Carewell (Health Care) Limited

St Mary's Care Home

Inspection report

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25 October 2016

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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 18, 19 and 25 October 2016 and was unannounced. This meant the staff and the registered provider did not know we would be visiting.

At our last inspection of St Mary's Care Home in May 2016 we reported that the registered providers were in breach of the following:-

Regulation 9 Person Centred Care

Regulation 12 Safe care and treatment

Regulation 15 Premises

Regulation 17 Good governance

Regulation 18 Staffing

The overall rating for this service was 'Inadequate' and the service was placed in 'Special measures'. This is where services are kept under review by CQC and if immediate action has not been taken to propose to cancel the registered provider's registration of the service, the location will be inspected again within six months. The expectation is that registered providers found to have been providing inadequate care should have made significant improvements within this timeframe.

Following the last inspection in May and June 2016 the registered provider sent us an action plan and provided us with regular updates.

At this inspection we found there were some improvements. However we also found there were further continued regulatory breaches.

There was not registered manager in post when we visited the home and there had not been a registered manager there for the previous 18 months. 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. The service had appointed a new manager who had applied for their Disclosure and Barring Check for their CQC registration process.

Medication administration procedures and systems were not robust and did not protect people living at the home from risk associated with poor medicines management. We found that the administration of medicines at the home did not follow best practice guidance.

We found that checks to verify staff's employment history were not carried out appropriately.

Chemicals being used at the home including professional type cleaners containing ingredients which were likely to cause injury if accidentally splashed or consumed did not have corresponding suitable information which could be used to promote safe storage and which could be followed in an emergency. Immediate steps were taken to improve safety once it was drawn to the attention of the provider.

We found improvements had been made where staff were now routinely recording people's fluid intake. But where this was low, no actions were put in place to address the issue. This meant people continued to be at risk of dehydration. The registered provider had also failed to ensure that some people's dietary requirements were accurately recorded in care files and this information was shared with catering staff. This posed significant risks to people's health and well-being.

The registered provider was not doing all that was practicable to keep people safe because some unoccupied bedrooms which contained dangerous items could have caused injury to people living at the home, staff or visitors.

The manager had appointed two staff as 'dignity champions' for the home. However we saw an example where a person's dignity was compromised.

We found examples where care plans gave incorrect or insufficient information to promote effective care or guide staff practice.

We found peoples care needs had not been reviewed when they moved back to the home from hospital where they had developed additional complex nursing and care needs.We found a number of examples where the service had not responded appropriately or in a timely manner to people's urgent nursing care needs. This included where people had specific conditions, required end of life care or skin pressure care issues. This included an instance where a GPs had recommended a follow up visit from a specialist nurse but the registered provider had failed to put this in place.

The registered provider did not meet the NICE guidelines in supporting people with dementia to take part in leisure activities during their day based on individual interest and choice.

At the last two inspections we found people's records were not stored securely. During this inspection we again found the same cupboard used to store people's old records was again unlocked. This meant people's archived personal records were not stored securely and the manager and registered provider had failed to improve previous breaches of the regulation.

We saw some audits [monitoring checks] had been put in place since our last inspection but monitoring had failed to identify significant omissions in the provision of care. We did not find a planned and structured system at the home which would routinely assess, monitor and improve the quality and safety of services and mitigate risks.

We saw the manager had held meetings with relatives to seek their views. The manager had sent surveys to relatives and was awaiting their return.

Visiting professionals told us staff worked with them in partnership to meet people's needs.

We saw staff using moving and handling equipment and throughout helping people to move they provided

them with explanations, encouragement and support.

Since our last inspection the registered provider had taken action to improve accident reporting.

We looked at the staff rotas and found the numbers of staff on duty were as described to us by the manager and no staff members had been transferred to another home to work whilst remaining on St Mary's rota.

Checks had been carried out on the building to ensure people we safe. There was a current fire risk assessment in place. Agency staff had been given instructions in the use of the emergency fire prevention / alarm equipment.

The registered provider had in place a whistle-blowing policy which explained to staff how to tell someone about worries they may have about the home.

The home was clean and tidy; cleaning was on-going during our inspection and staff were able to describe to us what actions they carried out during their cleaning to reduce the spread of infections.

We found the manager had carried out a supervision of all of the staff. Supervision is a meeting which takes place between a member of staff and their manager to discuss any concerns they may have, their practice and their training needs. Staff had also recently had their training updated.

The provider had made applications to the required authority to deprive people of their liberty when they considered it to be in their best interests. We spoke with the manager about the Mental Capacity Act 2005 [MCA] and Deprivation of Liberty Safeguards [DoLS] and found they understood the requirements of both.

During our inspection we found a number of breaches of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.You can see what action we told the registered provider to take at the back of the full version of the report.

Details of any enforcement action taken by CQC will be detailed once appeals and representation processes have been completed.

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.

Medication administration procedures and systems were not robust and did not protect people living at the home from risk associated with poor medicines management.

Checks to verify staff's employment history were not carried out appropriately.

Appropriate checks were carried out on the building to ensure people were safe.

Is the service effective?

Requires Improvement

The service was not always effective

People's dietary requirements were not effectively supported to ensure they had enough hydration or appropriate foodstuffs to meet their needs and best practice guidance.

The registered provider was not doing all that was practicable to prevent people injuring themselves in unsafe areas of the home.

The manager had made progress in providing staff supervision and there was new training arranged for staff to attend.

Is the service caring?

Requires Improvement

The service was not always caring.

We found end of life care was not coordinated in a timely manner.

Peoples dignity was not always successfully supported by staff at the home.

We found staff promoted good relationships with people.

Is the service responsive?

Requires Improvement

The service was not always responsive

We saw the registered provider had ensured people's care plans had either be rewritten or reviewed. However we found some people's care plans care plans had not reviewed or updated where people had complex, changing or urgent needs.

Some people's care plans gave incorrect or insufficient information to promote safe, effective care or guide staff practice.

The provider had in place a complaints policy. There had been no complaints made since the last inspection.

Is the service well-led?

Requires Improvement

The service was not always well led

The provider had failed to have a manager with the required skills, knowledge, abilities and experience to be registered with CQC for over 18 months.

Actions had been taken by the registered provider since the last inspection to improve the service.

Monitoring of the service by managers had failed to identify significant omissions in the provision of care.

There was not a planned and structured system at the home which would routinely assess, monitor and improve the quality and safety of services and mitigate risks.

People's personal records were not stored securely in an archive and the manager and registered provider had failed to improve this previous breach of regulations.

St Mary's Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 18, 19 and 25 October 2016 and was unannounced.

The inspection team consisted of two adult social care inspectors, a CQC specialist advisor in nursing care and a member of our information governance team who provided advice on records.

Prior to the inspection we contacted the local Healthwatch. Healthwatch is the local consumer champion for health and social care services. They gave consumers a voice by collecting their views, concerns and compliments through their engagement work.

Before we visited the home we checked the information we held about this location and the service provider, for example we looked at the inspection history, safeguarding notifications and complaints. We also contacted professionals involved in caring for people who used the service; including local authority commissioners. A notification is information about important events which the service is required to send to the Commission by law.

During our inspection we spoke with four people who used the service, and two of their relatives. We also spoke with the regional manager, the manager, six senior carers and care staff kitchen, administration and driver/handyman staff. We used the Short Observational Framework for Inspection [SOFI]. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed 10 people's records in detail and looked at other records such as those appertaining to people's medicines and their food and fluid charts.

Before the last inspection, the provider completed 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 did not ask for a new PIR for this inspection. The registered provider

also had sent us an updated action plan about improvements they had made to the service. We used this information to plan our inspection.

Inadequate

Is the service safe?

Our findings

At our last inspection in June 2016 we found the registered provider was in breach of Regulations 9, 12, 17 and 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Whilst we found the registered provider had made some improvements at this inspection we found continued Breaches of Regulations which affected the safety of people living at the home. At our previous inspection in May and June 2016 we identified that medication practices at the home did not ensure people's safety. Medication administration procedures and systems were not robust and did not protect people living at the home from risk associated with poor medicines management.

At this inspection we found records relating to medication were not completed correctly placing people at risk of medication errors. Medicines stock balance did not match records. We found there were signature gaps in people's Medicine Administration Records [MAR] for people who required nursing care. We could not verify if people had been given their medicines or not because stock which had been carried forward had not been calculated. The nurse on duty confirmed that medicine stocks for people receiving nursing care were not properly recorded when these were carried forward from the previous month. The nurse on duty confirmed they were unable to tell if medication had been administered or not.

We also found four instances where people who required support with their nursing care needs had not been given vital prescribed medication because the registered provider had not either secured sufficient stock of their medicines or one person had the wrong medicine stopped by staff.

Some people at the home required pain relief to be administered by patches placed on the skin. We examined the home's medication administration records where we found evidence to indicate that the pain relief medication for one person who used the service had not been administered in accordance with the prescriber's instructions. The records showed that they were at risk of an overdose. The nurse in charge of medication confirmed that the homes' procedures had not been followed.

We looked at how people at the home were supported to use topical medicines [treatments applied to the skin]. At the start of our inspection we found staff were accessing two locked cabinets containing people's topical medicines. These medicines were kept either in plastic baskets with people's names on them or were stacked on shelves in each cabinet. We found that some of the dates that these medicines had been first used had not been recorded. This placed people using them at risk of having medication applied which had become contaminated or which had reduced effectiveness due to age. We asked how staff knew when people were prescribed topical medicines. Staff told us they 'just knew.' We found a list of topical medicines on the top of the cabinets which was handwritten, undated and unsigned which appeared to have been used by staff for medication administration purposes. We observed a member of staff asking a senior staff member for one person's topical medicine which was not on the list that we had seen. Senior staff confirmed the person's topical medicine had changed. Staff told us the senior carers and the nurses completed the topical MAR [TMAR] charts at the end of the shift. One senior staff member said, "Everyone knows who has what cream and I trust the carers to administer this correctly and I just sign everyone's sheets for the whole day at night before I go off duty." We examined records for one person which showed

that they had a sore skin area on 10 October 2016 and were prescribed a topical medicine treatment. However their medication was not available at the home until 19 October 2016. Records showed that a topical medicine treatment had been applied by staff prior to the medicine being at the home. None of the personnel on duty were able to tell us what treatment had been given. This showed that medicines administration at the home was unclear and did not safeguard people living there from inappropriate or accidental administration of medicines.

On the third day of inspection the manager had changed the system for the administration of topical medicines. Staff had access to the TMAR and had sight of body maps which described where people's topical medicines should be applied. The manager told us that staff now signed the TMAR at the time that they applied the topical medicines. However when we reviewed the TMAR and the body maps, we found that not everyone who was receiving topical medication had a body map in place and there also were some gaps in the application records. This meant that the administration of topical medicines by staff at the home remained unclear and we could not be assured that treatments were taking place as prescribed. For example we found one person to have three TMARs in place and their topical medicines had changed, however the administration of their topical medicines was unclear.

Some people at the home had been prescribed medicines which were called 'controlled drugs' [CD's]. CDs are medicines which are liable to misuse and as such have stricter guidelines for storage, administration and disposal. We looked at the way that controlled drugs were stored and administered at the home and found that administration details had not been updated where people were no longer residing there. We also found that nursing staff were not always aware when urgent pain relieving medicines [that they were expecting] had arrived at the home and that records of these medicines were not always made. We found one person's medicines had been previously delivered to the home without an appropriate record being made. The nurse in charge of medicines told us, "It's ok as everyone knows where the drugs are written in the book." We found that the administration of medicines at the home did not follow best practice guidance such as that issued by the National Institute for Health and Care Excellence [NICE] entitled 'Managing medicines in care homes' and placed people at risk of poor treatment associated with poor or inaccurate medicines management.

We looked at the arrangements put in place at the home to ensure that chemicals used in the cleaning or maintenance of the home were stored and used safely. We sampled seven chemicals being used at the home including professional type cleaners containing ingredients which were likely to cause injury if accidentally splashed or consumed. We found five of the seven products we checked did not have corresponding suitable information which could be used to promote safe storage and which could be followed in an emergency. We asked the manager and the regional manager to show they were compliant with the Control of Substances Hazardous to Health [COSHH] Regulations 2002 [as amended] but they were unable to do so. The regional manager agreed that essential information was not available but immediately put these in place to protect people living and working at the home. Whilst immediate steps were taken to improve safety once it was drawn to the attention of the registered provider, the registered provider's systems or processes to assess, monitor and improve safety at the home had not ensured these were already in place.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

During this inspection we looked at the recruitment records of four people working at the home, all of whom had been employed since July 2016. We saw gaps in four records we looked at which meant recruitment procedures had not been followed.

Applicants had been asked to complete a job application form. In three out of the four records we looked at the section requiring the applicant to provide an employment history was incomplete. This was because the provider's application form did not require prospective staff to give the start date of their current employment. There was no evidence that this gap in people's employment history had been explored further by the registered provider as part of the recruitment process. This showed that the registered provider had not undertaken sufficiently competent and thorough background checks for staff before they started working with vulnerable people.

We saw on the job application form, prospective employees were requested by the registered provider to supply the names, addresses and contact details of two referees. On the job application form it stated that applicants must include their current or last employer without which their application would not be able to be progressed. However, despite this being the policy of the registered provider we saw in three staff members files two references, neither of which were from their last employer. This showed that checks to verify staff's employment history were not appropriately carried out.

We found in some employee's file there was no proof of identity including a recent photograph which would show their identity had been verified. This meant the provider had not maintained accurate records for staff employed at the home.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

We checked to see if the registered provider had in place risk assessments and found there were risk assessments in place about the building to reduce the risk of harm to people who lived there. We looked at people's individual risk assessments and found people had risk assessments in place when risks had been identified in their care plans. The risk assessments described to staff what actions they needed to take to reduce the risk of harm to people.

We looked at the staff rotas and found the numbers of staff on duty were as described to us by the manager. The manager assured us that since they commenced employment no staff member had been transferred to another home to work. We observed a staff member from another home working in St Mary's on our inspection. The manager explained a number of staff had been given holiday by the previous manager during the half term holiday and they had requested additional staff be brought into the home. We saw people received prompt attention. One staff member we spoke with told us, "We manage, we all work together." We observed one staff member who was working in a maintenance role on the day of inspection standing in the lounge. They explained to us the care staff had been called away and they were "Keeping an eye on them." This meant staff were working together to ensure people were safe.

Since our last inspection the registered provider had taken action to improve accident reporting. We saw accidents were now monitored using an electronic tool. The manager had reviewed the accidents on a monthly basis to check if any actions could be taken to prevent any re-occurrences. In addition we found people had falls risk assessments in place and staff had been trained in falls prevention training.

People had in place Personal Emergency Evacuation Plans (PEEPs). Since the last inspection the PEEPs had been located close to the front entrance. This meant rescue personnel had easier access to information on how people needed to be evacuated from the home. However we found one person had lived in the home for twelve days before their PEEPs had been put in the file.

Checks had been carried out on the building to ensure people were safe. There was a current fire risk

assessment in place. We found the registered provider had fire checks in place and fire alarms were tested on a weekly basis. Agency staff had been given instructions on how to turn off the fire alarm. We saw there were window restrictor checks in place. There were up to date gas and electrical safety checks in place as well as, water temperature checks, hoist checks and Portable Appliance Testing [PAT]. This meant the registered provider was checking the building to ensure people were kept safe.

The registered provider had in place a whistle-blowing policy which explained to staff how to tell someone about worries they may have about the home. The manager told us since the last inspection the home had not received any whistleblowing information.

The registered provider also had in place a staff disciplinary policy. Although there were no staff undergoing disciplinary procedures at the time of our inspection the policy gave guidance to the manager and staff what actions were required to keep people safe from inappropriate staff conduct.

We saw the home was clean and tidy; cleaning was on-going during our inspection. Staff showed us their completed cleaning schedules and were able to describe to us what actions they carried out during their cleaning to reduce the spread of infections. Staff told us about their approach to one person who usually did not want their room cleaned and explained they would seek their permission each day to go into their room and offer cleaning. The manager had carried out infection control audits and found the home was appropriately cleaned.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in July 2016 we found the registered provider was in breach of Regulations 12, 14, and 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. During this inspection we found the registered provider had made some improvements but had continued to breach some of these Regulations.

During our last inspection we found people were at risk of dehydration. We saw improvements had been made and staff were routinely recording people's fluid intake. Staff had accessed national guidance and knew they should be enabling people to drink approximately 1000 mls per day. However we found one person had consumed less than 1000 mls; on eight days within a ten day period. A doctor had visited the home and suggested the person may need subcutaneous fluids. These are fluids which are given to people in the space under their skin. We found there was no guidance of when subcutaneous fluids should be implemented for this person. There was no mention in the handover notes or daily accountability records, or a care plan to reflect when subcutaneous should be considered. We found that where people's fluid intake was low staff had recorded this on the handover sheet, but no actions were put in place to address the issue. This meant the provider had failed to establish when the person may need additional hydration.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

During the last inspection we found the registered provider was in breach or Regulation 9 and people were at risk of losing weight. During this inspection we saw people who were at risk of losing weight had their Malnutrition Universal Screening Tool [MUST] reviewed. We found people's weights to be stable and dietitians had been consulted. People were no longer at risk of malnutrition as the home had taken action, and staff were aware of when people had a poor appetite. We observed staff supporting and encouraging people to eat. However we found on one MAR record there were gaps in the recording where people needed to take prescribed nutritional supplements to maintain their intake. This meant that the registered provider could not demonstrate that people who needed nutritional supplements had actually been supported to take them at the home.

We carried out our short observation framework for inspection [SOFI] over a lunch time period and found people were supported to eat. Where people refused their meals staff offered them alternatives until they found something the person wanted to eat. We looked at people's dietary needs and found the information regarding the dietary needs of people with diabetes were in the care notes but not always accessible to all in the kitchen and dining rooms. For example we found kitchen staff were not aware that a person had been admitted to the home who required a specialist diet to support their diabetes needs. This person was at risk of not being in receipt of an appropriate diet for 13 days.

We found there were people living at the home who had specific dietary needs and required a particular diet to support their health and well-being. These included dietary needs to support diabetes or chronic obstructive pulmonary disease [COPD]. There was also no evidence that published guidance such as that

from the National Institute for Health and Care Excellence [NICE] entitled 'Chronic obstructive pulmonary disease in over 16s: diagnosis and management: NICE guidelines [CG101]' [published date: June 2010], had been considered or put in place at the home. There was no record of any specialist meals that had been produced which had taken their needs into consideration.

We spoke with the catering staff during our inspection who were aware of the need to use a sugar substitute and consider portion size for people diagnosed with diabetes, although there was no evidence of the levels of carbohydrates were considered for people to maintain their glucose levels. Following the submission of the draft report to the provider they told us people with diabetes are well catered for in the home and they had adapted meals for them. We found whilst there was evidence that guidance such as that produced by the National Institute for Health and Care Excellence [NICE] entitled 'Nutrition support in adults' [NICE clinical guideline 32] had been used at the home to assess people at risk of malnutrition the registered provider had also failed to ensure that some people's dietary requirements were accurately recorded in care files and this information was shared with catering staff. This posed significant risks to people's health and well-being.

This was breach of Regulation 14 [Meeting nutritional and hydration needs] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

We looked at the premises and at our last inspection found there were unoccupied bedrooms with doors open which contained trip hazards for people. During this inspection we also found unoccupied bedrooms with doors open. One unlocked bedroom had boxes of continence aids across the floor. In another room we found the radiator cover had been removed and a plank of metal was on the floor, alongside of which was an open packet of tacks together with two small pieces of wood nailed together with the nail sticking out. These could have caused injury to people living at the home, staff or visitors. This meant the registered provider was not doing all that was practicable to keep people safe. We drew these to the attention of the manager for her immediate attention.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

At the last inspection we found staff were not receiving sufficient support through supervision, appraisal and training. During this inspection we found the manager had supervised all of the staff. Supervision is a meeting which takes place between a member of staff and their manager to discuss any concerns they may have, their practice and their training needs. We saw the manager had met with staff at least once in August and September for supervision. Appraisal dates at the time of our inspection were being put in place.

Staff had recently had their training updated with falls prevention, dignity and information governance training. We saw the manager had updated their training planner and found that kitchen staff had received training in food safety. We also saw future staff training had been planned for nutrition and diabetes. People who came into the home on a volunteer basis were carrying out tasks which did not require specialist knowledge.

The Mental Capacity Act 2005 [MCA] provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards [DoLS]. We checked to see if the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found staff had been trained in the MCA and people had in place mental capacity assessments. The service had made applications to the required authority to deprive people of their liberty. We spoke with the manager about the MCA and DoLS and found they understood the requirements of both.

We saw people's consent had been obtained to live in the home. Where people lacked capacity we saw their relatives had been involved and relatives had been given the option to look at their family member's care plans. During our inspection we observed staff seeking people's permission before they carried out any tasks. Staff adhered to people's wishes. This meant staff understood the issue of consent.

Requires Improvement

Is the service caring?

Our findings

We looked at how people's end of life care in the home was supported. In some care plans we found people had not wished to specify details about their end of life. Some people had Emergency Health Care Plans in place plans which gave guidance to state they did not wish to be resuscitated if they had a medical emergency. People had been supported by a community matron to complete these plans. However when we looked at how end of life care planning was provided we found it was not carried out in a timely and coordinated way and people's needs had not been addressed. This meant staff were unclear about people's immediate care needs and plans to support end of life care were not in place.

The manager spoke to us and gave us the names of two staff who had been appointed as 'dignity champions' for the home. We saw this had been discussed in team meetings and staff had been approached to take on the role. However we observed situations where people's dignity was not promoted. For example one person was having their hair styled by a visiting hairdresser but was situated waiting in the corridor with wet hair and curlers whilst other people walked past. Staff attempts to intervene to protect the privacy of one person using the toilet were unsuccessful when the person declined the support from staff.

We observed staff chatting to people and using humour in their conversations. People responded well to staff and no one showed any distress when staff approached them. We found staff promoted good relationships with people. They spoke with us about behaviour which challenged them and what actions they needed to take to promote people's wellbeing. At times this meant engaging people in their current state and enabling them to engage in conversation, at other times staff left people and returned later to offer help and support. During our inspection we found there was no one in the home who was repeatedly distressed.

We used our short observational framework for assessment [SOFI] and found that staff displayed patience and kindness towards people over a lunchtime period. Whilst staff were offering people their meals people wanted to talk about other things. Staff listened to them attentively and then offered them a choice of meal. Where people were supported to eat, staff focused on them and engaged them in conversation over their meal. We observed that people sometimes changed their minds about their choice of food and drink, and staff remained calm and patient until they had got it right for the person.

We saw in people's care plans there were goals to promote and maintain people's independence. Staff encouraged people to be independent for example when eating their meal, or making their own choices. One staff member explained the risks this independence may incur and told us about one person who forgot they were unable to balance and may fall. They had offered the person an alternative choice of activity which distracted them and reduced their risk of falling.

We saw staff using moving and handling equipment and throughout helping people to move they provided them with explanations, encouragement and support.

We visited the home early in the morning and found staff spoke in hushed tones whilst trying not to disturb

people. People who were in bed at that time had been checked and been made comfortable. Staff explained to us which people liked to get up early, what they liked to do and which people preferred to stay in bed.

The manager demonstrated an awareness of how advocacy should be used to support people. Whilst there was no one in the home who had an independent advocate, we found there was an advocacy service available should people need independent support in their best interests.

The manager told us they were looking for ways to increase people's involvement in the home. We found the service involved relatives and visitors in the care of those in the home. One family was included in completing a social history of the person. Another family member provided their relative with support at mealtimes. Relatives were welcomed in the home at any time.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found the registered provider was in breach of Regulations 9, 12, and 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. During this inspection we found the registered provider had continued to breach these regulations.

We reviewed the care records of 10 people who were living at the home. The manager told us since the last inspection five out of 24 care file records had been re-written. The registered provider in their action plan to improve the service told us all care files had been reviewed.

We found in the transition from hospital to the home people's care needs had not been reviewed. For example in the handover notes used to pass over information from one shift to the next we saw there was a query where staff did not know if a person needed to continue oxygen therapy treatment. We found in the person's records they were expected to have oxygen therapy for 16 out of every 24 hours to maintain their health. The person had recently been discharged from hospital and transferred to nursing care. No one at the home was able to tell us about the person's need for oxygen. We drew this issue to the attention of the manager and the regional manager for their immediate attention. They spoke to the visiting GP and wrote a care plan for the person which gave staff guidance on how to care for the person.

We saw records which showed a GP had been called to see one person living at the home and had stated the person needed to be followed up by the tissue viability service because they were at risk or had already developed skin pressure damage. Three working days later we asked during our inspection if this had been done. The nurse on duty told us they could not find the number for the tissue viability service and would have to wait on the phone if they had to ring the single point of contact number because they kept people waiting in a queue. They had not yet made the call. We found this was not an acceptable response to the GP's request and placed the person who used the service at increased risk.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

We found one person who had recently been discharged from hospital and their care records had not been updated to reflect their transitional needs when they returned to the home.

We found another person's records indicated they had returned to the home from hospital following an illness in which their care needs had changed considerably. Despite these changes their care plan was not immediately updated on return to the home.

In a pre-admission assessment carried out by the registered provider we found there was no mention of one person's diabetes which had been listed as an area of need in the discharge plan following treatment in hospital. In the home's dependency tool diabetes was identified as a need. There was no dietary notification to the kitchen on admission. We found the information to be confusing and inaccurate. During our inspection a staff member took a copy of the diet notification to the catering staff. In addition in their

care plan for catheter care staff were to monitor output on food and fluid charts to ensure they were taking in sufficient nutrition and hydration. On two days staff had used the wrong chart with no output column and output had not been recorded. This showed this person's care needs had not been correctly recorded and documentation to demonstrate their contemporaneous care was not in place.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

We looked at the activities in the home and found there were laminated sheets explaining the daily activities. These were not being followed. A record had been kept of activities in individual files but these were not up to date and mostly stated what resident didn't want to do. We saw the manager had put in place a "Guess the baby" competition and had arranged a Halloween Party. The manager explained to us their view was not about always having in place large group activities but included staff spending individual time with people who used the service. We saw staff engaged people in conversation and on the morning of one of our inspection days, staff were painting people's nails. However, we found the registered provider did not meet the NICE guidelines in supporting people with dementia to take part in leisure activities during their day based on individual interest and choice.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

We saw the registered provider had in place a complaints process. The manager told us there had been no complaints since they had started to work in the service following the last inspection. People had been informed about making a complaint in the service user guide. The manager had met with relatives to hear their concerns about the service.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found the registered provider was in breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. During this inspection we found the registered provider had made some improvements but had continued to breach the regulation in a number of areas.

At the time of our inspection there was not a manager in place at the home who had been assessed by CQC as having the skills, qualifications, knowledge and experience to be the registered manager of the home. There had been no registered manager at the home for over eighteen months. The registered provider had appointed a manager who had been in post for twelve weeks prior to our inspection. The manager told us it was their intention to apply for consideration to register with CQC.

Since the last inspection the registered provider had drawn up an action plan to address the breaches and comments made in the previous report. We found actions had been completed for example making personal emergency evacuation plans accessible to emergency personnel, reviewing people at risk of malnutrition and improving staff supervision. This meant the provider had made improvements to the service.

At the last two inspections we found people's records were not stored securely, for example, we found a cupboard which contained people's archived records was accessible to people who lived at or visited the home. During this inspection we found the same cupboard used to store people's records was again unlocked. This meant people's personal records were not stored securely and the manager and registered provider had failed to improve previous breaches of regulations.

At the last inspection we found records were not always up to date and accurate. At this inspection we again found some people's care planning records were not up to date. We looked at handover sheets and found these were in regular use. However the notes made by staff on the handover sheets demonstrated they were sometimes unclear about people's care planning needs. When we checked people's care plans we found these needs had not always been updated. We found examples where care plans gave incorrect or insufficient information to guide staff on how to care for people.

The manager conducted daily walkabouts in the home and highlighted areas which required improvement. They explained to us that whilst the fabric of the building needed considerable improvement they preferred not to decorate bedrooms so people when they moved in could choose their own furnishings and wall colour.

We saw some audits [monitoring checks] had been put in place since our last inspection. The audits carried out included kitchen audits, health and safety audits and medicines audits. We saw the audits had generated a number of actions in a remedial report. However actions identified by the manager in their audits including their daily walkabouts had yet to be completed. The manager explained there were a number of tasks in the home which needed only a few minutes to complete but they were unable to achieve them all in a short space of time. We found audits carried out at the home had failed to identify significant

omissions in the provision of care. For example; care planning records and strategies; dietary needs; skin pressure care reporting and employment history. The manager and regional manager took action when these issues were drawn to their attention for example during our inspection the manager introduced a weekly medicines audit to address the concerns we found about people's medicines. Overall we found there was not a planned and structured system at the home which routinely would assess, monitor and improve the quality and safety of services and mitigate risks.

This was a breach of Regulation 17 Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

We saw the manager had held meetings with staff and relatives to both give direction and seek their views. The manager shared with us the views of the relatives who had attended the meeting and had discussed ways of improved communications. It had been agreed a newsletter was a way forward to let people's relatives and friends know what was happening in the home.

We found the manager had initiated relative surveys and at the time of our inspection was awaiting further feedback questionnaires to be returned to the service. We reviewed the surveys which had already been returned and found relatives had been largely positive about the service. One person had commented that the manager was just finding their feet and said, "I am very pleased with her."

We found the manager had recruited staff from the home where they had worked together previously. The manager had interviewed the staff and also provided them with references. The staff had also provided each other with references. This conflict of interests meant there was a lack of transparency at the home. We fed back our findings to the regional manager. Staff told us they were confident in the new manager and felt she had already made improvements.

People who were able to leave the home utilised the local community facilities. The manager had arranged a trip to the seaside to enable people to use local resources.

The service had an up to date Statement of Purpose, this is a document which tells people and their relatives what they can expect from the service.

Staff told us they had confidence in the new manager and felt they had made significant progress in the short time they had been managing the home. One member of staff told us, "Everything is so organised."

We looked at partnership working in the home and found there was partnership working in the home with other professionals. We spoke with three visiting professionals who confirmed to us the staff worked with them to meet people's needs. One visiting professional said, "I have been coming here a while now and I like to make sure the things they say will be done actually are; it's 'so far so good' [positive] at present."