Prime Care (GB) Limited

Leyland Rest Home

Inspection report

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Date of inspection visit:
31 May 2016
01 June 2016

Date of publication:
14 July 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 21September 2015 and identified breaches of regulation in the 'Safe' and 'Effective' domains. The breaches of regulation were in relation to not following the principles of the Mental Capacity Act (2005) and the management of medicines. This was the second consecutive breach in relation to medicines management. We asked the provider (owner) to take action to address these concerns.

We undertook an unannounced comprehensive inspection on 31 May 2016 and 1 June 2016 to check that the provider had met the legal requirements identified in 'Safe' and 'Effective'. The provider had not met these requirements.

Located close to Southport promenade and the town centre, Leyland Rest Home provides accommodation and care for up to 33 people. The building is a large Victorian property with gardens to the front and back. The home has three lounge areas, a dining room and lift access to all floors.

Twenty three people were living at the home at the time of the inspection.

There was no registered manager in post. They had left the service shortly before our inspection. A new manager had been appointed and they were planning to register. 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. This happened less than two weeks before the inspection.

People living at the home were not always receiving their medicines as prescribed by the doctor and at a time when they needed them. Medicines were not always stored securely. For example, a person managed their own medicines but the medicines were not stored in their bedroom in a safe way. Plans were not in place for medicines that were given to people when they required them. This was the third consecutive breach of the regulation in relation to the management of medicines.

The way in which mental capacity assessments were undertaken was not in accordance with the principles of the Mental Capacity Act (2005). Applications to lawfully deprive people of their liberty had been submitted to the Local Authority. However, an application to urgently deprive a person of their liberty had not been considered even though the person had left the premises shortly before our inspection. This meant the person was at risk of having their liberty unlawfully restricted if staff tried to prevent them from leaving the building again. This was the second breach of regulation in relation to seeking consent from people.

The staffing levels were inadequate to ensure people's safety was maintained at all times. The low staffing levels were identified as a concern at our inspection in March 2015. They had improved when we inspected the service in September 2015. Since then the staffing levels had been reduced again.

Care plans were not always being updated to reflect changes in people's needs and increased risk. Sufficiently detailed care plans had not been completed for people who had moved into the home, including people who moved there over a year ago. For example, a person who moved to the home over 12 months ago still had a 'mini' or temporary care plan in place that did not reflect the person's current needs. There was some confusion about the difference between a risk assessment and a care plan. People and/or their representative were not routinely involved in developing care plans or the on-going care plan reviews.

Although basic information was included in care records about preferred routines and likes/dislikes, staff engagement with people was task-orientated based on the routine of the home rather than person-centred to each person's specific needs. There were no social or recreational activities for people to participate in. People told us they were bored and just watched television every day.

Care records were disorganised, which made it difficult to locate current information. The service was moving towards an electronic care record system. Staff were not sufficiently familiar with the new system to locate information in a timely way. Paper copy care records were not always held securely and there was a risk they could be accessed by unauthorised people.

Adult safeguarding processes were not robust. We found reported incidents that should have been treated as safeguarding concerns but had not been. Records showed that 50% of the staff team were not up-to-date with adult safeguarding training.

Safe and effective recruitment practices were in place. Staff told us they received regular supervision and an annual appraisal. Staff training was not up-to-date.

We found that areas of the home, most notably bathrooms, were unclean and unhygienic. A detailed risk assessment was not in place to ensure people's safety was maximised during the refurbishment programme that was underway. We observed a fire door wedged open. This same door had been wedged open at a previous inspection and had not been addressed despite inspectors making the provider aware. The door had been addressed by the second day of our inspection. We could not be confident that wheelchairs were being used safely as we observed most wheelchairs had no footplates in place.

People had access to health care when they needed it, including their GP, optician and chiropodist. A visiting healthcare professional told us staff responded promptly and effectively to guidance and advice given about people's health care needs.

People expressed mixed views about the meals. Many people told us they were not satisfied with the quality and quantity of food provided at the home. They told us there was no choice to select from prior to each meal.

Staff were caring and kind in the way they supported people. They treated people with compassion and respect. They ensured people's privacy when supporting them with personal care activities.

A complaints procedure was in place. There was one complaint from 2015 and from the records we could see it had been managed effectively. There were no systems in place to seek feedback about the service from people living there, their families and visiting professionals.

Systems to monitor the quality and safety of the service were not robust. These included checks and audits, feedback systems and the incident reporting and analysis system.

The provider was not informing CQC of all the events we are required to be notified about.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

We are taking action to protect people due to the significant concerns found at this inspection and will report on our action when it is 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.
Medicines were not managed in a safe way. People were not always receiving their medicines as prescribed by the doctor.

Staffing levels were inadequate to ensure sufficient staff presence in shared areas of the home and to ensure the safety of people living at the home.
Not all incidents had been appropriately safeguarded in accordance with local procedures.

A detailed risk assessment was not in place to ensure people's safety was maximised during the refurbishment programme that was underway.

The premises were not clean. We found that areas of the home, mainly bathrooms, were unclean and unhygienic.

Effective arrangements for the recruitment of staff were in place.

Is the service effective?

Inadequate

The service was not effective.

The principles of the Mental Capacity Act (2005) were not being adhered to when assessing people's capacity with specific decision making. An urgent application to lawfully deprive a person of their liberty had not been considered following a vulnerable person leaving the building unnoticed by staff which placed them at risk of harm or injury.

Staff training was not up-to-date. Staff told us they received regular supervision.

People expressed mixed views about the meals. Many people told us they were not satisfied with the quality and quantity of food provided at the home.

People told us they had access to health care services when they needed it.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us that staff respected their privacy and dignity. They said that most staff were caring but some staff did not show a caring attitude towards them.

We observed staff treating people with kindness and compassion at the time of the inspection.

People did not always have choice, such as a choice of what to have for each meal.

People and/or their families were not involved in the development or on-going reviews of their care plans.

Is the service responsive?

Inadequate

The service was not responsive.

There were no social or recreational activities for people to participate in. People told us they were bored and just watched television every day.

Although basic information was included in care records about preferred routines and likes/dislikes, staff engagement with people was task-orientated based on the routine of the home rather than person-centred to each person's specific needs.

A complaints procedure and process was in place. There were no processes in place to seek feedback about the service from people living at the home and their families.

Is the service well-led?

Inadequate

The service was not well-led.

Systems to monitor the quality and safety of the service were not robust. These included checks and audits, feedback systems and the incident reporting and analysis system.

Care records were disorganised, which made it difficult to locate current information. The service was moving towards an electronic care record system. Staff were not sufficiently familiar with the new system to locate information in a timely way.

Care records were not always held securely.

Leyland Rest Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 31 May 2016 and 1 June 2016.

The inspection team consisted of an adult social care inspector, a pharmacist specialist and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home, including notifications and other information CQC had received about the service. We contacted the commissioners of the service to see if they had any updates about the service.

During the inspection we spent time with nine people who were living at the home and two family members who were visiting their relatives at the time of our inspection. We also spoke with the provider (owner), manager, four care staff, the chef and housekeeper. We also spoke with a visiting healthcare professional and an advocate (referred to as visitors in the report).

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 looked at the care records for four people living at the home, 19 medicine records, three staff personnel files and records relevant to the quality monitoring of the service. We looked round the home, including people's bedrooms, bathrooms, dining rooms and lounge areas.

Inadequate

Is the service safe?

Our findings

When we carried out a comprehensive inspection of the service in September 2015 we identified a breach of regulation in relation to the safe management of medicines. The 'safe' domain was judged as 'requires improvement'. This inspection checked the action the provider had taken to address the breach in regulation.

We looked at the systems in place for medicines management. We found concerns with 19 medicine administration records (MAR) we looked at. We also looked at storage, handling and stock requirements and found that appropriate arrangements for the safe handling of medicines were not always in place.

The registered provider had introduced an electronic MAR system since the previous inspection. Staff had not received sufficient training for the system and were unable to access the MARs without contacting the external company. The electronic hand held device had the ability to order medicines from the doctor and community pharmacy. Staff did not check what medicines had been ordered by the electronic device, which meant that seven residents had not been able to have their medicines as the ordering system had not been effectively used. Medicine audits had not been completed in a timely manner so assurance could not be provided that medicines had been given as directed by the doctor.

One person who was prescribed a medicine for diabetes was not given it as prescribed by the doctor. The person was prescribed two tablets in the morning; however, one tablet had been signed for as being administered 20 times in a four week period. The same person who was prescribed an anti-inflammatory cream to be applied twice a day had it applied four times a day on eight occasions. A second person who was taking a water tablet to remove excess fluid did not have it for seven days as it was not available. A pain relief patch prescribed for a third person that should have been changed every three days had been entered onto the MAR incorrectly as requiring changing once a week. The entry had not been checked by another member of staff and the person had been complaining of pain. Not administering medicines as prescribed can reduce the effectiveness of the medicine and can result in harm to the person.

Plans for people who required medicines as and when they needed it (often referred to as PRN medicine) were identified on the last medicine audit (January 2016) completed by the manager as not being in place. The manager confirmed that PRN plans had not yet been put in place. Plans for PRN medicine are important for people who may not be able to verbally communicate that they need the medicine as the plans guide staff in identifying, for example, if the person is in pain.

The minimum and maximum fridge temperatures were not recorded as per national guidance and therefore it was unclear whether the fridge had been outside of the recommended range.

We found that a controlled drug had not been entered into the register for 15 days and had not been entered when the error had been identified. Controlled drugs are medicines controlled under the Misuse of Drugs legislation, some of which need to be recorded in a controlled drugs register.

One of the people living at the home was receiving their medicines covertly (disguised in food or drinks). Although authorisation signed by the person's GP was in place, there was no evidence that a mental capacity assessment had been completed specifically with regards to medicines. Furthermore, there were no records of how the decision to administer covertly had been reached. Equally, there was no evidence that a pharmacist had been consulted about which medicines could be given covertly or how these should be given.

We observed liquid medicine and prescribed topical cream in a person's bedroom. The person told us they managed their own medicine. This was not being done in accordance with national safe practice as the medicines were not in a locked cupboard. On the second day of our inspection the medicines had been moved to a lockable drawer but it was not locked as the person did not have a key.

This was a continued breach of Regulation 12(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the incident reports for the previous two months and found two incidents that should have been safeguarded. They included a physical altercation between people living at the home and a vulnerable person who left the home and was not missed by staff. These had not been reported as safeguarding alerts to the Local Authority, which meant processes were not being followed to make sure people were protected from abuse. Training records showed that 50% of the staff team had either not undertaken or not completed up-to-date training in adult safeguarding. Not reporting safeguarding concerns was judged to be a breach of regulation at the inspection in March 2015.

This was a breach of Regulation 13(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A process was in place for recording accidents and incidents. There was a section to record that management had reviewed each report but these were incomplete on the forms we looked at. This may be why the two incidents we referred to above had not been treated as safeguarding concerns.

The care records showed confusion between what constituted a risk assessment and a care plan. For example, we were unable to locate a care plan for a person at a high risk to falls but found a risk assessment was in fact the care plan. This meant that staff may miss the care plan if it was titled a 'risk assessment'. Furthermore, the 'risk assessment' did not outline how staff should support the person to minimise the risk of falling. The same person used a hoist and the care plan was not detailed enough as it did not identify how the person should be supported to use the hoist and the type of sling to be used.

A person was identified from risk assessments as being a 'high risk' nutritionally and at 'high risk' of developing pressure ulcers. The person had lived at the home for over 12 months and had a 'mini' care plan in place. A mini care plan is completed by the service within five days of a person being admitted and a full care plan is completed within four weeks. A full care plan had not been completed for the person. Contrary to the risk assessments, the 'mini' care plan identified no concern with nutrition or skin integrity. This showed that care plans were not reflective of the findings of risk assessments so there was a risk of people receiving care that was not meeting their needs.

This was a breach of Regulation 12(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected the home in March 2015 we found the staffing levels were too low to ensure the safety of

people living at the home. When we returned in September 2015 the staffing levels had improved. However, we found at this inspection that the staffing levels on a day-to-day basis had been reduced again. The lounge was well occupied throughout the day and we observed long periods of time when staff were not supervising the lounge and other shared areas. Some people were just walking about without any supervision from staff. This meant people's safety was at risk, particularly as there was refurbishment work on-going on the ground floor.

All the staff we spoke with raised this as a concern and said there were not enough of them, particularly when providing support to people throughout the building, many of whom were living with dementia. There were three care staff on duty during the day to cover three floors, including supporting people who stayed in their bedrooms and people who used the lounge. This staffing level included a senior carer who was responsible for administering medicines at times when people needed support with either personal care or meals. This meant that two care staff were available to provide support for people at key times. Staff said the manager helped out if they could.

The people living at the home who we spoke with said there was not always enough staff available to help them when they needed it. A person said, "There is not always enough staff so you have to go and fetch them." Another person told us, "The staff are too busy to look after you." A person also said, "Staff are ok, there's just not enough of them. They do work hard." Equally, families expressed to us their concern about the low staffing levels. A family member told us, "Generally the staffing is short."

This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Refurbishment was taking place on the ground floor. The lounge had been moved temporarily to the dining room while the flooring was being replaced. We observed skirting boards had been removed, trailing wires and building materials located in areas people living at the home continued to have access to. We asked to see the risk assessment in relation to the refurbishment. It did not adequately address the risks to people. For example, it did not indicate how building materials and tools would be kept safe, and it did not identify and address the risk to people who liked to walk about, particularly people with dementia. It also did not take into account the increased noise level associated with the building work and the impact this could have on people's health and wellbeing. A large heavy radiator cover had been disconnected from the wall in the hall and was loose. This could present a risk if it fell against a person living at the home or a visitor.

We looked at the fire safety arrangements for the home. The fire prevention and precautions policy and fire emergency assessment plan were not up-to-date as they listed many people who were no longer living at the home. The manager confirmed that personal evacuation plans in the event of an emergency were not in place for each person.

We noted that a fire door leading to a bedroom was wedged open. We raised this matter about the same door at the previous inspection and made a recommendation but it had not been addressed. Wedging a fire door open is unsafe practice as the purpose of a fire door is to slow the spread of fire. In addition, retaining fire doors in an open position can weaken the fire closure mechanism. This means people are at risk in the event of a fire occurring. The maintenance person addressed the matter by the second day of the inspection.

One of the people living at the home was receiving oxygen treatment. We noted that the warning signage on the bedroom was not in accordance with routine hazard warning signage to indicate the use of oxygen. This had also been raised on a previous inspection.

Checks of the fire safety system took place on a regular basis and these included a fire alarm inspection/test, emergency lighting, fire fighting equipment, fire exit doors and smoke detectors. Other environmental and equipment routine checks were up-to-date and included electrical, gas, water safety, nurse-call system, hoist and passenger lift checks. We looked at the window restrictors in some bedrooms. They were flimsy, not tamper-proof and were not the correct type of restrictor in accordance with national guidance. A formal risk assessment of the window restrictors was not in place.

We observed used razors were accessible in bathrooms along with people's toiletries. This could present a risk to people, particularly people living with dementia. We found one of the toilets had a very lose and mobile toilet seat, which could present a risk to falling. We noted that wheelchair checks were last recorded in December 2014. The majority of the wheelchairs we looked at had no foot plates in place. We also saw foot plates in a bathroom with no wheelchair in the vicinity. This would suggest that staff were using wheelchairs without foot plates. Not using footplates can present a risk to the person using the wheelchair trapping and subsequently injuring their feet.

At a previous inspection one person complained about stifling heat in their bedroom. The window was broken and could not be opened far so it was difficult to ventilate the room in hot weather. We checked the room during this inspection and it was very hot; the window had not been fixed.

There were two housekeeping staff employed so cleaning took place every day. There were cleaning schedules and cleaning checklists in place. We had a look around the building and observed it was not very clean. There was dried in faeces in a number of areas, including toilet seats, commodes, doors and a person's chest of drawers. We observed dust, cobwebs and dead spiders in toilets and bathrooms, and there were dead flies on window sills in some areas. Extractor fans were clogged with dust and debris and we could see no evidence that they had been cleaned for some time. The radiator in the downstairs bathroom was filthy and there was no evidence to indicate that the radiator cover had been removed to clean it.

Clinical waste bins were not in all of the bathrooms and we observed soiled incontinence pads in domestic bins. The toilet in the sluice room looked like it was being used and one of the staff confirmed that one of the people living there used it. There were no handtowels in the sluice room and we noted they were missing from a number of other bathrooms. We also noted disposable aprons were not available in one of the bathrooms.

This was a breach of Regulation 12(1)(2)(d)(e)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the personnel records for three members of staff recruited in the last year. We could see that all recruitment checks had been carried out to confirm the staff were suitable to work with vulnerable adults. Two references had been obtained for each member of staff except one, who had just one reference on record. We highlighted this to the manager at the time of the inspection.

Inadequate

Is the service effective?

Our findings

When we carried out a comprehensive inspection of the service in September 2015 we identified a breach of regulation in relation to the service not following the principles of the 2005 Mental Capacity Act (MCA). The 'effective' domain was judged to be 'requires improvement'. This inspection checked the action the provider had taken to address the breach in regulation.

The 2005 Mental Capacity Act (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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At the previous inspection mental capacity assessments were generic in nature rather than decision specific as outlined in the MCA. Best interest discussions had not taken place with the families or representatives for people who lacked capacity to make decisions about their health and welfare. No improvements had been made at this inspection. The mental capacity assessments we looked at had not improved and continued to take a generic approach, and there was no evidence of family/representative involvement. For example, a mental capacity assessment concluded that a person had capacity but it did not indicate what decision the person needed support with making. Although the person was assessed as having capacity, it then went on to state that a relative was responsible for the person's "health and finances". This showed a lack of awareness and understanding of the MCA. The training records showed that the majority of staff had received training in MCA and DoLS.

DoLS applications had been submitted to the Local Authority for people who were identified as needing an assessment for a standard authorisation. A family member informed us that their relative who was vulnerable had left the building and returned to the family home, and staff had not missed them. This happened less than two weeks before the inspection. Although a DoLS application for a standard authorisation had been submitted for the person, an urgent authorisation had not been applied for following this incident. An urgent authorisation can be issued by the care home itself if it is necessary to deprive the person of their liberty before a standard authorisation can be obtained. It can last up to seven days but can be extended for a further seven days.

This was a continued breach of Regulation 11(1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout the day we heard staff appropriately seek people's consent before providing day-to-day care. For example, we heard staff ask people if they wished to take their medication or use the bathroom. We noted from the care records that consent was sought from people or their representative to take photographs of the person, share information related to their care and for staff to administer their

medication.

Since starting the in the role in December 2015, the manager advised us that they were working towards providing supervision and appraisal for all staff. The staff we spoke with said they had received one-to-one supervision recently. The staff personnel files that we looked at confirmed the staff had received a recent supervision session. The training that the provider required staff to complete in order to fulfil their role was not up-to-date. For example, not all staff had completed training in moving and handling. Fifty per cent of staff had not received training in fire safety. More than 50% of the staff team required training in infection prevention and control, including housekeeping and catering staff. Not all staff were trained in dementia care.

This was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014..

The feedback from people living at the home regarding the meals was variable. Some people said it was 'okay' or 'good' but other people were not happy and said the meals were not very good and unappetising. A person said, "Food is okay especially on Fridays – its fish and chips." Another person said, "It's **** - not fit for a dog sometimes." A person who was dissatisfied with the quantity and quality of the food and described it as 'poor' showed us photographs they took of two of the meals they received. For example, one photograph showed a plate with three small pieces of scampi, a few chips and no vegetables or salad. A family member told us their relative who was living at the home did not like the food.

The chef told us they were aware of people's likes/dislikes, food allergies and special dietary needs. However, a person told us the meal at teatime the evening before our inspection was something they did not like and the alternative was sandwiches, which they were not keen on either. They had not been offered a choice before the meal was given to them. Another person said, "I like toast in the morning with honey but they only give jam or marmalade." This showed that people's likes and dislikes in relation to food were not being taken into account.

We observed the chef advising people that the lunch would be pork steaks. It was only when a person did not want this that the alternative of a meat pie was offered. Although we were advised that extra food was available at each meal, when one of the inspection team asked for a lunch in order to dine with people and test the food they were told that the meals were made to order and there was not enough food to provide an extra meal.

Drinks and snacks were provided between meals at approximately 11.00am and 3.00pm. People told us drinks and snacks were not routinely available outside these times and people did not think they could ask. Water was not accessible to people at all times. At the previous inspection we were advised and saw that a fruit bowl was available for people to eat from throughout the day. We did not see a fruit bowl at this inspection.

Given some people's concern about the quality, quantity and choice of food we looked at people's weight monitoring records to see if there was any impact. The records showed people's weight from February to April 2016. We noted that three people had not had their weight checked during this time frame due to refusal or being in hospital. Alternative approaches had not been considered for the people who refused, such as arm measurements. Two of the people who refused to be weighed were identified through a nutritional assessment as a 'high risk' to malnutrition. Checking people's weight on a regular basis supports with establishing whether people are receiving adequate nutrition and hydration. In addition, it was recorded in the dietary needs assessment of the two people assessed as a 'high risk' that they had no special

dietary needs.

This was a breach of Regulation 14(1)(4)(a)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The environment was not designed to meet the needs of the people living at the home. Many people residing there were living with dementia and the environment did not take account of national guidance in relation to dementia-friendly environments. For example, colour had not been used to support people with finding their way about. The walls, doors and hand rails were in mute colours, which meant hand rails were not obvious if a person felt unsteady and tried to locate them. Bedroom and bathroom doors were not easy to distinguish from the walls. Colour had not been used in toilets, such a different coloured toilet seats to assist people in finding the toilet.

Bedroom doors did not include a name or photograph to support people with locating their bedroom. There was no directional signage; important to promote independence and support people to find their way about. Not all toilets included an appropriate sign to identify what the function of the room was. There was insufficient toilet and bathing facilities. For example, we were advised that a bath upstairs was out of use. Furthermore, a person living at the home used the toilet in the sluice room during the night.

There were no points of interest, such as photographs or artworks of a size that could be easily seen. Memory boxes or similar were not in place. People did not have independent access to the garden. Although a refurbishment programme was in progress, there was no recorded evidence to show that making the environment dementia-friendly was part of the programme. Nor was there evidence to indicate that people and/or families had been involved and contributed ideas regarding the refurbishment.

This was a breach of Regulation 15(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We could see from the care records that people had regular input from professionals when they needed it, including the GP, district nurse, optician and chiropodist. A record template was in place to record all consultations with health or social care professionals. Some people received specialist health care input when necessary. This included input from the local community mental health team and the diabetic nurse. We spoke with a visiting health professional who said, "The staff are quick at phoning if there are any issues. They are responsive to any guidance we give them."

Requires Improvement

Is the service caring?

Our findings

Although people we spoke with told us staff respected their dignity and privacy, there were mixed views expressed by people living at the home as to whether the staff were caring. People said most of the staff were caring. Some people named specific staff, highlighting that they were caring and kind even though they were busy and short staffed. Other people told us not all staff demonstrated a caring attitude towards them. A person said, "I'm not happy being here. Some of the staff don't go out of their way to make you feel happy." We were also told, "I put the staff in two categories CC-Caring Carers and DC-Don't Care." A family member said to us, "The staff are caring but they never have enough [staff] on."

Throughout the inspection we observed staff calling people by their preferred name and supporting people in an easy going and unhurried way. We heard staff explaining to people what was happening prior to providing care or support. They supported people with their personal care in a discreet and dignified way. The staff we spoke with demonstrated a warm and genuine regard for the people living there. They consistently told us they would like to spend more time with people if they had the time to do so.

We spent long periods of time in the lounge and did not observe any meaningful interactions between staff and people that did not involve a routine task or personal care activity. This was because staff were too busy with tasks. They popped in to check the lounge or see to someone's needs but did not have the time to sit and engage with people.

The nurse-call system was frequently activated throughout the inspection. All members of the inspection team commented on the noise/tone of the call system. The noise was loud and very disturbing; it sounded like a siren. We were concerned that if we found it loud and disturbing then what impact could it have on people living with dementia or other mental health needs. Staff advised us that there was a quieter tone to the system at nights. The provider said he would look into changing the tone of the alarm.

People told us they had not been asked their preferred gender of staff for providing personal care. We did not see in all of the care records we looked at that people's preferred gender of staff to provide personal care was recorded. We noted from the training matrix that the gender of staff employed at the home was mixed.

We observed a person having their mid-morning drink from a plastic cup. The person told us they usually got a cup like this but would prefer a "proper" cup as the tea tasted "funny" from the plastic cup. There was safety reason as to why the person was being given their drinks in a plastic cup. They said they would ask staff to change this. A family informed us that it was a common occurrence for their relative to be wearing other people's clothes despite their own clothing having name tags in place.

There was little or no evidence to show that people were involved in making decisions and planning their care and support. All the people we spoke with said they had no involvement in developing or reviewing their care plans. Equally, families told us they had not been involved in care reviews. The care records we looked at showed no indication of the person or their family being consulted about assessments and care

plans or invited to care reviews.

People said they had no involvement with planning the menus and there was no menu/choice to select from in advance of a meal. They said that usually sandwiches were the alternative. A person said to us, "There's not much choice but chef will do me an omelette." The chef told us there was a 4-weekly menu plan and that the menu for the day was on the dining tables. We did not see evidence of any menus available to people living at the home. We were advised that menus were reviewed with the people living at the home twice a year none of the people we asked had any recall of this. There was no recorded evidence to show that people living at the home being involved in reviewing the menu.

This was a breach of Regulation 9(3)(c)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager advised us that all people living at the home had someone to represent them if they needed it. The majority of people had had a family member as their representative but a small number had an advocate or legal representative. Local advocacy services were identified in the 'Service user's handbook', which was provided to people when they first enquired about moving to the home.

Inadequate

Is the service responsive?

Our findings

At the previous inspection the responsive domain as judged as 'requires improvement'. This was because people and family members told us there were very limited social and recreational activities to occupy people during the day.

We found during this inspection that the arrangements for social and recreational activities had not improved and had worsened. When asked about how they spent their day a person living at the home told us, "Its life – food/sleep/food/sleep. Being here, I just put up with it." People freely expressed that there was nothing to do except watch television. A person said, "It's not a good service. It's just the cheapest." Another said, "You just get left in a chair all day." Another person told us, "Generally I think the staff care but they are under a lot of stress because there are not enough of them."

Families supported the concern about the absence of activities. A family member said, "There are no activities/stimulation for people." Another told us, "They don't have activities because they don't have enough staff." Staff told us they had no time to facilitate activities with people and they said this was due to the staffing levels being reduced. They said they occasionally supported people to go for a walk locally but these opportunities were not frequent.

We looked at the 'Service user's handbook' that was issued to people when they were first considered a move the home. The handbook was updated in December 2015. It made reference to maintaining social networks and supporting people with activities of their choice. It stated that a cinema room was available but such a facility was not available. This may be why a person told us when discussing activities, "It's not what I expected."

Although basic information was included in care records about daily preferred routines and likes/dislikes, staff engagement with people was general task-orientated based on the routine of the home rather than person-centred to each person's specific needs. For example, we saw staff engage with people at meal times, tea breaks and when supporting with personal care. We observed people sitting in the lounge most of the day. The television was on but few were watching it. We observed the television was constantly losing signal, picture or power and it was not addressed by any member of staff.

People we spoke with said they did not know what the complaint process was or what would happen if they made a complaint. They told us they would inform a member of staff or the manager if they had any concerns. We noted the complaints procedure was located at the back of the 'Service user's handbook'. There was one complaint on record and this was from September 2015. It had been managed appropriately.

People told us they were not asked their views about the service or invited to provide feedback in the form of a questionnaire. They said meetings were not held for them to discuss the service or raise any concerns. We saw that a meeting was held with people living at the home on 23 May 2016. This was just to inform people that the lounge would be out of use whilst new flooring was put in place and that the lounge would move temporarily to the dining room. The meeting minutes did not list the attendees so it was unclear how

many people attended and whether families had been invited.

The 'Service user's handbook' stated that a 'service user/principal carers committee' was in place for people and their families to air their views. Families and people living at the home had not heard of this and there was no recorded evidence in place to indicate such a committee existed.

This was a breach of Regulation 9(1)(3)(b)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

When we carried out the comprehensive inspection of the service in September 2015 the 'well-led' domain was judged to be 'requires improvement'. Processes to monitor the quality and safety of the service were not robust. Audits carried out the home were not identifying some of the concerns we found.

A registered manager was not in post as they had left the service. A new manager had started at the home in December 2015 and they planned to apply to register with the Care Quality Commission.

Improvements had not been made with quality monitoring processes. Many of the issues we identified at the last two inspections had not been addressed, such as the lack of meaningful activities for people living at the home. An internal medicines audit was undertaken in January 2016. It identified some of the concerns we found with medicines but these had not been followed up and further medicine audits had not taken place. At previous inspections a process was in place to audit each of the care records every three months. The care records we looked at had not been audited for at least nine months. This meant the currency and quality of risk assessments and care plans were not being monitored.

Cleaning checks were established but did not identify the issues with cleanliness we found. Equally, checks of the environment had not addressed all concerns, such as a fire door inappropriately wedged open on a regular basis. We had raised this matter at previous inspections. There was no system in place to monitor and analyse accidents and incidents; a key stage in determining whether there are any emerging themes or patterns in relation to safety matters.

We asked staff what improvements they thought needed to be made to the service. They consistently told us more staff were needed on each shift so they had the capacity to support people with activities/outings and have time to complete paperwork, such as care plans.

A new electronic care record system had been introduced shortly before our inspection. The management and administration of medicines was being coordinated through this system. We were concerned that the manager and staff were not sufficiently knowledgeable about the system to monitor that medicines were being managed effectively. The manager advised us that all care records were in the process of being transferred to the electronic system. However, when we asked staff to locate specific pieces of information on the system for us, they were either unable to find it or it took a considerable amount of time to locate it. This meant the system was not effective or fully accessible to all staff. Therefore our focus had to be on the paper copy care records, which were still in use by staff.

We found that the paper copy care records were in a disorganised state. It was difficult to locate the most up-to-date information as there were old records located alongside new records. In addition, some care plans were updated by handwriting over the original typed care plan. This meant there was confusion as to what the most up-to-date entries were and whether assessments and care plans were being reviewed in a timely way. A visiting professional who had regular access to a person's care records expressed concern about the state of the care plans and described them as, "disorganised" and "having to hunt for

information". We determined that care plans were not always updated to reflect people's changing needs. For example, we noted that two people's needs regarding skin integrity had changed but care plans had not been revised to reflect this.

The paper copy care records were stored in a locked cupboard in the foyer of the home. We observed on two occasions during the inspection that people's care records had been left out on the desk in the foyer without any staff present. We also noted that that the computer in the foyer with electronic care records open and evident on the screen had been left unattended. This meant records related to people living at the home were not kept secure at all times and could be accessed by people living at the home and visitors to the home.

There were no systems in place to seek feedback about the service, including from people living at the home, their families or representatives and others, such as professionals providing a service to the home.

This was a breach of Regulation 17(1)(2)(a)(b)(c)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that incidents had occurred at the home that met the criteria for notifying CQC. We checked out records and could not locate these notifications.

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