Mrs Helen Burridge

Riddlesden Rest & Convalescent Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on 25 August 2016.

We last inspected Riddlesden Rest and Convalescent Home in January 2014. At that inspection we found the service was meeting all the legal requirements in force at the time.

Riddlesden Rest and Convalescent Home provides personal care to a maximum of 10 older people, including people who live with dementia or dementia related conditions. Nursing care is not provided.

A registered manager was not required as the home was run by the registered provider. 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.

People said they felt safe and they could speak to staff as they were approachable. However, there were not enough staff on duty to provide safe and individual care to people. People said staff were kind and caring. However, we saw staff did not always interact and talk with people. There was an emphasis on supervision and task centred care. People were not always protected as when new staff were appointed robust recruitment processes were not used. Staff had received training about safeguarding and knew how to respond to any allegation of abuse.

Systems were not in place to ensure the health and nutritional needs of people were well-managed. People had access to health care professionals to make sure they received appropriate care and treatment. The advice and guidance given by professionals was not always followed to make sure people received the care they needed. We had concerns about some aspects of medicines management.

Regular staff knew people's care and support needs. However, care records we looked at were not all up-to-date. Risk assessments did not accurately identify current risks to the person as well as ways for staff to minimise or appropriately manage those risks. Records did not accurately reflect people's current care and support needs to keep people safe and to ensure all staff were aware of their current individual care and support needs. Detailed individual information was not in place to help staff provide care to people in the way they wanted. People's privacy and dignity were not always respected.

Staff received some opportunities for training to meet peoples' care needs. Induction training was not carried out with staff new to the service to ensure they met people's needs in safe way. A system was in place for staff to receive supervision and appraisal but staff supervision records were not available.

Staff did not have a good understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. People were offered limited choices about aspects

of their daily lives. There were limited activities and entertainment provided for people to remain stimulated.

The registered provider told us the home had a quality assurance programme to check the quality of care provided. However, there were no records available to evidence this. The systems used to assess the quality of the service had not identified the issues that we found during the inspection to ensure people received safe and effective care that met their needs. A complaints procedure was available although it required updating. People told us they would feel confident to speak to staff about any concerns if they needed to. Not all areas of the home were clean and well maintained for the comfort of people who used the service.

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, it 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 measure will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Although people told us they felt safe we found systems were not in place to ensure their safety and well-being at all times. Records did not accurately reflect risks to people's safety. People's medicines were not always managed appropriately

Staffing levels were not sufficient to provide individual care to people. Robust vetting procedures were not in place to ensure that new staff were suitable to work with people.

Staff were aware of different forms of abuse and they said they would report any concerns they may have to ensure people were protected.

There was not always a good standard of infection control.

Is the service effective?

Inadequate

The service was not effective.

Staff were supported to carry out their role but they did not receive all the training they needed to do their job effectively.

Staff had limited understanding of the requirements of the Mental Capacity Act 2005 when best interest decisions needed to be made on behalf of people, when they were unable to give consent to their care and treatment.

Systems were not in place to manage and monitor effectively people's nutritional needs.

Peoples' healthcare needs were not met as specialist advice was not always sought when required.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were kind and caring but there was an emphasis on task centred care rather than individual care and support of people.

People's privacy and dignity were not always promoted.

There were limited opportunities for people to be involved in daily decision making and they were not helped to make choices.

Is the service responsive?

Inadequate

The service was not responsive.

People did not always receive support in the way they needed because staff did not have detailed written guidance about how to deliver people's care. People's care plans did not accurately reflect the current needs of people.

Written information was not available for all people to make staff aware of the person's individual preferences, likes and dislikes.

People had limited opportunities for activities and going out.

Up-to-date information was not available to inform people if they needed to complain.

Is the service well-led?

Inadequate

The service was not well-led.

The registered provider managed the service. Staff told us they were supportive and could be approached for advice and information.

The systems used to assess the quality of the service had not identified the issues that we found during the inspection. Therefore the quality assurance processes were not effective as they had not ensured that people received personalised care that met their needs in the way they wanted.

Records required to ensure the safe and efficient running of the home for the well-being of the people who lived there were either not in place or not available.

Riddlesden Rest & Convalescent Home

Detailed findings

Background to this inspection

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

This inspection took place on 25 August 2016 and was unannounced. The inspection team consisted of two adult social care inspectors.

Before the inspection we reviewed information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities who contracted people's care. We spoke with the local safeguarding teams.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during the lunchtime meal.

During the inspection we spoke with six people who lived at Riddlesden Convalescent and Rest Home, two visitors, two relatives, the registered manager, two support workers, one cook and one domestic. We observed care and support in communal areas and looked in the kitchen, bathrooms, lavatories and some bedrooms after obtaining people's permission. We reviewed records that were available to show how people's care needs were being met and how the home was managed. These included care records for five people, three people's medicines records, the staff training matrix, maintenance contracts and staffing rosters.

Other records such as recruitment, training and induction records for staff, staff meeting minutes, meeting minutes for people who used the service and relatives and quality assurance audits were not available.

Inadequate

Is the service safe?

Our findings

Due to some people's complex needs we were not able to gather their views. Other people who used the service said they felt safe. People's comments included, "I feel safe with the staff," and, "I buzz if I need any help."

We had concerns although people said they felt safe there were not enough staff to meet people's needs in a safe and timely way.

Our observations and staffing rosters showed on the day of inspection and on some other days there were not enough staff to meet people's needs. The registered manager told us staffing levels were determined by the number of people using the service and their needs. Our findings did not support that people's dependency levels had been taken into account to ensure sufficient staff over the 24 hour period. At the time of our inspection there were 10 people who lived at the home who were supported by the registered provider and a support worker. The registered provider told us during the day there were usually three staff on duty however staffing rosters for July and August 2016 showed three staff were not always on duty each day as there were only two staff rostered. Some people needed two staff for their moving and assisting needs. This meant other people were left unsupervised whilst the two staff members were busy with people. We observed people had to wait for assistance, they were not always supervised and their needs were not attended to in a timely way.

We had concerns that ancillary tasks such as cooking and domestic work were carried out by support workers when ancillary staff were not on duty. For example, the cook started at 10:00am and the registered provider told us support workers prepared breakfast as this was served from 7:00am until 11:00am. The provider told us there were 15 hours a week allocated to cleaning the building. However, we found some areas of the building were not clean and identified odours in two rooms. We considered there were insufficient ancillary as support staff had to supplement the ancillary hours whilst they were on duty to ensure an adequate standard of tidiness and cleanliness and provision of food to people. This meant they were not available to provide direct care and support to people. The provider told us there were ancillary staff vacancies due to long term absence however additional staff had not been arranged to carry out these duties when regular ancillary staff members were not available.

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

We had concerns people did not receive safe care and treatment.

Risk assessments were carried out but they did not include all risks specific to the person such as for losing weight, choking, falls and pressure area care. They were not reviewed regularly to ensure they remained relevant, reduced risk and kept people safe. For example, one person's records showed they had fallen and broken their hip. A falls risk assessment had been completed after the fall but this information had not been transferred to a care plan to help reduce the likelihood of the person falling again. The accident book

showed the person had fallen again after this incident. Safety rails were in use on one person's bed but no risk assessment was available to determine if this type of equipment was suitable and safe for the person. A person was prescribed thickened fluids because of difficulties with swallowing and no risk assessments were available to record the risk of choking or aspiration and the need for thickened fluids.

Regular analysis of incidents and accidents did not take place. Incidents were not reviewed to see where any trends and patterns were identified and to take action to reduce the likelihood of them recurring.

A personal emergency evacuation plan (PEEP) was not available for each person taking into account their mobility and moving and assisting needs. This was for if the building needed to be evacuated in an emergency.

We saw the records for a person who occupied a room with an external door which was a fire exit. The record stated the bedroom must only be occupied by a person with 'full mental capacity' and who was 'immobile and non-wandering.' We saw the room was occupied by a person who lived with dementia and was mobile and their moving and handling assessment stated, "Can wander and become unsteady when tired." This meant the person was at risk if they left the building unobserved by the fire exit.

We had concerns with some aspects of medicines management.

Medicines were not stored safely or securely. Medicines that required cool storage were not stored appropriately. They were kept in an unlocked container in the kitchen fridge. This meant they could be accessed by people who were not authorised to handle medicines, such as the cook. Appropriate arrangements were not in place for the storage of controlled drugs (These are medicines that require extra checks and special storage arrangements because of their potential for misuse.)

People were not supported with their medicines safely. The review of medicine administration records (MARs) showed some people, including people who lived with dementia, did not always receive their medicines as prescribed. For example, the MAR for one person between 18 July and 25 August 2016 showed they had refused their medicine on several occasions. This included a medicine to treat diabetes which was to be administered three times a day. It had not been taken by the person for 18 doses. A prescribed supplement for calcium had not been taken for 24 doses. A nutritional supplement prescribed to be given twice daily over this period had only been administered on 22 occasions. The provider told us the person's relatives had raised concerns with the General Practitioner (GP) about the person refusing their medicines and they said the GP had then visited the person and discontinued some of the medicines and told the provider "not to worry" if the person refused their medicines. We looked at the person's care records and there was no written evidence to confirm these discussions had taken place. The last recorded visit from the GP was April 2016. Following the inspection the provider told us it was them, not the relatives, who had raised concerns with the GP about the medicines and told us this information was recorded in the person's notes.

A person was prescribed a weekly pain patch, which was a controlled drug. Our checks of the person's MAR and controlled drug register showed the patch, that was due to be administered on the morning of the inspection had not been administered by 2:00pm. The provider told us this had been missed because of the inspection. However, they told us they had noticed the person was in pain and we advised them to administer the patch immediately which they did.

There were no systems in place to record the administration of topical medicines such as cream and ointments. The registered provider told us records were only completed when the creams had not been

applied by staff. No MARs were available to record the use of these ointments and creams and there were no body maps or written details to inform staff how often or where on the body to apply the cream or ointments. The creams were not stored safely as they were kept in people's bedrooms. In one person's bedroom we saw a barrier cream and emollient cream were being used. We saw the emollient cream had an expiry date of 26 June 2016 and was still being used. This was subsequently removed by the staff member. The barrier cream had no prescription label and no opening date recorded on the tub to show when it had been prescribed and started to be used.

A medicine profile was not available for each person that included an up-to-date photograph of the individual to help identify the person to ensure medicine was administered to the correct person. There was no written information that detailed how a person liked to take their medicine. For example, on a spoon, one tablet at a time or with a particular type of drink.

There was no written guidance for the use of "when required" medicines, and when these should be administered to people. These medicines might include for pain relief or agitation and distress. The provider showed us protocols they had written which they said they were in the process of putting in place to advise staff when the person may need them.

We saw the provider's medicine policy was undated and unsigned, so it did not show if it was the most recent policy. It lacked detail as some aspects of medicines management were not included to provide guidance to staff. For example, there was no guidance for staff about what to do if a person was asleep or not available to take their medicine. There was no information about the use of covert medicines (Covert medicine refers to medicine which is hidden in food or drink.) We discussed this with the provider and directed them to the National Institute for Health and Care Excellence guidance, "Managing Medicines in Care Homes."(March 2014).

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

We had concerns that people were not kept safe as staff had not always been recruited correctly.

The necessary checks had not been carried out before new staff began to work in the home. We spoke to one staff member who was working in the kitchen and they told us that recruitment checks including two written references and a Disclosure and Barring Service (DBS) check had not been completed before they started work. The DBS provides information to potential employers about whether an applicant is debarred from working with vulnerable people and/or whether the applicant has previous criminal convictions. We were shown an application form, DBS check and one reference for one staff member who had been employed since the last inspection. The provider was unable to provide the recruitment records for another recently recruited staff member who was working in the home or for any other staff members employed to show how they had been recruited.

This was a breach of Regulation 19 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

We identified there were ineffective infection control and standards of hygiene within the home. There were no hand drying facilities in the communal lavatory. The handrail next to the lavatory was corroded and the flooring required replacement for effective infection control as it was discoloured and lifting from the base around the lavatory pedestal. We observed some staff did not wear protective clothing when they went into the kitchen into the areas where food was being prepared. We observed at lunchtime plates of food were

uncovered as they were taken to people's bedrooms and communal areas where people chose to sit. The registered provider told us that this would be addressed.

The registered manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities and independent investigations were carried out if necessary. We viewed the safeguarding records and found concerns had been logged appropriately by the registered manager. One safeguarding alert had been raised by the registered provider since the last inspection. It had not been categorised as safeguarding by the local authority. The concerns raised by the provider were waiting for review and were on going at the time of inspection.

Staff had an understanding of safeguarding and knew how to report any concerns. They were able to describe various types of abuse and tell us how they would respond to any allegations or incidents of abuse and knew the lines of reporting within the organisation. They told us they would report any concerns to the registered provider or deputy manager.

The registered provider had arrangements in place for the on-going maintenance of the building. Routine fire safety checks took place and repairs were carried out. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the hoist and bath hoist.

Inadequate

Is the service effective?

Our findings

People we spoke with were positive about the food. They said they enjoyed it. Their comments included, "I'm not difficult to please," and, "The food is okay, there's plenty to eat."

We had concerns effective systems were not in place to ensure all people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. Accurate records were not in place to ensure people's nutritional needs were always met by staff and regularly reviewed.

People were assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST), their weight was monitored and recorded any incidence of weight loss. However, these assessments were not regularly updated and evaluated with information that was transferred to a nutritional care plan with advice and guidance for staff to help improve the person's nutrition. One person who was at high risk of malnutrition had not had their MUST tool completed since September 2015 and their records showed they had continued to lose weight over some months. The person's care records showed the district nurse had advised the person should have a fortified diet and lots of snacks. The person was prescribed a nutritional supplement twice a day but medicine administration records showed this had only been given once in 10 days. We discussed this with the registered provider who told us they were not fortifying the person's diet but were waiting for a prescription from the nurse for fortified juice. Therefore the provider had taken no action to ensure this person received the extra calories required to increase their body weight. We followed this up immediately after the inspection to check that appropriate action was being taken by the provider.

Another person's MAR showed they were prescribed a thickening agent to thicken their drinking fluids, to be given 'as directed', and there were no signatures to show it had been given. It had been prescribed due to a person's difficulty with swallowing. The provider told us they only gave it sometimes as the person did not like it. A nutritional care plan was not available to show why the person was prescribed the thickening fluid and a record was not available to state the person did not like to take it. Staff we asked were not aware of anyone having the need for thickened fluids. We asked the provider to check with the Speech and language therapy team (SALT) to clarify how and when this person should be receiving thickened fluids.

We looked around the kitchen and although it was stocked with fresh, frozen, tinned and home baked food. We did not see ingredients such as butter and full fat milk to use as part of people's diet to fortify them. People did not receive a fortified diet if they needed to increase weight and be strengthened. The registered provider told us they did not use them for other health reasons such as cholesterol issues. We had concerns there was lack of understanding and specialist advice had not been taken from professionals such as a dietician where people were at risk of losing weight.

Another person's weight records showed they had lost weight over the last year and they had not been weighed since May 2016. The MUST tool had not been completed since September 2015. A nutritional care plan was not in place and there was no record to show what action had been taken as a result of the weight loss.

Daily 'fluid balance' charts were in place to monitor where people had been identified as at risk of poor hydration. The fluid intake charts did not record the daily fluid target or total amount of fluid intake the person had taken. Where people had been identified as at risk of poor nutrition and losing weight staff had not completed a daily 'food balance' chart to monitor the amount of food they ate daily. This meant where people were at risk of malnutrition a nutritional care pan was not in place, food charts were not used and nutritional assessments were not up to date to monitor the risk of malnutrition to the person.

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

We had concerns people were not all supported to meet their health needs in a timely way.

People were not all supported to maintain their healthcare needs. People's care records showed they had input from a range of health professionals such as, General Practitioners (GPs), district nurses, opticians and a speech and language team (SALT). Records were kept of visits. Care plans however did not reflect the advice and guidance provided by some external professionals. For example, the district nurse or GP. Records showed professional healthcare advice was not always sought in a timely way. For example, the issues with some people's poor nutrition had not been identified by the provider or staff until CQC intervened at inspection. We saw records where a person, who was to be escorted to a GP appointment had their appointment cancelled twice, as the relative who was going to take them, was not available to take them. The GP subsequently contacted the home and asked for a staff member to escort the person so they could attend their appointment. This did take place.

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

We had concerns that records did not contain detailed information about people's mental health and the correct best interest decision making process, as required by the Mental Capacity Act 2005. The Deprivation of Liberty process had not been followed and some people were being restricted to keep them safe.

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

There was limited understanding of the MCA and best interest decision making, when people were unable to make decisions for themselves. Records did not contain information about people's mental health and the correct 'best interest' decision making process, as required by the MCA. Best interest decision making is required to make sure people's human rights are protected when they do not have mental capacity to make their own decisions or indicate their wishes. Records did not contain assessments, where necessary to assess people's mental capacity to make particular decisions. People's care records did not show when 'best interest' decisions may have needed to be made. For example, if people refused medicines or nutritional supplements. We considered people's 'best interests' were not considered and advice and guidance was not followed to try to ensure the health and well-being of some people with regard to medicines and nutrition when it was refused. Records were not available to show that advice and guidance had been sought to ensure what was in the person's 'best interests'.

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). The registered provider and staff were not aware of the Deprivation of Liberty safeguards and processes had not been followed to consider when a person's normal freedoms and rights were being significantly restricted. As a result no authorisations were in place and none had been processed although some people did lack mental capacity and they were being confined within the home to keep them safe.

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

We had concerns staff had not all received training in safe working practices and the required training to carry out their role.

Three staff members told us they had not received training in safe working practices since they started to work at the home although they told us they had received the required mandatory training in their previous employment and it had not yet expired. One of these staff told us since starting at the home they had received moving and assisting training by another staff member, who was not a designated trainer to show the correct procedures.

Staff told us when they began working at the service they had an opportunity to shadow a more experienced member of staff. Staff files were not available to show if staff received regular supervision and an appraisal to discuss their training requirements and work performance. Most staff spoken with said they received supervision from the registered provider or deputy manager. They told us they were supported to carry out their caring role. They said they could approach the management team at any time to discuss any issues.

The staff training matrix showed one staff member had not received any training since 2014. We also found two staff members were not included on the training matrix despite one being named on the duty roster in July. A staff member who was working on the day of inspection was also not included. This meant it would have been difficult to ensure the staff received the necessary training and it was kept up-up-to-date.

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

The staff training matrix showed staff had some other opportunities for training and this included infection control, continence, diabetes awareness, pressure area care, dementia care, mental capacity and epilepsy. Several staff had completed National Vocational Qualifications (now called diploma in health and social care) at different levels to give them more insight into people's care and support needs.

We noted some areas of the building were showing signs of wear and tear. Paintwork was scuffed and chipped on skirting boards and doorways in some areas including corridors, communal areas and bedrooms. Some bedroom walls were marked. Lighting was poor down one corridor leading to bedrooms as several bulbs were missing from the side lights. One relative told us they thought their relative's bedroom was cold. The carpet was frayed at the entrance into the main lounge from the corridor by the lavatory. The kitchen door banged noisily to its rebate and the noise disturbed people sitting in the lounges.

Staff told us a verbal handover took place when staff changed duty, at the beginning and end of each shift. A staff member told us, "We have a handover to talk about what needs doing and what's been going on." This was so that staff were aware of the current state of health and well-being of people. Most staff members said communication was effective although a formal written handover did not take place that recorded aspects

of people's health and well-being, moods and behaviour. Written messages were also left for staff in a notebook in the kitchen.

Requires Improvement

Is the service caring?

Our findings

People who could comment were all positive about the care and support provided by staff. Their comments included, "Staff are very nice, I couldn't find anywhere better than here," "Staff are 100%" "It could be better, the staff could show a little more sympathy," "Staff are good," and, "Staff treat me with respect." A staff member told us, "The home I worked at before was bigger and we never got time to spend with the residents because we always had other jobs to do, whereas here, we get to know the residents and get spare time to do activities and have 1-1 time."

We had concerns about some aspects of care people received.

We saw staff did not always have time to interact with people except when they carried out care and support. We observed people who were more assertive interacted together or tried to get staff involvement. As staff were busy they didn't always have time to respond to a person's request so the person kept asking different staff members. We saw staff did not have the opportunity to engage and interact with some people and encourage their awareness and interest in their surroundings. We saw people sat sleeping for much of the time. We observed one person whose records stated they had pressure area care needs and required a change of position and their foot to be elevated remained in their wheel chair for five hours. They were not assisted to their specialist chair in the morning after breakfast and remained in their wheelchair all day until after 3:00pm before they went for bed rest.

We observed a lunchtime meal and considered improvements were required to people's dining experience. Some people sat at the dining table while others sat in communal areas or their bedrooms. The table was laid with a tablecloth and cutlery but no napkins, condiments or menus were available on the table. The meal was disorganised. For example, we saw one person's meal was served before the person was assisted to the table. Another person already seated, who had no food, was becoming agitated as they tried to reach the plate of food. When the person was brought to the table, they said, "It (meal) will be cold now." People were not offered a choice of meal, portion size or asked if they wanted gravy which was already served on their food as meals were brought to the table ready plated. One person was served a bowl of beef stew and bread and butter. When we asked the provider why the person was served this they told us the person would not be able to manage the turkey escalope. A person who was served turkey escalope, and did not want it, was offered a sandwich as an alternative rather than another hot meal. Five people sat at the dining table and one staff member assisted them to eat, or provided prompts and encouragement. They moved from person to person and knelt by one and stood over another person as they assisted them rather than sitting down next to the person and helping them during their meal. Other people, who were eating in other areas, waited for the rest of their meal until staff had time to check if they required anything else, or any assistance. People waited to be helped from the table for some time, after their meal was finished. After their meal most people returned to their armchair and went to sleep as staff were not available as they were busy supporting people.

We saw people were not always encouraged to make a choice and be involved in decision making. For example, with regard to meals and other activities of daily living. Pictorial menus and photographs about

food were not available to help people make a choice of food. We saw at lunch time people were not verbally offered a choice of meal, or if they were undecided shown two plates of the available meal to help them make the choice by smell and visually. An activities board was displayed which contained some information to keep people orientated and aware of their surroundings.

Some people could tell us they were offered choices and involved in daily decision making about other aspects of their care. For example, rising and retiring routine. One person commented, "It is up to me when I get up." People's care plans did not contain detail of how staff were to support people, including people who lived with dementia with their choice if they were unable to tell staff verbally.

Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well. Staff described how they supported people who did not express their views verbally. Staff observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain. Some information was recorded in people's care plans. The information was not detailed so new staff and staff who did not know people so well would be able to recognise signs of pain and what the person may be communicating. For example, one care plan recorded, "Staff to monitor [Name] for signs of pain by assessing their non-verbal communication and discussing [Name]'s needs with them." Another stated, "Staff to watch for facial expression to see what is being communicated." There was no detail or examples to show what the facial expressions may mean.

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

We had concerns that people's privacy and dignity were not always respected.

Staff knocked on people's doors before entering their rooms, including those who had open doors. Most people sat in communal areas but some preferred to stay in their own room. Staff were observed to be respectful in their approach with people. They called people by their preferred name. Staff we spoke with were able to explain how they would preserve people's privacy, for example when providing personal care. We saw staff discussed personal care discretely with the person. A person's care plan also referred to respecting the person's dignity when providing personal care. However, we noted a number of rooms, which were overlooked, either by adjoining houses or the windows looked out onto the hallway. They did not have any screening to provide privacy when the person was in their room and the curtains were open. We saw net curtain rails were available but the provider told us people removed the net curtains that had been in place. They told us they had put the curtains back up but one person kept removing them. In one case a neighbour had contacted the home to inform them a person could be observed in their room as they undressed. We discussed with the provider options to protect people's privacy such as frosted glass where a person could look out clearly but people could not look in.

We noted some items of clothing and an item of underwear were displayed over a radiator in the hallway by the entrance to the home and on the radiator in the communal area where people were sitting. We discussed the inappropriateness of this and the lack of respect for peoples' dignity and privacy. We were informed by the provider people were used to it as they would have done it in their own home. We advised it was not appropriate in this environment as people were living in a shared environment.

This was a breach of Regulation 10 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Family members we spoke with told us they were kept informed about any changes in their relative's condition. One relative commented, "The staff keep me up to date with any changes."

We were told the service used advocates as required and a person had been supported by an Independent Mental Health Care Advocate (IMHCA) because they lacked the mental capacity to make decisions with regard to their well-being before they moved into the home. Advocates can represent the views for people who are not able to express their wishes.

Inadequate

Is the service responsive?

Our findings

We had concerns records did not accurately reflect people's care and support needs.

Records did not accurately reflect peoples' current care and support requirement. They did not contain all the required information to ensure people's needs were met by staff. They contained assessments and some were transferred to care plans but we saw they were not all up to date and did not reflect people's current needs. These included for mobility, personal care, nutrition and other needs. People's support plans were not all updated monthly to reflect any change in people's care and support needs.

Information from risk assessments was not always transferred to care plans to ensure accurate care was provided. For example, for mobility. Risk assessments and care plans were not in place to advise what staff should do if people refused to accept any assistance or refused their medicines or staff intervention.

Care plans were not all in place to provided details for staff about how the person's care needs were to be met. Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was not always transferred to people's care plans. For example, in one person's daily records there was an entry in June 2016 which recorded they had low sodium levels and their fluid intake was therefore limited each day. There was no care plan in place that provides guidance to staff about how this person should be supported with this need. The same person also had diabetes, dementia and low weight and there were no care plans in place to address these support needs. Care plans for the person had not been updated since April 2016, despite the person's condition altering after an admission to hospital. Other people's records showed documentation such as care plans and assessments had not been recently evaluated to make sure they still reflected people's needs accurately. This was necessary to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

Not all care plans gave instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. They did not detail what the person was able to do to take part in their care and to maintain some independence. Information was contradictory in one care plan as it stated the person was to be checked at night two hourly, and another section stated the checks should be hourly.

Some people's care records contained a "Do not attempt cardio pulmonary resuscitation" (DNACPR) directive that was in place for the person. This meant healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

There was no evidence to show that reviews or meetings took place for people and their relatives to discuss their care and to ensure their care and support needs were still being met. The provider told us the local authority had not carried out reviews for some time. There was no evidence of reviews being carried out by staff within the home. Reviews were necessary to make sure people's needs were still being met. Relatives we spoke with said they were kept informed if there was any change in the health needs of their relative.

People did not have a 'social history with information collected from the person and their family that gave details about the person's preferences, interests and previous lifestyle. It is important information and necessary for when a person can no longer tell staff themselves about their preferences. Information was not available about peoples' likes, dislikes and food preferences when they were unable to communicate this verbally.

We were told resident meetings took place every month but meeting minutes were not available to show what was discussed and how people were kept informed and consulted about ideas for activities, outings and menus. A member of staff told us, "There was a resident's meeting recently."

We were told activities were provided and these included, Music therapy, ball games, foot massage, arts and crafts and exercises. No activities took place during the inspection. We were told entertainers came into the home and people especially enjoyed the singing. Some people were supported to access the community and two people were supported to retain previous contacts with the social club they had attended and the pub. A local hairdresser visited fortnightly, a person was supported to access a hairdresser in the local community and a person from the local Catholic church brought Holy Communion to a person. Seasonal parties took place and parties for national celebrations such as the Queen's Diamond Jubilee were also enjoyed.

People said they knew how to complain. A person commented, "I'd tell the staff." People had a copy of the complaints procedure in the information pack they received when they moved into the home, however we saw it was out of date as it referred to the previous regulator. We were told a record of complaints was maintained however it was not available. We were told none had been received since the last inspection.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

Inadequate

Is the service well-led?

Our findings

We had concerns the audit and governance processes had failed to ensure satisfactory standards were maintained.

The registered provider was present and assisted us with the inspection. They appeared to know the people using the service and the staff well. The running of the home was disorganised and the registered provider was unable to locate or provide a significant amount of records requested for inspection purposes. Some of the records that were provided were out-of-date. This meant documentary evidence was not available to show the home was run safely and for the benefit of people who used the service.

We were told by the provider audits were carried out regularly to monitor the quality of care provided. For example, an annual medicine was carried out by the local pharmacy. A health and safety audit was also carried out annually. However the registered provider was not able to provide documentary evidence of these audits. The registered provider was unable to provide evidence to show that other more regular audits took place to check on the service provided. For example, monthly audits of documentation, staff training, medicines management, accidents and incidents, infection control, nutrition, skin integrity, falls and mobility.

There was no evidence of a robust auditing and governance process to check the quality of care provided and to keep people safe. As there was no evidence of audits it could not be evidenced if follow up action was taken as a result of previous audits where deficits were identified and follow up action was required.

The provider told us they regularly analysed incidents and accidents that had taken place. They said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of re-occurrence. We viewed the accident book and saw the person who had fallen and broken their hip returned home and fell again. We did not see evidence of any action taken to reduce the risk of falls by use of for example, sensor mats to alert staff when the person may move to get up and walk. The provider was not pro-active and strategies were not in place to protect people. They informed us such equipment would not be any help as the person would have fallen by the time they reached them.

We found the systems in place for managing and mitigating risk were inadequate. Lack of review of care records failed to identify that these did not contain the information staff needed to safely care for people or to highlight that they were out of date. Neither, did the systems highlight the training gaps and the lack of understanding staff had around the Mental Capacity Act 2005. The environment had not been audited effectively as it had not ensured that all areas of the building were decorated and had a good standard of hygiene and that they were well-lit.

The culture did not promoted person centred care, for each individual to receive care in the way they wanted. Information was not available to help staff provide care the way the person may want, if they could not verbally tell staff themselves. People were not encouraged to retain control in their life and be involved in daily decision making.

Staff told us staff meetings happened regularly but no meeting minutes were available to show what was discussed and the frequency of meetings.

The registered provider told us they monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to people. We were shown a blank questionnaire to show the questions people and relatives were asked. We were told a survey had taken place in 2016 but the results were not yet analysed. The survey results from 2015 were not available.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

People and visitors told us the atmosphere in the home was pleasant and welcoming. We observed staff were busy and people had to wait for assistance. Most people told us they were happy at the home and with the leadership at the home. Staff said they felt well-supported by the management team. They said they could approach them to discuss any issues.