAs were on duty, five mornings where there were three HCAs on duty and one morning where there were only two. In the afternoons, there were 10 afternoons where four healthcare assistants were on duty in this unit, and four mornings where three healthcare assistants were on duty. On the afternoon of 7 June there were two HCAs on duty, and on 6 June only one.

Staffing levels on the ground floor at night consisted of one nurse and two HCAs, and this appeared to be taking place throughout the days we looked at, although on 2 June there was only one HCA on duty at night.

Within the Rainbow unit, there was usually one nurse on duty during the day, although on nine occasions a

senior car worker was on duty instead of a nurse, who the provider told us was trained to administer medicines and was able to cover the medicines round. The provider told us that there were four HCAs on duty upstairs, but the rota showed that on six mornings in the three weeks we looked at there were three on duty, and on 4 June there were two HCAs in the morning. There were also seven afternoons where three HCAs were on duty and on 4 and 8 June, two HCAs were upstairs in the afternoon.

In line with the provider's assessment, there were two HCAs on duty at night and 1 nurse, but on two nights (30 May and 2 June) there was no nurse on duty upstairs. The provider told us that the manager and deputy manager provided additional cover when staff had called in sick and they were unable to provide cover using agency staff. However, there were only two members of the management team able to provide care to people, and even with this additional cover the service would be below the required staffing levels.

This constituted a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Most people that we spoke with told us that they felt safe living in the service. Comments included, "I do feel very safe here and all my belongings are well looked after. All round I'm taken care of" and "I am safe. They do their best here." However, two people we spoke with expressed concern that one member of staff handled them roughly. For example, one person said, "Everything that is mine here is well looked after but I don't always feel safe. There is one carer who is rough and pulls me around when she is doing personal care. I think they think I am a nuisance to them." We raised these concerns with the registered manager. They took action and informed us that that person was not a permanent member of staff and would no longer be working at the service. People told us that they could raise concerns about their safety with staff. For example, one person said, "I am sure you can chat with any of them and they would escalate it discreetly and appropriately" and another said, "You can chat and they only record what they have to or they will tell you if they need to take it further."

Staff we spoke with understood how to recognise signs of abuse and were confident that managers would take concerns seriously if they were raised. All staff had received training in safeguarding adults. Where allegations of abuse, including neglect were raised the provider had met its responsibilities to inform the local authority and to notify the Care Quality Commission (CQC).

The provider was carrying out other checks of the safety of the building. For example, managers carried out a two-monthly health and safety check, which included verifying that staff training was up to date, and that the weekly checks of the fire alarm had taken place. This also included checking that escape routes and corridors were clear, that first aid kits were in place and moving and handling assessments were completed, with checks of lifting and handling equipment. A yearly check was carried out on all hoists and lifting baths to verify that these were safe for use in August 2016, and this was due to be reviewed in August 2017. However, we did observe two people using equipment which required maintenance. One person had a wheelchair which squeaked loudly when they used it, and another person had a walking frame with worn rubber feet. The RM told us that the maintenance person checked people's wheelchairs on a weekly basis and showed us records that this had been done. They also told us that going forward, walkers would also be checked weekly. There were up to date checks carried out of the gas and electrical system and Portable Appliance Testing (PAT) was in date.

The provider also carried out "Resident of the day" checks, whereby a person's room was checked for areas of safety, such as electrical equipment, furniture and working window restrictors. The provider told us that they did not have a central register of window restrictor checks and would implement one. During the day time the front door was monitored by a full time receptionist, and this door was protected by a key code

outside of office hours. We observed the receptionist informing a member of staff when they would be leaving the desk for any reason.

Checks were carried out of all call bells on a weekly basis, and maintenance staff had recorded when batteries were replaced on people's bells. The bell had different tones for calling for assistance and for emergencies, and we observed staff attending to these promptly. People we spoke with were generally satisfied with the response. Comments on the call bell system included, "I use the bell and they come quickly at night and during the day. I keep the bell next to me. It reaches me in bed and to my chair", "They come when they are ready. I wait less at night" One relative said, "They are very short on staff and they come as soon as they can and they do let [my relative] know they have heard her bell. She can reach it without problems."

The provider had a system of checks in place of smoke detectors and fire extinguishers, monthly tests of the emergency lighting system and weekly tests of the fire alarm system. Planned fire drills were taking place monthly, and the provider had documented the staff response to the alarm. One person told us, "The manager seems to have regular fire drills." The provider had completed Personal Evacuation and Egress Plans (PEEP) for each person, which indicated the level of support they would need to evacuate, any disability which would affect their ability to leave the building and any additional equipment the person would need to leave the building safely. These were used to give staff a summary of people's evacuation needs, which were updated monthly. Areas where oxygen was stored were labelled appropriately. We also saw that the provider completed records of incidents and accidents, including unexplained bruising and falls. This included a monthly summary of the types of incidents, whether the cause of the incidents was known and whether there were any risk factors which needed to be considered.

At our last inspection we raised concerns about the safety of the lift, as it required a keycode to open the door, so there was a possibility that people could become stuck in this lift. At this inspection we saw that the provider had provided emergency instructions for people in order to call for help in the event they became trapped, and staff responded promptly to the alarm when we tested this.

The provider used a falls risk scoring tool in order to identify when people may be at risk of falls, and where people were at risk, had completed falls risk assessments which were reviewed monthly. There were also moving and handling risk assessments which were used to identify people's ability to move, the extent to which they could co-operate with staff supporting them to move, the safest methods for making transfers, how many staff were required and whether any specialised equipment was required. There were records in bathrooms of when staff had checked the water temperature prior to supporting people to bathe or shower.

Where people chose to smoke, the provider had completed risk assessments and smoking care plans. One person's plan stated that they would be supervised by staff when smoking outdoors and that they would wear a fireproof apron to reduce the risk of burns. On the day of our inspection we saw that this person was supervised by staff but was not wearing their apron; the person told us they usually did when their key worker was present, but that they were on holiday.

The provider had safer recruitment measures in place. This included taking up references where people had previous employment in health and social care, and obtaining proof of people's identity, address and their right to work in the UK. Prior to starting work, the provider had carried out checks with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, in order to help providers make safer recruitment decisions. The registered manager had completed an audit of all files to ensure that all necessary information was stored on the file. We saw evidence that nursing staff were appropriately registered with the Nursing and Midwifery Council (NMC), and verified this information

against the online register.

People told us they received their medicines safely and were satisfied with the support they received. Comments included, "It's always on time and I know what it is for because my carer tells me" and "I know myself what my medication is for. They talk me through it if it is new. It's on time." People's care plans contained information about their medicines, including whether they wished to self-administer their medicines. Where people took medicines on an "as needed" (PRN) basis, there was a clear protocol for when people should receive these medicines including the maximum dose and when this needed to be reported to the person's doctor. We looked at the Medicines Administration Recording (MAR) charts of four people who used the service, and saw that medicines were signed into the service and checked by a different staff member, and that staff had correctly completed these to account for medicines, including gels and creams. The provider carried out a monthly medicines audit, which included verifying the list of staff signatures was up to date, ensuring that staff had received medicines training and observations of their competency to administer medicines. The audit also included taking a sample of five people's medicines, and verifying that the MAR was correctly completed, with medicines safely stored with no excessive stock.

We saw that controlled drugs were safely stored and that checks of stock were carried out every week. Some people received controlled drugs such as morphine.

The provider had a policy in place for administering homely remedies such as paracetamol, which had been signed off by a doctor. However, we saw that one person had been administered paracetamol regularly in line with this policy even though they were also prescribed regular doses of paracetamol with instructions to not take this with any other paracetamol-containing product; this did not protect the person from the risk of accidental overdose.

We also saw that the provider had measures in place to protect people from polypharmacy, specifically annual medication reviews. Polypharmacy is the use of four or more medicines by a patient, generally adults aged over 65 years old. Some people were taking a high number of medicines, including one person who was prescribed 10 regular medicines, and another person who took nine separate medicines. There was a system in place for people's medicines to be reviewed annually. This meant that the risk from these medicines interacting would be reviewed by a GP.

Requires Improvement

Is the service effective?

Our findings

People did not always receive adequate support to receive enough to eat and drink. We saw that people had nutritional care plans in place, which were reviewed monthly. There was also a nutritional risk assessment in place for people, which included monthly assessments of people's scoring under the Malnutrition Universal Screening Tool (MUST). We saw that people's weights were recorded weekly and used to calculate people's Body Mass Index (BMI) scores, and that when staff were concerned about people's weights they had made a referral to a dietitian. However, we found that these were not always followed up by staff. Nutritional care plans were used to inform guidance which was sent to the chef, which included information on people's allergies, food intolerances, preferences and use of thickeners.

We received mixed views from people about the quality of the food and the support they received at mealtimes. Comments included, "The food is quite nice and you get choices. They come round with a list in the mornings some time and ask what you would like. I eat in my room because I prefer it and they are happy with this and they give me the assistance I need", "It is quite good and they give me my special diet" and "I have a jug next to me in my room. If I am in bed they pop it on the table so I can reach it." One person said, "The food is not great, it is an acquired taste…There's little imagination with the menus, the options are not good and they're not appetising." Another person said, "I can't always reach [my jug]." The service also shared the results of its residents survey with us, which had several questions for people about the food on offer and their mealtime experiences. The results of this were positive."

Where people received support to eat, we saw that this was carried out in a suitable way. For example, we observed people at mealtimes both upstairs and downstairs receiving their food promptly and receiving encouragement to eat and drink. We observed one person being supported by two staff in their bed to eat, with suitable encouragement offered by staff. People we spoke with in the downstairs unit told us, "We didn't have to wait long" and "It's what I asked for."

However, we had concerns about the support that three people who ate in their rooms upstairs received. One person was unable to leave their bed and was extremely thirsty, this was not noted by staff and we had to ask a staff member to bring them a drink. One person had their lunch placed in front of them by a staff member but received no support to eat this. On the second day we observed the same, and that staff took their sandwich away after half an hour after having not eaten it; however this person's food and fluid intake chart showed that they had eaten this sandwich. We observed another person who was in their bed over lunchtime who did not receive lunch; a staff member told us they declined lunch due to the hot weather, however their food and fluid intake chart showed that they had eaten mashed potato and yoghurt at this time. We discussed this with the registered manager who agreed that this should not have been recorded. The management was disappointed to hear what we had seen and said that they would take action to investigate.

The upstairs dining room was not clean, table cloths were dirty and tables had crumbs from previous meals. We saw that a plate with covered sandwiches was left out in the kitchenette area throughout the day, with meat and egg fillings, even though it was an exceptionally hot day.

This constituted a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We saw that the provider had taken steps to improve the look and feel of the premises. This included providing new furniture throughout the building, and new non-slip flooring in all communal areas, and was in the process of replacing carpets in people's rooms. Areas of the building had been painted, and many toilets and bathrooms had been comprehensively refurbished. We saw that spare equipment including hoists and wheelchairs were now stored in disused bedrooms and not in communal areas. Areas of the building had been painted and were cleaner and brighter. A member of staff, "The old paint made you feel down." There was a sensory room on the first floor, with objects and pictures relating to a trip to the seaside. One part of this room was decorated with pictures of films stars, and another part was decorated with pictures of the royal family to reflect people's interests. There was a large rainbow painting which had been provided by local schoolchildren, which the provider told us people enjoyed looking at. The upstairs unit had been named the Rainbow unit in respect of this. There were handrails in place along corridors, but these were not available throughout a sloped area on the first floor.

We saw that there were memory boards outside of people's rooms; these included objects and pictures relevant to the person who lived there, including information on their previous occupation, place of birth and family life. However, aspects of the building did not promote a dementia friendly environment. For example, there were a number of clocks in communal areas but the majority of these were not showing the right time and some had stopped altogether. The registered manager apologised for ths and saw that it was rectified. There was a large menu board in the upstairs dining room; this had not been completed, and had pictures on it which were not related to what was currently on the menu. Communal areas had signs indicating areas such as the toilet, lounge and shower room, although these were not always pictorial and were often placed higher up on doors which would have been out of people's eye line.

In some cases the provider did not obtain consent to care in line with the Mental Capacity Act (2005) (MCA). The Act 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. Assessments included information on people's ability to consent to care, but this was not always adequately completed. For example, one person had not signed their care plan, and a permission to consent to the use of bedrails had been signed by their GP but not the person, even though there was no assessment of their capacity to consent to either their care or the use of the bedrails. There was also a form in place entitled 'Enabling Care Priorities' for a person without capacity, this included collecting information from family members and professionals on what elements of care would be important to the person and what would make them happy or comfortable, including information on whether a person had made advanced treatment decisions or had a legal representative. We saw this completed for this person even though there was no evidence they lacked capacity. The registered manager explained that the home had recently revised its forms and procedures with respect to mental capacity assessments and best interests decisions and had reviewed everyone's capacity to make decisions. They said that their new procedures complied with the MCA but it was possible that the people we mentioned still had not had their paperwork fully updated.

For other people, the provider had completed mental capacity assessments and there was evidence of best interests meetings having taken place.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are

called the Deprivation of Liberty Safeguards (DoLS). We saw that where people were deprived of their liberty, for example by being unable to leave the unit due to locked doors, the provider had applied to the local authority to do so, and had informed the Care Quality Commission when the application was approved. For one person, we could see that a DoLS application had been made concerning other aspects of their lifestyle but not in relation to the use of a safety belt which was used on their wheelchair. The provider had completed an audit of when people may be subject to DoLS to ensure that an application had been made to the local authority, this showed that the provider was complying with this requirement, but was not checking whether CQC had been notified of this.

We recommend the provider take advice from a reputable source on ensuring that existing measures for obtaining consent to care are used effectively to ensure compliance with the MCA. The provider told us they had been reviewing these issues over the past six months and would continue to work to improve in this area.

Staff had received training around the MCA and DoLS and there was information displayed for staff on noticeboards reminding them of their responsibilities under the Act. The provider maintained a matrix of staff training which showed that staff had received yearly training in mandatory areas. These included dementia awareness, dignity in care, safeguarding adults, infection control, moving and handling, health and safety, first aid, control of substances hazardous to health (COSHH), recording and communication. There was information on the training plan for the rest of the year displayed on a notice board for staff.

When new staff joined the service they received an induction booklet, which showed that they had discussed policies, fire safety, the use of call systems, security in the home, emergency procedures and residents rights, and that they had been introduced to people who used the service. This was signed off by the new staff member and a more experienced staff member who served as their mentor.

Comments from people who used the service and their relatives were positive about the skills of staff. These included, "They are a good lot, they seem well trained", and "I am confident they are trained well and have good guidance from the management." Staff told us they received suitable levels of training, with comments including, "We do training a lot, you've got to find it useful", "We get enough training, it's compulsory and we all need it" and "I'd be able to get extra training if I need it…there's so much training."

Staff received a twice yearly supervision in line with the provider's policy and a yearly appraisal. Supervisions were used to discuss areas relevant to the staff members practice such as their response to call bells, safety issues, team working and the administration of medicines. The registered manager maintained a system for monitoring supervisions to ensure that these were carried out in line with the provider's policy.

People told us that they received suitable help to maintain their health and wellbeing. One person had recently been unwell and told us, "The staff that were on [at the time] were excellent and I couldn't have asked for more. This highlights the contrast between those who are good." Another person said, "The doctor comes once a week and I think more if you really need him." A relative told us, "They call me if [my relative] is unwell or if the doctor has been called." The provider had documented people's health needs and obtained a history of people's physical and mental health needs at the time of people's assessments. This included an assessment of people's mental health needs including the person's memory, orientation, behavioural concerns, and whether they had a history of depression, self-harm or harm to other people. There were records on people's files of regular visits from a doctor, and some people had been seen on a weekly visit if there were concerns about their health. There was also evidence that the provider had arranged visits from opticians and dentists, and where necessary, referrals to specialists such as physiotherapists and community dentists.

The provider also used an initial screening tool to assess if people were in pain, and if necessary this was used to compile a full pain assessment tool. This included information for staff on what factors may make the person's pain better or worse, whether there had been recent changes in the type of pain or its location and whether current medicines were effective in controlling this.

Requires Improvement

Is the service caring?

Our findings

Many people we spoke with were positive about the caring attitude that staff displayed. Comments included, "They are caring. They seem to worry if you feel ill and they help you by bringing hot drinks to make you feel better", "The nurses are great here" and "Some of them are fine, I have a great keyworker." However, other people expressed concerns about some of the staff team, including two people who complained that they were handled roughly by staff. Some comments included, "Some rush too much and it makes me feel unsafe" and "There's two or three that should not be here, you know the minute they put their hands on your, they're rough…they see you more as an object than a person."

We observed many kind interactions between people who used the service and the staff team. However, we had concerns about some aspects of care. For example, on observing people in the lounge we noted that one person was distressed and holding their dress in their hands; they explained that they were wet and had been waiting for a staff member to assist them. We pointed this out to staff and they apologised to the person for not coming sooner and provided reassurance to the person. In another instance we observed that a person was wearing wet and soiled trousers and informed staff of this as they were not aware. Staff provided support to the person to go to the toilet, however on their return we observed that the person was still wearing the same wet trousers. Another person we observed appeared to have dried faeces under their fingernails and another person's fingernails were also soiled.

Several people told us that staff were not able to make time to speak with them. Comments included, "They are just too busy to spend much time with us on a one to one basis", "They do have a chat, they are just busy and do not spend long" and "A couple are in too much of a rush to show much care to you. I feel a little neglected and sad at times."

This constituted a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Care plans included personalised information about people, including information on their previous occupation, their regular visits, family life, hobbies and interests, life histories and former occupations. Most people told us they were involved in their care planning, one person told us, "I think my views and desires are taken on board and even recorded." There was also information on people's assessments on communication needs, including whether people had hearing and visual needs and their preferred modes of communication.

Staff had received training in promoting dignity, and the provider had signed up to the dignity challenge. There was a board in the dining room with quotes from people who used the service about what dignity meant to them. Staff we spoke with told us of how they worked to maintain people's dignity. Comments included, "As a carer I like to treat them equal and with respect", "You lock the door, you cover people whilst washing" and "They're human beings, they have feelings and I know I like my dignity myself."

Comments from people and their relatives included, "They do knock on the door" and "I think they respect

[my relative] and give him/her the respect he/she needs" and "[My relative} is definitely treated with respect and has dignity. He/She is fiercely independent and they still encourage him/her to be." However, one person said, "I don't like it when they reach across me to help me, they don't tell me, they just do it" and "They stroll into my room when they like."

Requires Improvement

Is the service responsive?

Our findings

We found that aspects of care did not respond to people's needs and wishes and that this impacted on their health and wellbeing.

One person told us their care plan said they were to have a shower weekly, but that this had not taken place. Staff had recorded in daily logs when they had provided personal care to people, but it was not clear whether this was in reference to personal care given in bed, or bathing and showering. For this person, we checked records of bathing temperatures and saw that they had last been bathed 29 days ago. For another person, despite their care plan requiring them to have a shower weekly, we found that according to bathing temperature logs they had not had a shower for 19 days. Another person's care plan stated they were to have weekly showers, bathing temperature records showed that this was taking place, but on one occasion they had not had a shower for 10 days. A person who used the service said, "The quality of personal care is very low as they have no interest in you as a person." One relative told us, "[My relative] is always clean but I know he/she would like more than one shower a week."

One person told us that they did not receive support with oral care, and told us, "I haven't cleaned my teeth in a year." The person's dependency profile stated they may require assistance with this, but their oral assessment stated that they didn't need assistance to brush their teeth. This had been reviewed, but did not outline the level of support required or changes due to the deterioration in the person's oral health. At a dental appointment last year they had not experienced any problems, but complained of tooth pain at an appointment in February this year, and in May 2017 the person's dentist reported that they had multiple broken teeth and extensive cavities. Care workers had not recorded that they had provided support to this person to brush their teeth but the provider gave us written statements from care workers stating that they had offered this support, although it had been frequently refused and had now had carried out a risk assessment relating to the person's refusal of oral care.

We saw that one person was put to bed around 4pm on two consecutive days, despite this being a warm and sunny day. We raised this with the registered manager on the first day of our inspection, but found that the person was in bed on the second day at 4:45pm. The person told us, "They put me to bed at ten past four, I don't want to be in bed. I'd rather go to bed more like six or seven." The provider explained that when people came to live at the service, they were asked if they would like to have a regular bedtime and when they would like that to be. This was then incorporated into their care plan and the staff would tell them when it was that time but they could go to bed anytime they liked.

This constituted a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Another person had suffered a fractured hip, and a care worker told us that they were nursed in bed because they were unable to bear weight, however the person was able to raise both legs in an exercise motion, and told us that they wanted to get out of bed. The provider commented that if people are well enough to get out of bed, they would not be prevented from doing so, but that this person was not yet able to bear weight.

They were being treated for a fracture and a leg wound, and also suffered from confusion, meaning that they could no longer understand the impact of their injuries.

When people started using the service the provider carried out a detailed assessment of people's needs. This included assessing the person's needs and preferences for personal care, their ability to consent, allergies, mental and physical health history, nutritional needs, communication, continence and mobility. This was used to compile care plans in areas such as hygiene, nutrition, breathing, resting, sleeping, mobility and continence. These plans were reviewed monthly and used to review the person's dependency levels for staffing purposes. Plans included a photograph and information on the person's next of kin, keyworker and whether cardio-pulmonary resuscitation should be attempted. We saw that DNACPR orders (Do Not Attempt cardio-pulmonary resuscitation orders had been completed by a suitable health professional and were placed on people's files where appropriate.

The provider had an activities programme in place. At the time we arrived, the week's timetable was missing from the main lobby, but was replaced soon after our arrival. Weekly activities included knitting, bingo, arts and crafts, movie screenings, a choir and hairdressing and beauty therapy. The provider also had special activities such as a gardening group with local schoolchildren, a classical music session and seasonal activities to celebrate events such as New Year, Valentines Day, Pancake Day and Easter. The provider held parties and barbecues for people using the service and their relatives during the year.

Care plans were in place for how people socialised, including what people liked to participate in and things that people would like to do. We saw evidence that when people preferred not to join in group activities, that co-ordinators would visit people in their rooms and carry out activities such as manicures and chatting with them. The activities co-ordinator told us, "I go to people's rooms with the newspaper and chat, and tell them what the activities are for the day. I visit all residents every day….We take them out to the market, sometimes to the shops and a nearby café." The activities co-ordinator was responsible for collecting newspapers and delivering them to people on a daily basis.

The provider employed two activities co-ordinators, but one was on leave when we visited. The activities co-ordinator on duty told us, "When we only have one [co-ordinator] we ask staff to help." Some care workers told us they thought there should be more activities. Comments included, "They don't get to go out enough", "There's not enough activities" and "They get activities with the lady, if they can't come down the activity comes upstairs, sometimes I do my own like sing and make them laugh." The provider told us that sometimes people did go out, such as the recent trip to a museum and a planned trip to a park. However, many people preferred to stay in. The home did work actively to bring the community into the home. For example, the home opened for Care Home National Day and Dementia Awareness Day, and a special celebration for the opening of its new garden. There was a barbecue last year and another planned for this year. Children from the local school come for gardening and singing. The local church comes once a month to give a service with communion. The home also has a library which visits every three weeks with a new selection of books. A hairdresser visited the service fortnightly.

The garden had new furniture and raised flowerbeds which had been purchased by the Friends of George Potter House Group. We saw that people were involved in planting and maintaining the garden, and there were instructions from the gardener for people who used the service to water the plants whilst the staff member was away.

Comments from people included, "I watch TV and documentaries and join with the parties and the barbecues, I think I am kept entertained" and "I read a lot in my room and the library visits occasionally, I have to say I am quite bored." A relative told us, "All [my relative] wants to do is go to the pub it would be

nice if there was someone who could take him/her, and maybe another for company but they are too short of staff and very busy." The home explained that when people come to the home, they are asked what activities they would like to do. These are then incorporated into their care plan and this is reviewed every month. We were also shown that they asked how people felt about the activities on offer in their residents survey. The feedback on this had been positive.

The provider maintained a system for monitoring and investigating complaints. Where complaints were received, these were recorded along with a summary of the complaint and actions taken by the registered manager. This included speaking with staff about the complaint or agreeing new processes for sharing information. People told us they were able to make complaints to the registered manager. One person said, "I would complain to the manager as I find her a good listener and she has become more proactive."

Requires Improvement

Is the service well-led?

Our findings

Following our previous comprehensive inspection in May 2016, the management team had implemented an action plan to address our concerns about the service. This included addressing areas of the appearance of the building, the legibility of care plans and implementing systems to monitor staff training and supervisions and complaints. We saw that in many areas this had been effective, and at our focused inspection in December 2016 we found that the provider had taken sufficient action to address our concerns about the service. For example, managers had overseen replacing worn and dirty floor coverings and replaced all the furniture which was unsuitable for use. Large areas of the building had been repainted and some bathrooms and toilets had been refurbished, which meant the overall appearance of the building was significantly more pleasant. Similarly, the action plan included measures to ensure that people's engagement in activities was more accurately recorded, which we saw had improved. The registered manager told us, "All our action plans were completed, it's now about sustaining improvements." One person who used the service said, "There have been a lot of improvements in many areas." However, since our last inspection, some areas of care had clearly deteriorated.

The registered manager had established a system of monthly audits to be carried out by her and the new deputy manager. There was a yearly planner of checks which were to be carried out with due dates, and these were signed off when they were completed. For example, in the month of May, the registered manager had scheduled and carried out checks of medicines, catering, care plans, the presentation of the home, incidents and accidents, infection control and health and safety. These had identified some areas of concern, such as the home presentation audit which had identified that some areas of the building were not fresh smelling and that menus were not always displayed, but had not identified some of the other areas of concern that we found.

A care plan audit was in place, and as a result of this we found that care plans were now legible and suitable for their purposes. However, these audits were not designed in a way which picked up on issues. For example, although care plans were checked, these were not checked against how care was delivered, which meant that managers did not identify that some people did not receive care in line with their plans.

We also found that some important daily records, such as turning charts and nutritional charts had not been checked, and this meant that in many cases these were incomplete or did not constitute a true record of the care that people had received.

This constituted a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People who used the service were complimentary about the registered manager. Comments included, "The management is very proactive now", "She is very nice and makes time for a chat now and again", "She seems very busy but always greets me", and "I think she tried but she is run off her feet." Comments from staff included, "Managers are supportive", "She's a good manager, she really does her best to make us happy" and "I think we've got a good team, we all get on well which helps."

We saw that the registered manager maintained a yearly schedule for team meetings amongst all the different team which constituted the service; these included a general meeting, one for managers, nurses, domestic staff, laundry, catering and care workers. We saw that meetings took place regularly and were used to clearly identity staff responsibilities and clarify expectations. For example, the maintenance team meeting was used to discuss the importance of weekly checks of call bells, bedrails, fire alarm systems and water temperatures, which we saw was taking place.
A meeting of people using the service and relatives had taken place in May, which was used to raise awareness of dementia and to discuss issues relating to the service. However, before this time the previous meeting had taken place in September 2016. One person told us, "They are meant to have a residents meeting but this was cancelled." Shortly after our inspection, the registered manager sent us minutes of a residents and relatives meeting which had taken place the following week. This was used to review the progress of the building's refurbishment and redevelopment and changes to the staff team, as well as to inform people that the service had recently been inspected and to discuss upcoming events.

The provider also worked with community groups in order to provide an improved service to people who used the service. This involved working with a local school, who contributed to the service by holding concerts and providing paintings and help in the garden. There was also a Friends of George Potter Group who held activities in the service and had recently contributed new garden furniture and planters.

The provider had also recently carried out satisfaction surveys amongst the staff team, people who used the service and their relatives. Only a small number of staff had responded to this survey, but we saw that 10 people had responded to the residents survey and these were generally positive. Most relatives who responded felt they were consulted about their relative's care and support, and all respondents to this survey were positive.

The provider was displaying its registration certificates and up to date ratings from CQC. We saw that the provider was meeting its responsibilities to inform us of significant events.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users were not treated with dignity and respect 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity 17(1)(2)(a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and treatment of service users did not meet their needs and reflect their preferences 9(1)

The enforcement action we took:

A warning notice was issued against the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way as the provider did not do all that was reasonably practicable to mitigate risks to the health and safety of service users; equipment and premises used by the service provider were not safe to use for their intended purpose and were not used in a safe way 12(1)(2)(b)(d)(e)

The enforcement action we took:

A warning notice was issued against the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Service users did not receive suitable and nutritious food and hydration which was adequate to sustain life and good health or, where necessary, support to eat or drink 14(4)(a)(d)

The enforcement action we took:

A warning notice was issued against the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent and experienced persons were not deployed to meet the needs of people who used

the service. 18(1)

The enforcement action we took:

A warning notice was issued against the provider