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Tiled House

Inspection report

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Date of inspection visit:
11 August 2016
12 August 2016
15 August 2016

Date of publication:
14 October 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on the 11, 12 and 15 August 2016 and was unannounced. During our previous inspection on 27 and 28 October 2015 we found two regulatory breaches in relation to the unsafe management of people's medicines and unsafe recruitment practices for the employment of staff. Following the inspection, the provider wrote to us to say what they would do to meet these legal requirements by December 2015. During this inspection we checked whether the provider had completed their action plan to address the concerns we had found. We found the provider had made the required improvement in their recruitment practice. However, we identified that improvement actions from the previous inspection remained outstanding and further improvements were required to ensure the management of medicines was safe and met the requirements of the regulation.

Tiled House provides accommodation and nursing care for up to 29 older people, most of whom are living with dementia. The home is in the village of Shawford, near Winchester. People have access to gardens.

A registered manager was not in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered person'. 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 previous registered manager left the service on 11 March 2016. A new manager was appointed in March 2016 and they have applied to us for registration.

The provider had not made the improvements required from our previous inspection to ensure the proper and safe management of people's medicines. Not all people had guidance for the use of 'as required' medicines to ensure they received the appropriate treatment when required. We identified some errors in the recording of people's medicines and not all medicines were safely stored. People's medicines were not always administered in a safe way to prevent errors. Medicines incidents and errors were not always identified and acted upon to protect people and ensure the safe management of their medicines.

People's individual risks were not always managed safely. A wound management plan was not in place for a person with a wound and the wound had not been fully assessed, checked or treated due to the lack of communication by staff to each about this. People were not always assisted to transfer safely by staff using the correct equipment or support. The correct equipment was not always available to meet people's individual moving and handling needs in line with their assessed needs. Risks to people were not always fully assessed or acted upon to mitigate the risk and guidance on how to support people to minimise risks was not always followed. This meant people were at risk of inappropriate or unsafe care and treatment.

At our last inspection we made a recommendation about the prevention and control of infection. At this inspection we found other evidence that showed the appropriate standards of hygiene and cleanliness to prevent the risk of infection were not adequately maintained. The provider's system for checking and ensuring infection control practices were followed to minimise risks to people was not robust enough to

protect people from risks associated with infection control.
The environment was not maintained to a safe and appropriate standard. This meant people could be at risk of accidents and incidents because they were exposed to ineffective safety and security practices.

There were not always enough staff deployed to monitor people's safety and meet the needs of people in their rooms and in communal areas of the home. Records showed the staffing levels were not always at a safe level as determined by the provider. Not all staff had completed the training as required by the provider to ensure they could provide people's care effectively. There was high use of agency nursing and care staff due to staff vacancies and this had impacted on the continuity of care people received and the regular staffing in the home. The provider did not assure themselves that all nursing staff had completed training in safe medicines management; wound care, diabetes and tissue viability although they were responsible for people's treatment needs in these areas. Staff did not receive regular supervision to enable them to identify solutions to problems, improve care practices and to increase understanding of work based issues. The provider did not ensure that there were enough suitably competent and experienced staff to meet people's needs safely at all times.

The provider had made the required improvement from our previous inspection to ensure staff were recruited safely. Staff were aware of their responsibilities to report incident and concerns to the manager to safeguard people from the risk of abuse.

Mental capacity assessments and best interest decisions were not always carried out or recorded to agree the restrictions in people's care and treatment when they lacked the capacity to give their consent; or for specific care and treatment decisions. Not all staff had completed training in the Mental Capacity Act (2005) and could evidence their understanding of this and how this applied to the people they supported. Some people's rights under the MCA were not met.

People spoke to us positively about the food in the home and people's dietary needs were catered for. Whilst we saw that action had been taken to protect people from some of the risks associated with eating such as actions to prevent the risk of people choking. The monitoring of people's food and fluid intake was not effectively completed to enable staff to evaluate whether people were receiving sufficient food and hydration to prevent a deterioration in their health.

People and their relatives told us most staff were kind. Our observations included interactions between staff and people that were kind, reassuring and compassionate. However not all staff responded to people living with dementia who had behaviours that could challenge others in a caring or consistent way. People's choices were not always respected and at times people's needs were not met in a respectful and caring way. People were not always treated with dignity and respect.

People were at risk of inappropriate care and treatment. Staff did not always have the information they needed to meet people's needs and preferences. Care plans were not always readily available to staff and care plans required review and updating to consistently reflect people's current needs preferences and risks. Systems in place to guide and enable staff who did not know people well to meet their needs and preferences were not consistently applied. People did not always receive person centred care in line with their assessed needs. People's health risks were not always monitored, reviewed and evaluated in line with their assessed needs to ensure they received the appropriate care and treatment.

People's care did not reflect all their needs. For example it was not evident people were supported to engage in meaningful occupation or activities to meet their social needs. This is important for people living with dementia who can benefit from activities that improve their physical and mental symptoms. People

were at risk of deterioration in their health and well-being due to a lack of stimulation and activities to meet their social and emotional needs.

People remained at risk from unsafe or inappropriate care and treatment because the provider had not taken the steps to mitigate the risks identified at our previous inspection and through their own quality assurance processes in a timely manner. We saw the provider had developed an action plan to address shortfalls in the quality and safety of the service identified through concerns raised by the local authority, an external consultant and their own audits. This action plan required further development to identify all the areas where quality and safety were being compromised and to drive improvements to the service people received.

Records relating to the care and treatment of people were not always fit for purpose. People were at risk of receiving inappropriate or unsafe care through the provider's failure to maintain accurate, complete and contemporaneous records in respect of their care and treatment.

We were concerned that insufficient management resources were available to ensure the service people received met the requirements of the regulations and provided safe and appropriate care and treatment. Day to day leadership for staff on the floor was provided by inconsistent nursing staff due to the high level of nursing staff vacancies. Whilst we saw the manager had informed staff about improvements required these had not been made and were not evident in staff practice. Staff told us some of the nursing staff were unhelpful and inconsistent in their leadership approach. The staff team had not been sufficiently developed to ensure they always displayed the right values and behaviours towards people. Whilst the provider and manager were developing strategies to make improvements to the culture of the service and the standards of care that people experienced. This required more time to ensure the improvements planned were embedded into practice.

We found a number of breaches of the regulations you can see what action we told the provider to take at the back of the full version of the report.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's medicines were not managed safely. Improvements were required to meet the legislative requirements and to protect people from the unsafe management of their medicines.

People's individual risks were not always managed safely. Risks to people were not always fully assessed, monitored or acted on to mitigate the risk. People were at risk of unsafe care and treatment.

The appropriate standards of hygiene and cleanliness to prevent the risk of infection were not adequately maintained. People were not adequately protected from risks associated with infection.

The provider did not ensure there were enough suitably competent and experienced staff to meet people's needs safely at all times.

Staff were aware of their responsibilities to report incidents and concerns to the manager to safeguard people from the risk of abuse.

Is the service effective?

Requires Improvement

The service was not always effective

Staff did not always have the training they needed to meet people's needs and ensure their safety. The provider had not ensured that all staff were competent to meet the requirements of their role. Staff had not all received regular supervision and appraisal. People could be cared for by staff who were not adequately trained or supported in their role to provide effective care and treatment.

Not all staff had completed training in the Mental Capacity Act (2005). Mental capacity assessments and best interest decisions were not always carried out when people lacked the capacity to give their consent. The legal rights of people were not always upheld.

The monitoring of people's food and fluid intake was not effectively completed to enable staff to evaluate whether people were receiving sufficient food and fluids to prevent the risks from malnutrition and dehydration.

People living with dementia were at risk from unsafe and inappropriate safety and security measures in their living environment.

Is the service caring?

Requires Improvement

The service was not always caring

Some staff demonstrated kindness and compassion towards people. Not all staff responded to people living with dementia who had behaviours that could challenge others in a caring or consistent way. This meant some people experienced distress and agitation due to a lack of understanding and care shown towards them.

People's choices were not always respected and at times the people's needs were not met in a respectful and caring way. People were not always treated with dignity and respect.

Is the service responsive?

Inadequate

The service was not responsive.

Staff did not always have the information they needed to meet people's needs and preferences. Care plans were not readily accessible to staff or up to date to ensure there was consistent guidance available to staff to meet people's needs.

People did not always receive care in line with their assessed needs. The monitoring, review and evaluation of people's needs was not always carried out to ensure their care was safe and appropriate.

People were at risk of experiencing deterioration in their mental and physical well-being because their activity and social needs were not assessed, planned for or met.

There were systems in place to investigate and respond to complaints. No complaints had been received since our last inspection however, people's relatives told us the manager had responded to concerns they had raised

Is the service well-led?

Inadequate

The service was not well-led

Insufficient action had been taken to address the requirements from our previous inspection and the concerns identified through the provider's own quality assurance system in April 2015. Management, leadership and staff resources were not sufficient to achieve the required improvements to meet the regulations and ensure people received safe care and treatment

People were at risk of receiving inappropriate or unsafe care through the provider's failure to maintain accurate, complete and contemporaneous records in respect of their care and treatment.

The service was not driven by a shared understanding of values and behaviours to underpin the quality of care people received. The service had been struggling to maintain consistency of staff which had made it difficult to develop a positive culture based on consistent good practice.

Tiled 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.

This inspection took place on 11, 12 and 15 August 2016 and was unannounced. During this inspection we checked that improvements planned by the provider had been made to meet the requirements following our inspection of 27 and 28 October 2015. The inspection was completed by three adult social care inspectors.

Prior to our visit we reviewed the information we held on the Tiled House. This included previous inspection reports, any concerns raised about the service, and notifications. Notifications are information about important events which the service is required to send us by law which give us information about how incidents and accidents were managed. We did not request a Provider Information Return (PIR) at the time of our visit as the provider would not have had time to complete one. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We obtained this information during the inspection.

Prior to the inspection we received information from a senior practitioner in the Winchester south community team and a West Hampshire safeguarding adults nurse. During the inspection we spoke with three social workers from Hampshire and a social worker from Tess Valley community team. Following the inspection we spoke with a social worker from the Winchester community team and a West Hampshire safeguarding adults nurse. During the inspection we spoke with eight people and the relatives of three people. We spoke with the manager and the provider's general manager, three care staff, three nurses, one member of domestic staff and the chef.

We reviewed records which included seven people's care plans and daily notes. We reviewed people's medicine administration records and documents related to the management of people's medicines. We observed nursing staff administering people's medicines and staff interactions with people which included lunch time sittings. We reviewed five staff recruitment and induction files and records related to staff

performance issues, staff supervision, appraisal and training records. We reviewed records relating to the management of the service. These included; staffing rotas for the period 30 May 2016 to 14 August 2016, quality assurance records, policies, audits and schedules.

Inadequate

Is the service safe?

Our findings

At our inspection of 27 and 29 October 2015 we found that people were not adequately protected against the risks associated with medicines. PRN protocols for the safe use of medicines to be taken 'as required' were not in place for some medicines used by people to manage epilepsy and agitation. This was breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to safe care and treatment. Following the inspection, the provider wrote to us to say what they would do to meet these legal requirements by December 2015.

At this inspection we found that some people who were prescribed medicines to be taken 'as required' to help them manage agitation and behaviours that may challenge others did not have a PRN protocol available. This was important so that staff administering medicines can identify triggers to the behaviour and indicate at what point the medicine should be administered. Although the provider's action plan to address these concerns had stated protocols for all as required medicines were in place by December 2015 and were to be audited to ensure the improvement was sustained we did not find this to be evident. This was a continuing breach of regulation 12of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some prescription medicines are controlled under the Misuse of Drugs Act 1971. These medicines are called controlled drugs (CDs). Providers are required to have procedures in place to ensure that CDs are safely managed and that staff follow these to keep people safe. Some other medicines are also recommended in current NHS guidance to be stored and recorded in the same way. We found errors in the recording and stock totals of two of these medicines. We also found that some unusable stock of these medicines were stored with other useable medicine. Although checks were in place to monitor the safe management of these medicines it was evident that these errors had not been identified or investigated to establish what had happened to prevent further errors and the risk of misuse. People could be at risk of errors in the administration of their medicines when these are not correctly recorded and accounted for.

People were at risk because staff did not always handle medicines safely and people did not always receive them as prescribed. One person was prescribed a medicine to be taken as required to 'calm' them in specific circumstances. This medicine had mistakenly been included by the pharmacy in a blister pack which contained the person's daily medicines. This error had not been identified by staff and the person was therefore taking this medicine not as prescribed and potentially unnecessarily. The persons care plan described how the use of this medicine could result in the person becoming more 'unsteady' and increase their risk of falls. A boxed stock of this medicine was also available which was not recorded on the person's Medicine Administration Record (MAR). One tablet was missing from this stock but there was no current record to show when this had last been administered and whether it had been administered in addition to the daily dose or not. There was a risk the person could have taken more of the medicine than prescribed. The manager took immediate action and phoned the GP who advised the medicine was to be given as required only.

One person had not received their time specific medication, however there was no record on the person's

MAR as to why. This medicine could not be given after the person had eaten so they were not able to have their medicine once the error was discovered. We observed a nurse administering medicines, we noted that people were given several tablets on one spoon to swallow in one go. During the administration of one person's medicines a tablet was found nearby on the floor. The nurse could not identify the medicine and whether this had fallen during the administration of the person's medicines or previously as all the tablets had been given together. We observed a nurse administering medicines whilst answering the main phone to the home. This could potentially distract the nurse and possibly result in a medication error. People's medicines were not always administered safely.

People medicines were not always stored safely. Temperatures were taken daily of the medicine room in the morning. However, we noted the room temperature exceeded the safe range of 25 degrees during the second afternoon of our inspection. Records for the month showed the maximum temperature had been reached on two previous days and exceeded the safe range on one other day. Medicines can be damaged when stored in temperatures outside of the safe range. This meant people could be at risk of receiving ineffective medicines. Some topical creams were not dated when opened to ensure they remained in date for safe use. Topical creams are used on the skin to treat or prevent ailments. Some medicines which were to be disposed of were mixed with current stock medicines on a counter in the medicines room. People's boxed medicines were stored together in a cupboard and not separated which could cause an error. For example; an error had occurred when an agency nurse had identified an emergency medicine used for a person to control a seizure was not in stock resulting in a person attending accident and emergency. However, the medicine had been in stock but not identified by the nurse. The medicines room was reorganised during our inspection to address some of these issues and the manager assured us this would be maintained. This was a continuing breach of regulation 12of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always being protected against the risk of harm, for example; a person told us they were in pain because of a wound to their leg. There was no wound care plan in place and no written record of when the wound had last been checked and dressed. Care of the wound had not been mentioned in the staff handover and was not identified on the written summary available for agency nursing staff. The nurse made no reference to the person's wound or pain relief needs for this whilst administering their morning medication, although they later told us they were aware of it. We spoke to the manager about this and on checking the wound the manager told us the dressing needed to be changed and contacted the tissue viability nurse to review the person. This person had a history of diabetes and leg ulcers which meant they had an increased risk of developing more ulcers. There was a risk the wound could deteriorate when there was no clear plan in place to monitor the site and ensure safe care and treatment was provided.

We observed a person being assisted to move by staff using a hoist. The equipment used was not as detailed in their care plan and could place them at risk of harm. We observed another person being supported to transfer from their chair to stand, by one staff member who partially assisted them by pulling them up under their arms. The person's risk assessment stated they were to be supported to transfer 'by guiding hips' only and required two staff to assist them. Incorrect moving and handling techniques can place people at risk of injury. Information about people's moving and handling needs was not always clear or consistent for staff. This meant they could be placed at risk of inappropriate care leading to them experiencing an injury.

An occupational therapist had carried out an assessment of people's moving and handling needs and informed the manager of the hoist slings required to meet people's needs and enable each individual to have their own sling. The occupational therapist stated that several of the slings in use are unsuitable for use and need to be disposed of as soon as replacements are in place. The occupational therapist had notified them on 4 July 2016 of these requirements. Although the manager had requested the slings were purchased

by the provider this had not been done. People were at risk of harm from the use of inappropriate equipment and moving and handling techniques.

We make recommendations to signpost providers to potential action they can consider to help them improve the quality of the service they provide to people who use it. We follow up recommendations at our next inspection. At our last inspection on 27 and 29 October 2015 we made a recommendation to the provider about improving infection control practices. At this inspection we found there were risks to people from poor infection control practices. The provider's infection control procedure stated an audit would be carried out every three months to ensure best practice standards were maintained. We saw the last audit had been carried out in December 2015. This meant infection control standards were not being regularly monitored in line with the provider's procedure.

We saw the provider had introduced a weekly cleaning schedule for beds. We checked bed cleaning schedules for some people and found they had not been completed as required. Some schedules were blank and others had one entry. Care staff were responsible for completing mattress cleaning and changing bedding and recorded when completed. Care staff told us they did not have time to clean mattresses. One staff member said "We don't get time to clean the beds. We change them when soiled or once per week but it's usually every two days or so". An action plan dated 14 May 2016 and updated on 25 May 2016 identified that mattress cleaning records had not been completed at both checks. At this inspection we were concerned that the lack of regular mattress checks and bed cleaning could mean people were not adequately protected from the risks of infection. For example; one person was doubly incontinent and their care plan indicated there was a risk of faeces in their room. The room was malodourous and the bed cleaning schedule had not been completed to show the mattress had been regularly cleaned. Another person who was on bed rest had a condition that posed an infection control risk had a blank bed cleaning schedule. Another person's bed smelt strongly of urine and the bed clothes were not clean, although we brought this to the manager's attention during the morning the bedding had not been changed by the end of the day. This meant people could be at risk of infection from unclean bedding and mattresses.

We found several areas of the home were not clean. This included some people's bedrooms and some bathrooms and communal areas. Our findings included; cobwebs, damaged beds, unclean rooms, bathrooms, sink and damage to bathroom floors and baths. A toilet riser seat and commode container and commode lids which were heavily soiled and stained. We checked the cleaning schedules for the home from 23 May to 8 August 2016 which were not fully completed. The cleaning schedules did not evidence that people's bedrooms had been cleaned regularly and this included the bedroom of a person with a known infection control risk. Staff told us there were not enough staff resources to achieve a satisfactory standard of cleanliness in all areas. From our observations it was evident appropriate standards of hygiene and cleanliness were not adequately maintained to protect people from the risk of infection.

We saw some staff disposed of Personal Protective Equipment (PPE) such as disposable gloves in a refuse bin and not in clinical waste bins. There was an open sharps bin containing used needles in an unlocked bed room where the person was no longer resident. A sharps bin is a disposal unit for used syringe needles or other sharp clinical instruments which should be securely stored to prevent the risk of injury which can cause infection. We found soiled bedding on a chair in a bathroom that had not been put into a red bag to prevent an infection risk and indicate it was soiled and required washing on a sluice laundry programme at a high temperature. There was a risk that people could be exposed to harm due to the poor prevention and control of infection.

People were not always adequately protected from the risk of harm due to the shortfalls in the security and safety of the environment. There were risks due to damaged windows and window restrictors, inadequate

storage of cleaning products, rooms housing electrical and heating equipment and stair gates not securely closed at all times. Staff used an alarmed side door to remove clinical waste and rubbish from the home to the bins. We observed that when the alarm sounded staff did not investigate the reason for this. We asked staff about this who told us they knew the times when staff regularly used the door so did not need to check. We were concerned that people could use this door and staff would not check because they would assume it was a staff member and people at risk of leaving the premises alone could be placed at risk.

There was a long loose red wire hanging outside the bedrooms of two people, a broken facia board under their sink which was open with a nail sticking out from it. Outside the medicines room there were a number of items which caused an obstruction and would present a risk of accident to people and staff. Maintenance faults when identified were reported to the provider's maintenance team for repair or renewal and completed. The manager took action during our inspection to remedy some of these concerns. However, an effective system was not in place to regularly check the safety of the environment and address hazards which could put people at risk of harm such as those we found during our inspection.

People did not always receive the appropriate care and support they required to keep them safe. People were not always protected from the risks associated with the management of their medicines. Risks to the health and safety of people were not always assessed and sufficiently mitigated. There was not always sufficient equipment to meet people's needs safely and risks to people from healthcare infections were not adequately controlled. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

We saw that the kitchen staff recorded opening and closing checks for the kitchen. All produce in the fridge was covered and labelled appropriately. We checked the cleaning schedules for the kitchen. We saw that overall they were completed in full. This meant people were protected against risks associated with food contamination and unhygienic kitchen facilities.

The manager told us the staffing level was calculated using information from people's skin integrity risk assessment and an assessment of their dependence in relation to their daily care needs. We were told this calculation had last been carried out in May 2016 by the operations manager and the manager was not aware of the results. The manager told us they felt the staffing level was "perfectly adequate" for people's needs. The calculation was not available at the time of our inspection, however neither of the methods used to calculate staffing levels identified the number of staff or the skill mix required to provide people's support or the amount of time taken to give that support.

During our inspection there were several occasions when we were asked by people who were in their rooms or in communal areas for help because no staff were available or within hearing. One person who was unable to leave their room was heard by us several times during the inspection calling for staff. Their care had recently been reviewed by a safeguarding adult's nurse who had concluded their bedroom door should be open, they should be checked at least hourly and a member of staff should be available nearby on the first floor. This person was at high risk of falling or harming themselves and was unable to use a call bell. We found their bedroom door was usually shut, there were no staff routinely available on the first floor and records did not evidence the person had always been checked hourly. We responded to another person who was calling out for help. Their room was out of hearing of staff. They were unable to use their call bell and were unable to mobilise independently. We checked their daily notes at 11.40 and there was no record that hourly checks had been made on their welfare since 07.00. There was no record of food or fluid having been offered to them or taken by them although a staff member confirmed the person had eaten breakfast, we were not assured that hourly checks on their welfare had been made. One person said they had not been able to get up and dressed when they wanted to due to the lack of staff available. There were not always

enough staff available to meet people's needs in a personalised, safe or timely way.

Staff were not always deployed in a way that kept people safe. There were two lounges where most people spent the day. We observed at times no staff were available to people in both of these lounges and we were asked on several occasions by people for assistance. People in the lounges included those at a high risk of falls, people with behaviours that could challenge others and people who were unable to mobilise independently and required staff assistance. People were unable to use the call bell because they could not mobilise independently and the call bell was out of their reach. Those people who used walking frames to support them were without these close to hand as they were stacked at the far end of the room. One person with behaviours that could challenge others was walking about in the lounge. We had been told they were to be monitored when around some other people who were in the lounge. There was a risk that people could experience harm because sufficient staff were not deployed to meet people's needs and ensure their safety.

The manager told us there was a daily staffing complement of one nurse and four care staff in the morning and three care staff in the afternoon. In addition one staff member supported a person who required one to one support. One nurse was rostered at night along with three care staff, one of whom provided one to one support. We looked at the staffing rotas for the period 30 May 2016 to 14 August 2016. Records showed there were 20 shifts when the care staffing complement was below that described as a requirement by the manager. A staff member told us when there were less than four staff it was "dangerous and impossible". All the staff we spoke with told us there were not always sufficient staff available to meet people's needs. This included people's activity, safety and personal care needs. There was a high use of agency staff for both nursing and care due to staff vacancies. Whilst the provider aimed to use the same agency staff wherever possible, due to the high level of staff vacancies this was not always possible. Staff told us when a number of staff that did not know people well worked the same shift, staffing levels and skills were even more stretched. A staff member said "It's OK when we've got permanent (staff) on and five (staff) (even until 14:00) is so much better four is hard work plus the one to one. We need to get the people dressed and down that don't want breakfast in their room otherwise they have to wait." The layout of the home meant that when people were being supported with personal care in the morning the communal areas of the home were often without staff, although people who had known risks were in these areas.

The failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's care and treatment needs was a breach of regulation 18 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Our inspection of 27 and 29 October 2015 found that recruitment procedures were not robust enough to protect people from the employment of unsuitable staff. Full employment histories and recorded explanation of any gaps in employment were not available for all staff. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to fit and proper persons employed. Following the inspection, the provider wrote to us to say what they would do to meet these legal requirements by December 2015. At this inspection we found the provider had taken the required action to ensure staff were recruited safely and the required pre-employment checks were carried out.

All staff with the exception of one care staff member had recently completed safeguarding training. This was to ensure staff understood their role and responsibility to report incidents appropriately and immediately when concerns were identified. Staff we spoke with were aware of their responsibilities and were able to describe to us the signs of abuse and the reporting procedures. Records showed that when concerns had been identified the manager had reported and investigated these and acted on them to protect people from harm.

Requires Improvement

Is the service effective?

Our findings

Permanent staff completed an induction into their role in the home that included three days shadowing experienced staff to learn about people's needs. An induction checklist was completed to ensure new staff were made aware of; evacuation procedures, fire procedures, health and safety, the Control of Substances Hazardous to Health (COSHH), moving and handling and techniques and infection control procedures. We spoke with two agency nursing staff who confirmed they had completed an induction during their first shift that included; fire procedures and emergency information, a written and verbal handover of people's needs and a tour of the building. One agency nurse said the induction had been "helpful".

Staff did not always have the training they needed to meet people's needs and ensure their safety. We reviewed staff training records and these showed that not all staff had completed the training as required by the provider to ensure they could provide people's care effectively. No care staff had completed equality and diversity training and two care staff had completed basic food hygiene. Records showed out of nine care staff only two care staff had completed infection control training hygiene. Although we saw the provider had taken action to ensure the majority of care staff had recently completed training in; safeguarding, Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (2005) not all care staff had completed this training.

Nursing staff had not completed wound care training, diabetes care or training in tissue viability although people they supported had needs in these areas. The manager told us they would book training for nurses in these areas. The provider used two agencies to provide nursing staff. One agency provided evidence of nurses training in medication management. One agency did not provide this information and this was not requested by the provider so they could not be assured these agency nursing staff had the competency to administer peoples medicines safely. Agency nurses worked alone during the weekend days and at night to administer and manage people's medicines. Improvements were required to ensure people were supported by staff who had completed training to meet their needs effectively.

The provider had not ensured all staff were competent and received the appropriate training to enable them to carry out their duties effectively to meet people's care and treatment needs. This was a breach of regulation 18 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014

The manager told us they were responsible for staff supervision and aimed to provide six supervision sessions a year with staff and an annual appraisal. Some staff including the permanent nursing staff did not have an up to date annual appraisal. The provider had identified that staff supervisions were out of date in April 2016 and they had not been completed at a second check on 25 May 2016. We reviewed the record of staff supervisions which showed three permanent staff had received one supervision session since 12 July 2016. Four regular agency staff had received one supervision in August 2016. Whilst we could see the manager had made a start to address these shortfalls regular supervision and appraisal is important to ensure staff are supported to provide people with effective care. Supervision and appraisal ensure staff receive, support, guidance and feedback on their performance and identify their professional development needs. The manager assured us they were acting to address this and appraisal forms had been sent to staff

to complete and supervision sessions had been planned. More time was required to ensure this improvement was fully implemented and sustained in practice. We reviewed three staff records which showed that action had been taken to address staff performance when it had fallen below the expected standards.

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 Mental Capacity Act 2005 (MCA). The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The manager informed us they were reviewing DoLS applications made by the previous registered manager to check applications had been made and their review date. Where applications were required the manager was in the process of making these applications. We saw the review had been partially completed. A number of applications were awaiting assessment by the local authority. However, not all decisions made had followed the principles of the MCA. Records showed that a mental capacity assessment and a best interest decision making process were not always in place to evidence decisions were being appropriately made to agree the restrictions detailed in people's care plans for example if they required regular supervision, whilst awaiting the outcome of the DoLS application. The manager told us "My understanding is if anyone is behind a locked door and needs bedrails we would need to do a DoLS." The MCA requires that a person-centred approach is applied to each individual to determine if their care can be provided in a less restrictive way prior to seeking an authorisation for a deprivation of their liberty. This meant people's rights under the MCA may not be met.

It was not evident that other specific decisions taken on behalf of people who lacked capacity were in their best interests and as least restrictive as possible, in accordance with the MCA. For example, in relation to the use of bed rails. Bed rails can be a form of restraint if a person lacks the mental capacity to consent to their use because they restrict the freedom of movement for the person. Some of the people who had bed rails may not have been able to make an informed decision for themselves that included; the risks, complications and alternatives due to their mental capacity. We saw bed rails were in use for people who were described as lacking the mental capacity to make decisions about their care and treatment. These decisions had been made without completing a mental capacity assessment and a best interest decision making process was not recorded in the person's care plan. Some people's rights under the MCA may not have been met.

Some people's care plans included evidence of a mental capacity assessment for specific decisions such as; a flu vaccination and the provision of personal care. Other examples showed that although a mental capacity assessment had been started for a decision they had not been fully completed. Mental capacity assessments and best interest decisions were not evident for all specific decisions made where a person may lack the capacity to agree to them. The provider had identified that improvements were required to ensure mental capacity assessments were carried out and best interest decisions were recorded in relation to specific decisions and had taken some action to ensure staff completed training in the MCA (2005). However, records showed that four out of the ten permanent staff responsible for people's care and treatment had not yet completed this and a permanent staff member we spoke with told us they did not know about the MCA.

The failure to ensure where people could not give their consent the registered person had acted in accordance with the MCA 2005 was a breach of regulation 11of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

People and their relatives were mostly positive about the food on offer in the home. A person said "I like the food. They will offer me something else if I do not like what is on the menu". A person's relative said "My mum is very well fed. The food is very good." Another relative commented "the food is alright" and a person said "There is not much of a choice at teatime". People's dietary needs and preferences were known by the chef who kept a record of people's needs, likes and dislikes. They also used labelled trays to ensure people received their correct diet such as; diabetic and vegetarian. We observed lunch time in the home and saw that people were offered a choice of meal by choosing from two plated meals shown to them. This is helpful for people living with dementia who may struggle to recall an option they made prior to the meal being served. However, we noted several people were shown the same meal which was then given to people to eat so their choice was not freshly prepared.

There were two dining areas available in the home and some people ate in their room. Staff supported people to eat when they required assistance and we saw staff were mostly attentive and helpful to people as needed. We observed one staff member who was supporting two people to eat at the same time, the staff member stood over one person whilst assisting them to eat in between supporting another person to eat their lunch in the lounge area of the dining room. This meant these people were not receiving appropriate person centred support with their eating needs. Other staff supported people whilst sitting at the same level as them and providing to food to them at their own pace providing person centred support.

People's nutritional needs were assessed using a risk assessment malnutrition tool. The manager told us that people were supported to gain weight through fortified diets and a person told us how they had been supported to gain weight. Recent referrals had been made to the dietician and Speech and Language Therapist (SALT) to ensure people at risk were supported appropriately with their nutritional and safe swallowing needs. We saw, for example, a person had a detailed plan of care in relation to their risk of choking and staff were supporting the person in line with this guidance.

People at risk of poor nutrition and hydration had monitoring records in place to record what they had eaten and their fluid intake. However these were not always completed to ensure the monitoring would be effective in evaluating the food and fluid needs of the person. We saw examples of where food and fluids had not been recorded or totalled. For example, one person's records did not show that they had eaten although staff told us they had eaten breakfast. This meant their food intake could not be effectively evaluated.

A person at risk of poor hydration and nutrition did not have a regime recorded as indicated on their monitoring records. Their food record did not show the amount the person had eaten which meant their nutritional intake could not be monitored effectively and they had lost three kg in the past month. The fluid record was not always totalled and an individualised daily fluid intake target had not been identified. This is important to enable staff to monitor whether the person's fluid intake was sufficient to prevent and reduce the risks from dehydration. This could place people at risk of poor nutrition and hydration. The manager was taking action to address the shortfalls in people's monitoring records and we saw an example of where an improvement had been made. However more time was required for this improvement to be fully implemented and embedded into practice.

A person told us "I can see the GP, dentist and opticians when I need to" and we saw a record was kept of contact with the GP and other healthcare professionals in response to people's individual healthcare needs; Records showed referrals had been made to the SALT, dietician, occupational therapist and mental health

services for assessment.

Requires Improvement

Is the service caring?

Our findings

We asked people and their relatives about the caring approach of staff. One person said "Staff are wonderful. They are such a nice bunch" another person said "Some staff are better than others." A person's relative said "I don't know if the staff know my mum, staff always say hello and she waves at them but there are a lot of agency staff I don't think they get to know people" and another person's relative said "The staff are very kind to my mum".

Most people living at Tiled House were living with dementia and some people had behaviours that may challenge others. We observed interactions between staff and people both at lunchtimes and in communal areas throughout our inspection. Our observations showed that people received inconsistent responses from staff when they became agitated or were at risk of displaying behaviours that may challenge others. We observed some positive interactions such as staff speaking to people in a calm and friendly manner, providing reassurance and offering people choices and at these times people were engaged and enabled to express their needs. On other occasions we observed staff interactions which resulted in a poor experience for the person. For example; we saw a staff member insist a person give them two aprons they were carrying and were happily folding. We observed this person often spent their time picking up objects and folding them. The person did not want to give up the aprons and as a result threw one across the room and became visibly upset and agitated. We spoke to the manager about this who told us the staff member should not have taken away the items from the person because "It is a trigger to their challenging behaviour to confiscate items from (the person)". The person then proceeded to pick up a pressure cushion which smelt strongly of urine and hugged this to them to replace the other items.

On another occasion we observed a person had become distressed and agitated and was calling out to a staff member. This person's care plan described how staff should respond to the person in these circumstances by spending time with them and providing reassurance. However the staff member ignored the person and walked away. We observed a staff member who was busy responded to a person's request for company by asking a person with behaviour that may challenge others to sit with the person although the person requiring company was agitated and calling out. The person was then told to "shut up" by the person asked to sit with them. The care plan of the person requesting company stated they should not be sat with another person who 'dislikes' their behaviour because they will be told to 'shut up'. People with behaviours that could challenge others were not always supported in a consistently caring and person centred way.

We observed another staff member ask a person if it was OK to put an apron on them at lunch. The person said "no I don't need that" and the staff member ignored this and said "you do" and put the apron on them. The staff member then removed the person's feet from their wheelchair footplates without asking them and the person resisted. When we asked the staff member why they did this they said "I don't know if it would be comfortable for them to eat like that." However, they did not ask the person what they would prefer. This meant people were not consistently treated with kindness and respect by all staff.

Staff did not always show concern for people's wellbeing in a caring and meaningful way. We observed the

time staff spent with people was mostly task centred with the exception of a person who received one to one staff support at all times. During our inspection staff were not seen to spend time with people in any meaningful occupation other than supporting people with their physical care needs and some friendly interactions. We heard three people complain that staff did not talk to them, that staff were often busy. We observed some staff on occasions with people in the lounges and these staff were watching the TV and not interacting with people. On one occasion a person was ignored who was trying to get the staff member's attention whilst they (staff member) were watching TV. This resulted in the person becoming more insistent and agitated. On several occasions the staff member providing one to one support to one person was alone in the lounge with several other people, some of whom had behaviours that may challenge others and were at high risk of falls. During one observation a person at high risk of falling started to get up from their chair the staff member shouted across at them several times to "sit down" in a punitive tone of voice as they were unable to go to their assistance. The person appeared confused and was then attended to by another person's relative. We observed a staff member assist a person to use a commode in somebody else's bedroom. When asked the reasons for this, the staff member said that their carpet had just been cleaned and the person never uses their room during the day. These interactions meant the relationships between staff and people receiving support did not demonstrate dignity and respect at all times.

The failure to ensure people were treated with dignity and respect at all times is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us that two people living in the home were nearing the end of their life, although not actively receiving end of life care at the present time. One person had a care plan in place which described their wishes and plan of care for the end of their life. The other person did not have an end of life care plan in place. The safeguarding adults nurse had recently reviewed this person's care plan and identified an end of life care plan was required. This was to ensure the person's preferences and choices were known to staff and those that matter to them so they would receive appropriate care and their choices were respected. The manager has said this would be completed by 5 September 2016.

Inadequate

Is the service responsive?

Our findings

People were at risk of receiving care that was not appropriate to their needs and did not reflect their preferences as staff did not have up to date information to meet people's needs. People's care plans were recorded on an electronic system and a paper copy was also available for staff to access in the event of a system failure or if they did not know how to use the electronic system. However, we found information was inconsistent between the two systems and the paper copy did not always reflect the information on the electronic system. This was important because all staff with the exception of the permanently employed nurse told us they relied on the paper files and there was a high use of agency nurses and care staff who would not always be familiar with people's needs. For example; a person who was at risk of developing pressure ulcers did not have a care plan or risk assessment to guide staff on their needs available in their paper care plan and the electronic care plan had last been reviewed in January 2016. Another person had inconsistent information on their moving and handling requirements in their paper file although the electronic care plan referred staff to the paper file for guidance and we saw they were transferred using incorrect equipment. A person at risk of seizures from epilepsy had inconsistent information about the timing of when to use their emergency medicine. The provider was aware of people's care plans requiring an urgent review to ensure they reflected people's up to date needs and were available to all staff. They had started to address this and the provider had identified this would be achieved by 19 August 2016.

It was not evident that people's identified needs were consistently met in practice. For example; we reviewed a person's care plan which included an assessment of their needs in relation to their mental health diagnosis by a psychologist. The psychologist had recommended the person was engaged in activities which would give them connection with other people and a sense of achievement. There was no care plan in place to support their activity needs and we observed they were not engaged in any meaningful activity throughout our inspection. Their daily notes did not indicate they had participated in any recent activity. This person told us "I have to really want to get up in the mornings as there is nothing to do as staff are always very busy." This meant the person was at risk of deterioration in their mental wellbeing.

A person's care plan identified they required their legs to be raised when seated due to their health condition. We observed the person sat without their legs being elevated and asked a member of staff whether this was required. The staff member replied "oh yes" and then raised the person's feet. A person at risk of developing a pressure ulcer was not supported by sitting on a pressure relieving cushion. During our inspection the person's social worker reviewed their care and asked for a pressure reliving cushion to be used as they were complaining of a 'sore bottom'. The cushion was supplied, however during the following day we noted the cushion was not used. The person then retired to bed because of the pain they experienced on sitting. People were at risk of deterioration in their health needs because they did not always receive person-centred care to meet their assessed needs.

It was not always evident that people's health risks were monitored, reviewed and managed to meet their assessed needs, for example; where a person's wound had not been recorded and a treatment plan in place. One person had experienced a seizure and had attended a hospital accident and emergency department; however, there was no record on their care plan of this incident to indicate their planned care had been

evaluated and reviewed following this incident to ensure their planned care remained appropriate. Records to evidence people's skin care needs, bowel monitoring, fluid and food intake were not fully completed to enable the effective evaluation of the care and treatment given to meet their needs. We saw that three people's care plans indicated they suffered from constipation and that daily monitoring was required to ensure they received appropriate treatment to prevent the risks of ill health from this condition. However, the monitoring information was not completed, evaluated or reviewed to ensure action was taken to prevent the risks to people from this condition in line with their assessed needs. We could not be assured that people's needs were monitored, reviewed and evaluated to ensure they received appropriate care and treatment.

One person living with diabetes who was an insulin dependent diabetic had a diabetes care plan in place to manage this. However, there was insufficient detail in this care plan for any staff unfamiliar with this person's needs to follow , including regular updates and reviews of the care plan to ensure the guidance remained appropriate to meet any changing needs. For example it was unclear at what below and above readings of the person's blood glucose levels staff would need to make a referral to health care professionals such as the GP. Records showed two occasions in July 2016 when the person's blood glucose readings had significantly varied. Although we were told by a nurse that action was taken to report concerns to the GP when the person's blood glucose fluctuated, records did not evidence this or show the outcome and whether any actions had been identified as a result.

Pain assessments are used to establish whether someone with a cognitive impairment is in pain when they may not be able to communicate this. Whilst pain assessments were available for some people they were not available for all people identified as being unable to indicate that they were in pain. For example; two people were prescribed 'as required' medicines for pain relief. Their PRN protocols stated they were unable to verbalise pain, however a pain assessment was not available for either person. There was a risk that people with a cognitive impairment may be in pain but not receive suitable pain relief. Sufficient guidance was not available to staff, including staff who may not know the person well, to ensure people's assessed needs were known and responded to appropriately.

There was a high use of agency staff in the home which meant staff could be unfamiliar with people and their needs and preferences. One agency staff member told us because the care plans were not up to date it was 'difficult' to know about people. Some permanent staff told us it was particularly difficult when the majority of staff on shift were from agencies because they would not know people's needs and preferences and would not necessarily be working alongside other permanent staff. People's care plans included a document entitled 'care for me'. This document outlined people's care needs and included their abilities and preferences. The manager told us this document was available in people's rooms to guide staff who may not know the person well about their needs and preferences. This was important because some people were not always able to express their needs and preferences. The action plan dated 14 April 2016 had identified these needed to be available in all rooms and this had not been completed by 25 May 2016 when checked. This document was not available in all the rooms we checked during our inspection. This could mean that people received care and support that was not in line with their needs and preferences.

We were also told by the manager that a system of 'resident of the day' was in operation. By focusing on the care needs of one person each month this system helps staff to learn more about the person, understand their needs and check their care is appropriate to meet their needs. We asked two permanent staff members about this, one staff member did not know what we were talking about. The other staff member did not know who was resident of the day but told us where this was identified in the staff room. When we checked there was no one nominated for resident of the day. When we asked the manager about this they were not aware that the system was not being used. Due to the high use of temporary staff, systems to guide staff on

how to support people to meet their needs and preferences were important, particularly as some temporary staff were working together on shifts led by agency nursing staff. We could not be assured all staff knew how people wanted to receive their care and treatment.

We observed a staff handover given by the night nurse to the day nursing and care staff where an update was given on how people had spent the night and any particular areas of concern. A written handover sheet was also provided that included people's mobility needs and medical history. However, the information given did not contain sufficient detail to ensure staff who did not know people well would provide appropriate support. For example; those people who required regular turning to alleviate the risk of pressure ulcers, those people at risk of falls, people who required assistance with eating and drinking, or a person who required wound care were not identified on the sheet or discussed in the handover. One agency staff member told us there was insufficient accessible recorded information to enable agency staff to know people's up to date care and treatment needs. This meant people could be at risk of inappropriate care and treatment.

People living with dementia benefit from participation in meaningful activity and occupation which can improve their physical and mental symptoms and provide a better quality of life. People at Tiled House who were able to express an opinion said "There is nothing to do here other than when we have visitors" and "there is nothing to do". Two people, including a person who was on bed rest told us it was "boring" and one person said "There is nothing to do and no one to talk to people just walk past you don't talk to nobody in here you sit down with someone and they don't talk to you". A person's relative said "There are rarely any activities, which is why you see so many people sleeping." Another relative said "There is not enough going on to stimulate their (person) mind. Nothing here just sat in a chair all day long and not much talking between care staff and people; it's almost too late for them (person)." During the three days of our inspection we did not observe that staff engaged with people in an activity, other than the person receiving one to one support. A daily or weekly programme of activities was not in place and the manager told us activities were provided by outside groups such as visiting animals and creative talks once every two months. A care staff member told us "We do a bit of colouring in with people, one person goes on the computer; we have exercises every other Monday. And once every two months they come in with animals. Now and again we stick a film on if people want it". Another staff member told us that although care staff were asked to provide activities in the afternoon there were not enough staff to enable them to do so consistently.

We observed that people were mostly sat all day in one of the two lounges. A TV was on in both lounges although people were rarely watching this and music was playing in one of the lounges with the TV sound turned down. The music provided included Christmas carols which may further confuse people when the month of the inspection was August and some rock tunes. We saw some people responded to songs they knew from the past by singing along. Singing to familiar tunes from the past can be helpful for people with dementia and aid memory recall. Although the weather was fine we did not see people using the garden except for a person who was able to mobilise independently. At times most of the people in the lounges were sleeping in their chairs. It was not evident from the care plans we reviewed that people's social and activity needs had been considered or assessed. People can experience deterioration in their health and wellbeing when their needs for social activity and stimulation are not met.

People did not always receive appropriate person-centred care and treatment based on an assessment of all their needs and preferences, including their social needs. This was a breach of regulation 9 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

The complaints procedure was available as part of the welcome pack given to people on admission to the

home. The procedure was not displayed within the home and the manager said they would address this. The home had not received any complaints since our previous inspection. People's relatives told us they were confident the manager would listen to them and act on their concerns For example a person's relative said "The manager is very good. I would be happy to raise any concerns if I had any with them. Another relative said "My mum raised a concern previously. The manager investigated it by the book."

Inadequate

Is the service well-led?

Our findings

We looked at the systems in place to assess, monitor and improve the quality and safety of the service provided and ensure the requirements of the regulations were being met. We saw the provider had undertaken an audit on 14 April 2016 which had identified actions for improvement. This had been updated on 25 May 2016 when several areas were found to be still outstanding. We were concerned that improvements required during our last inspection and those identified in the provider's audit had not been completed by this inspection, for example; we found people were still not adequately protected against the risks associated with medicines and infection control. The provider's audit had identified improvements were required in the cleaning of communal areas and bedrooms, availability of information on people's preferences, daily monitoring including mattress cleaning and fluid intake, people's personal handling profiles, activities, supervisions and the recording of topical medicines. We found all of these requirements to be outstanding at this inspection. This meant people remained at risk from unsafe or inappropriate care and treatment because the provider had not taken the steps to mitigate the risk identified at our previous inspection and from their own audit.

The provider's general manager told us the provider recognised that quality assurance processes required improvement and they had engaged an external consultancy to help them achieve this. In July 2016 the provider had commissioned a consultant to carry out an audit against the Health and Social Care Act 2008 (regulated activities) Regulations 2014. The consultant identified a number of areas for improvement. Later in July 2016 concerns were raised by the local authority following a review of some people's care. The provider had produced an action plan resulting from the findings of these audits and concerns. These concerns included; the accuracy of care plan documents, compliance with the MCA (2005), document storage, moving and handling profiles and equipment and incident reporting. The completion date for these actions was by 9 August 2016. The action plan required further development to ensure all the shortfalls we identified during this inspection were included, for example; activities, staff training, competency and support, staff deployment and staffing levels. The provider had been unable to achieve the improvements within the timescale and this was being reviewed at the time of our inspection. The systems and processes in place to identify where quality and safety were being compromised were not always effective and responded to in a timely manner.

The provider did not maintain a complete up to date record in respect of each person's planned and received care and treatment. We found several examples which did not contain an accurate record of the care and treatment provided to people or evidence of decisions taken in relation to their care and treatment that were in line with the Mental Capacity Act (2005). Agency staff, including nurses and staff that did not know people could not rely on people's care plans or the written handover information provided. This meant they were unable to develop a good understanding of people's identified needs and risks and what action they needed to take to support people appropriately.

The provider had not ensured that records kept to inform care decisions including, daily fluid intake, bowel monitoring, positional change recording forms and wound plans were sufficiently monitored to mitigate the risks to people. Action had not been taken to ensure the information in these records were accurate and

could be used to evaluate people's the effectiveness of the planned and delivered care and treatment. Some people were prescribed topical creams to support their skin integrity when they were assessed as at risk of developing a pressure ulcer. We reviewed the records of topical cream application for people at risk of developing pressure ulcers and saw that they were not being completed to evidence the cream had been applied as prescribed. The provider had identified this shortfall in their audit of 14 April 2016. The action plan update identified the improvement had not been made by 25 May 2016 and should be completed within two weeks. We found the records were still incomplete. This meant we could not be assured from monitoring records that people were being protected from the risk of pressure ulcers. Records were not always securely stored to protect people's confidentiality, for example people's records of their daily care were left unattended in the lounge on two occasions during our inspection.

The provider did not effectively implement their systems in place to improve the quality of the service provided and did not maintain accurate records. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection a registered manager was not in post. The last registered manager left in March 2016 and the current manager has submitted an application to us for registration in June 2016.. At our previous inspection we raised concerns about the working arrangements of the registered manager and the lack of support from the provider for their role. At this inspection we found the manager was not required to work shifts and a deputy manager was in post to support the management of the home. However, the deputy manager was one of two permanent nurses employed and worked as part of the nurse rota. The deputy manager held the responsibility for updating people's care plans. They told us this had not been possible because when they worked a shift there was not time to update the care plans and they were under increased pressure due to the lack of permanent nursing staff to share the responsibility for care plan reviews. Although the deputy manager had been given additional time to update the care plans during the week of our inspection we saw their time was mostly taken up with the induction of agency nurses, due to the lack of permanent nursing staff employed. The manager told us their biggest challenge was to ensure the standards of documentation improved (care plans). However it was not clear the provider had ensured there were sufficient resources available for them to achieve this within the timescale of their action plan.

Leadership within the service was inconsistent. There were no senior care staff employed and due to the responsibilities of the deputy manager and the high use of agency nurses it was not evident there was always sufficient or effective leadership on the floor from senior staff who knew people well and were able to ensure people received appropriate care and treatment. Care staff told us that some of the nursing staff were more helpful and supportive than others and that leadership support from nurses was inconsistent. The manager told us they planned to work alongside staff to support a consistent approach and to "help them (staff) do things the way I want and lead by example". We saw the minutes of a staff meeting that had taken place on 18 April 2016. The manager had raised some of the issues we had identified during our inspection such as; health and safety concerns including infection control and environmental safety. The attitude of some staff in not engaging people and watching TV, encouraging staff to interact with people and provide activities and the importance of completing the monitoring information of people's health and welfare needs. However, as these concerns were still apparent during our inspection the leadership resources in place may not be sufficient to inspire and motive staff to achieve the required improvements.

We asked the manager about the provider's vision and values for the service. They told us they had "not come across them". Staff we spoke with were not aware of there being a vision or set of values that underpinned their practice. The provider's general manager told us that it was part of the provider's development plan to formulate these. The manager told us they aimed to empower both staff and residents and welcomed feedback and they wanted people to "be happy". Our observations evidenced that people

were not always supported by staff who displayed the right values and behaviours towards people. The manager told us a quality assurance survey was sent out to people and their relatives in February 2016 however this had not been 'chased' by the previous manager and no feedback had been received. The manager said they would be looking at how they could get meaningful feedback from people and their relatives to ensure people's experience of the care and support provided could be taken into account to drive service improvements. The provider's general manager told us a development plan was in place to "get the whole feedback cycle going, we need to work on this". This included asking staff about their level of engagement with their employers so they could look at ways to develop a positive culture with staff. The provider required more time to implement these improvements and ensure they were embedded into practice.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive appropriate person-centred care and treatment based on an assessment of all their needs and preferences, including their social needs. Regulation 9 (1)

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The failure to ensure where people could not give their consent the registered person had acted in accordance with the MCA 2005. Regulation 11(1)(2)(3)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way. Risks to people had not always been assessed and mitigated. People's medicines were not always managed safely. Equipment used by the provider was not used in a safe way and there was insufficient equipment available to ensure the safety of people and meet their needs. The risks to people from infection were not adequately controlled by the assessment, prevention and detection of those risks. Regulation 12 (1)(2)(a)(b)(d)(e)(f)(g)(h).

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to ensure compliance with the regulations were not implemented effectively to identify and act on risks and quality concerns. Accurate comprehensive records were not kept of people's care and reatment decisions. Regulation 17 (1) (2) (a) (b) (c) and (f)

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that sufficient numbers of suitably competent, skilled and experienced persons were deployed to meet the needs of people at all times. Staff did not always receive the training, supervision and appraisal to enable them to fulfil the requirements of their

role. Regulation 18 (1)(2)

The enforcement action we took:

Warning Notice