MMCG (2) Limited

Blenheim Care Centre

Inspection report

Ickenham Road
Ruislip
Middlesex
HA4 7DP

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 22 May 2018 and was unannounced.

The last inspection of the service was on 27 September 2017 when we rated the service Requires Improvement for all key questions and overall. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the service to at least 'Good'.

At this inspection on 22 May 2018 we found that there had been some improvements. However, the service remains Requires Improvement in all key questions and overall.

Blenheim Care Centre is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service is registered to accommodate up to 64 adults. At the time of our inspection 53 people were living at the service. Accommodation was provided on three floors. Eight younger (under 65 years of age) and ten older adults with physical disabilities and nursing needs lived on the ground floor, 17 older people living with the experience of dementia lived on the first floor and 17 older people with nursing needs were living on the second floor.

The service was owned and managed by MMCG (2) Limited, part of the Maria Mallaband Care Group, a private organisation providing care services in England. MMCG (2) Limited took over the management and ownership of the service on 4 August 2017.

The manager had been in post for two weeks at the time of our inspection. They had started the process of applying to be registered with the Care Quality Commission, by applying for their enhanced check with the Disclosure and Barring Service. The previous registered manager left the service in September 2017. There had been two other interim managers since this time. Neither had applied to be registered. 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 and associated Regulations about how the service is run.

The risks to people's safety and wellbeing had not always been identified, assessed and mitigated. This meant they were at risk of receiving care and treatment which was not appropriate or safe and did not meet their needs.

Medicines were not always managed safely at the home.

The staff supporting people did not always receive the supervision, guidance, support and appraisal they needed to effectively care for people. Their competencies at meeting people's needs were not always being assessed so people were at risk of receiving inappropriate care and support.

People were not always treated with dignity and respect or in a personalised way.

People's care was not always designed in a way to meet their needs and reflect their preferences. Furthermore, they did not always receive care which met their individual needs. For example, people did not always have enough to drink or the support they needed to wash and shower.

People told us that they were lonely and did not have the care and support they needed to meet their social and emotional needs.

The provider's systems for monitoring and improving the quality of the service were not always effective.

There were not enough permanent, regular staff deployed to provide consistent and effective care which met people's individual needs.

We found six breaches of Regulations during the inspection. These were in respect of person centred care, dignity and respect, safe care and treatment, nutrition and hydration, good governance and staffing.

We are taking action against the provider for failing to meet Regulations. Full information about CQC's regulatory responses to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

We received some positive feedback from people using the service, with one person telling us, ''It is all grand here.'' Likewise, some visitors told us they were happy with the service. One of their comments included, ''I think [the provider] has some good ideas about the future of this service. Everything is good here and it is improving.''

People's needs were assessed when they first moved to the service. There was evidence that the staff worked closely with other healthcare professionals to make sure people's healthcare needs were being met. The staff made referrals in a timely manner when people's needs changed and followed the advice and guidance of other professionals.

The provider had suitable procedures for the recruitment and training of staff. These included making checks on their suitability and providing training in line with the requirements of this type of service.

There were suitable systems for identifying and responding to safeguarding alerts, incidents and complaints. These included working with other agencies to protect people from the risk of further harm and learning from when things had gone wrong.

The provider was in the process of improving the environment and had plans to make the design and decoration more attractive and reflective of good practice guidance for services for people living with dementia. The building was appropriately maintained and the provider ensured that checks were carried out on the environment and equipment, regarding safety and cleanliness.

People liked the manager and felt that they had started to make improvements. They expressed concerns about the changes in management and felt that this had impacted negatively on the service, however, they told us they were able to speak with the new manager and that they had responded appropriately. The provider and manager had started to make arrangements to improve the service. These included recruiting a large number of permanent staff and reviewing and updating records.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

The risks to people's safety and well being had not always been assessed, planned for or mitigated.

There were not enough staff deployed at the service to provide consistent care and support because a high proportion of the staff were not permanent. As a result, people were not always being cared for in a way which reflected their preferences or met their needs.

Medicines were not always managed safely at the home.

People lived in a safely maintained and clean environment and there were appropriate systems for checking this and the equipment being used.

The provider had systems for recognising and reporting abuse and responding to accidents. These included learning from incidents so that the service could be improved.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The staff did not always receive the supervision, support and guidance they needed to care for people in an effective way.

People's nutritional and hydration needs were not always planned for or met.

The environment did not meet best practice guidance for people living with dementia, but the provider was making improvements in this area.

The provider made sure that staff received training relevant to their role.

People had consented to their care and treatment and where they lacked the mental capacity to do so the provider had acted in accordance with the Mental Capacity Act 2005.

People had access to the healthcare services they needed and were supported with their healthcare needs.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

The staff did not always respect people's dignity, independence or human rights. Not everyone was given choices about their care, and the staff did not always respect the choices people made.

However, some people commented on how kind and caring the staff were and we observed some positive interactions where staff were caring and kind.

People told us they had been involved in planning their own care.

People's privacy was respected.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People were not always supported in a way which met their needs and preferences.

People knew how to make a complaint and felt the provider responded to these.

People received the care and support they needed at the end of their lives.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

We identified multiple breaches of Regulation. These showed us that the provider was not operating effective systems to assess, monitor and improve the quality of the service or mitigate risks.

However, the provider had plans for the future and had started to implement these to make improvements.

Blenheim Care Centre

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 checked 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 22 May 2018 and was unannounced.

The inspection team included two inspectors, a member of the medicines inspection team, a nurse specialist advisor 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 the inspection visit we looked at all the information we held about the service. This included the last inspection report and the provider's action plan in response to this, notifications from the provider and information from external sources (such as people using our share your experience web forms). Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We spoke with representatives from the local authority (London Borough of Hillingdon) who regularly visited the service to undertake quality checks.

During the inspection visit we spoke with nine people who used the service and visiting relatives of three people. We observed how people were being cared for and supported. Our observations included using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us. We spoke with the manager and other staff on duty, who included nurses and care workers, both permanent workers employed by MMCG (2) Limited and temporary workers from staffing agencies. We spoke with a visiting healthcare professional.

Our inspection included observations of the environment and equipment being used. We also looked at the whole care records for nine people who used the service and part of the care records for a further six people, the staff recruitment records for six members of staff, records of staff supervisions and training and other records used by the provider, for example meeting minutes and audits. We looked at policies, storage, administration records and systems relating to medicines.

At the end of the inspection we gave feedback about our findings to the manager, the regional director and the provider's quality and compliance inspector.

Requires Improvement

Is the service safe?

Our findings

At the inspection of 27 September 2017, we found there were enough staff to keep people safe, but people sometimes had to wait for care and support. In addition, the planned use of staffing meant that sometimes staff worked for many consecutive days without sufficient time off.

At this inspection on 22 May 2018, we found that there had been improvements with the scheduling of staff shifts so that they did not work consecutive long days without sufficient breaks. However, the provider had experienced a significant reduction in the amount of permanent staff who were employed and as a result a large proportion of the staff were temporary and were sourced from staffing agencies. For example, on the day of our inspection two of the four nurses on duty were permanent, and one of these nurses was undertaking her induction. The other two nurses (each in charge of caring for people on one floor) were from a staffing agency. Seven of the 11 care workers on duty were also from a staffing agency. The provider's records reflected that this situation was usually the case with 207 care worker shifts and 30 nurse shifts being carried out by temporary agency staff during the month of April 2018.

This meant that there was a lack of consistency of approach and care. The staff supporting people did not always know their needs or how to support them. Some of the temporary staff we spoke with told us they had only worked at the service a few times. They explained that they received an induction into the home and the people they were supporting which lasted approximately 15 minutes. As a result, they were not familiar with people using the service or able to provide personalised care which reflected individual needs and preferences. However, the provider had evidence that the temporary staff working at the service had up to date training in relevant areas and that the staffing agency had undertaken checks on their suitability to work with vulnerable people.

We found that people still had to wait for some care and support. For example, staff supporting people to get washed and dressed told us that some people were not given this support until 12pm which was just before lunch time. This was the case on the day of our inspection, with some people telling us that they did not wish to be in bed but that no one was available to support them to get up. A recent concern, raised by a visiting healthcare professional and investigated by the local safeguarding team, also found that one person regularly did not receive the personal care as planned. People using the service and relatives confirmed this, explaining that they did not always receive care and support when they wanted and needed it.

We also observed that staff did not spend time talking with people or offering company and social activities. Therefore, their emotional, social and leisure needs were not being met because insufficient staff were deployed to meet these needs.

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

All of the people we spoke with confirmed that in an emergency situation or if they called for help they were

given this support.

The provider told us they were in the process of recruiting to the vacant staffing positions. We saw evidence of this and 16 members of staff had been interviewed and offered positions subject to satisfactory checks which were taking place at the time of our inspection. The records of staff who had been employed showed that the provider undertook appropriate checks on their suitability, which included checks on their identity and eligibility to work in the United Kingdom, a full employment history, references from previous employers, checks on any criminal records from the Disclosure and Barring Service and a full induction into the service and organisation.

The provider had not always taken action to identify and mitigate risks. During our inspection visit we found the door to an electrical meter cupboard and a sluice room, which held chemical cleaners, were unlocked. The rooms remained unlocked for the duration of our visit. People using the service had access to these rooms.

On the day of our inspection a visiting healthcare professional attended the service. At 11.45am they found that the pressure relieving mattress on one person's bed had been switched off. The person had been in bed since the previous afternoon. It was not clear how long the equipment had been turned off for but the mattress had deflated indicating that this had been the case for some time. The person had been assessed as at high risk of developing pressure sores. This risk was increased because of the failure of staff to ensure the pressure relieving mattress had been switched on. The person's care notes included records of hourly comfort checks. None of these had identified that the mattress was not switched on.

The staff had assessed risks to people's safety and wellbeing but they had not always developed plans to show how people should be supported in these areas of need. For example, we looked at the care records for three people who sometimes expressed themselves through verbal and physical challenges. This need had been identified and the staff recorded incidents of when this had happened. But the risk assessments and care plans did not include strategies for supporting these people. For example, there was no evidence that the staff supported people to find alternative ways to communicate or to resolve the issues which led to their frustrations. In another example, a person had returned from a hospital stay with changes in their needs. Whilst these were identified the person's risk assessments had not been updated to record the increased risk of choking which was related to their health condition.

The home had a medicine management policy in place. However, we found some documents used to support medicines management processes were from previous provider. This could lead to errors as guidance was not available in the current medicine policy on how to use them.

Some people were prescribed medicines such as pain killers and laxatives (medicines used to treat and/or prevent constipation) on a when required basis. We found guidance was not in place to advise staff on how to give these medicines. This meant staff would not be able to give people these medicines consistently.

Some people were prescribed creams and ointments to be applied to their body. These were stored in peoples' own rooms and recorded when applied by staff on separate charts. However, we found staff did not annotate date open on the creams which meant these may have passed their recommended shelf life.

The charts which showed when prescribed creams had been administered were not complete and showed gaps where no administration or reason for non-administration had been recorded. For example, the prescribed cream administration chart for one person included eight doses where no information had been recorded during May 2018. 10 doses for a second person, a further eight for a third person and four for a

forth person. The staff had signed to say they had given creams for the evening dose on the day of our inspection (a time in the future) for three of these people. Therefore, these records indicated that people had not received medicated creams as prescribed or that staff were incorrectly completing the charts.

Some people were prescribed high risk medicines such as anticoagulants and insulin to manage their long-term health conditions. Anticoagulants are medicines prescribed to prevent blood clots. Insulin is prescribed to some people with diabetes to help control their blood glucose levels. We found guidance was not available for staff in people's care plans to identify likely side effects of these medicines and information was not available on how to manage them.

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

Medicines were stored securely at the correct temperature. Staff checked and recorded this daily. Unwanted medicines were recorded and disposed of appropriately.

We observed staff give people their medicines in the afternoon. Staff members were caring and gained permission before giving people their medicines. With the exception of problems identified with recording of prescribed creams, we found that staff members recorded each medicine that was given to people on their Medicine Administration records (MARs)

We looked at MARs and care plans for six people. The provider had recorded important information such as the name, photograph and medicine sensitivities to help staff give people their medicines safely. We found no gaps in the MARs. This provided assurance people were being given their medicines as prescribed.

The provider had responded appropriately following people falling. They had undertaken assessments of their wellbeing and ensured people received the right medical support. They had assessed the need for additional equipment to help keep people safe and reduce the risk of injury if they fell. These assessments were regularly updated. The provider had appointed a member of staff to take a lead in working with the local authority to look at ways of preventing falls.

People using the service and their relatives told us they felt safe there. They said that they did not feel anyone was being abused and they had never seen anyone being treated in a way that concerned them. Most people told us that the call bells were answered promptly when they needed attention. With one person commenting, ''If they are not too busy they come straight away and it is the same at night.''

There was enough suitable equipment at the service, including hoists, profiling beds, air mattresses and accessible showers and baths. Equipment was regularly serviced and cleaned. People requiring the use of a hoist had their own sling/s which were stored in their bedrooms. The staff undertook regular checks on the suitability and safety of equipment.

The health and safety of the environment was subject to regular checks. For example, equipment used for detecting and fighting fire, water temperatures and safety, electrical appliances and window restricting devices. Records of checks were maintained and action had been taken when concerns were identified. There was a suitable fire procedure which included individual evacuation plans. The staff were aware of how to respond in event of an emergency and the support each person would need to evacuate. The provider had a contingency plan which outlined the action to be taken in different emergency situations.

The provider had a suitable procedure for safeguarding people. There was information about recognising

and reporting abuse for service users, staff and visitors on display around the service. The staff received training regarding safeguarding adults and were able to tell us what they would do if they suspected abuse. The provider had worked with the local safeguarding authority and other agencies to investigate allegations of abuse and put in place protective measures to help prevent the risk of future harm for victims of abuse.

The provider kept a record of safeguarding alerts, accidents and complaints. There was evidence to show how they had responded to these. These records showed how the individual incident was dealt with and how lessons were learnt for the future to prevent reoccurrence. For example, the manager held regular meetings with the heads of each department at the service where they discussed any concerns and shared ideas about how improvements could be made. The provider's senior managers regularly visited the service and the manager explained that they shared ideas and information from across the company so that lessons could be learnt from other services as well as Blenheim Care Centre.

People were protected from the risk of the spread of infection by the provider's arrangements related to the prevention and control of infection. Domestic staff were employed to carry out cleaning and we saw that they attended to this throughout our visit. People told us that the home was generally clean. We observed the staff using gloves and aprons when cleaning or delivering care and there were appropriate arrangements for the disposal of these and clinical waste. The provider undertook regular audits of infection control and cleanliness.

Requires Improvement

Is the service effective?

Our findings

At the inspection of 27 September 2017, we found the staff did not always have the support and supervision they needed to effectively care for people. The provider was aware of this and had started to address this issue. They completed an action plan telling us they would make the necessary improvements by the end of February 2018. The provider's most recent action plan written in May 2018 following their own internal audits, had identified that they had not achieved the improvements they wanted and had revised the target date for this to June 2018.

At the inspection of 22 May 2018, we found that staff were not receiving regular supervision or appraisals of their work. The manager in post at the time of our inspection was the third manager since the previous inspection. In addition, there had been changes in the senior staff group with the deputy manager, clinical lead and a number of nurses leaving the service. This meant that the arrangements for supporting, supervising and appraising staff had not been implemented as planned. Records of individual staff supervisions showed that they had not received these since 2017. In addition, there was little evidence of regular staff meetings or any appraisals of staff competencies in 2018. The staff systems for communicating with each other included handovers of information at each shift change. These were sufficient to make sure basic needs were identified and discussed, but there was a lack of planning and direction for the staff. As a result, people did not always receive consistent care which reflected their needs and preferences. The lack of supervision and staff appraisal meant that this had not always been identified or acted on.

At times people were placed at risk because the staff were not working effectively together to meet people's needs. For example, one person's care records included specific guidance from a healthcare professional about how the person must be supported when eating and drinking to avoid injury. At lunch time on the day of our inspection, a temporary member of staff started to support this person. They were not supporting the person in the way the guidance had specified. After five minutes and when the member of staff asked what to do because the person was not eating, there was a change so that a permanent member of staff, familiar with this person's plan, supported this person instead. Had the staff team been properly supervised and deployed this risk could have been avoided by ensuring only familiar staff supported this person at all times. Similarly, a member of temporary staff brought another person their meal and left this with them. The person was unable to manage without assistance and was left until ten minutes later when another member of staff offered to support the person.

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

We discussed this with the manager and they agreed that they would develop a plan to ensure that staff received adequate supervision and support. They were in the process of recruiting a new clinical lead who would work alongside staff supervising them, appraising their work and offering guidance.

We found that there had been improvements in the training of permanent staff. New staff undertook training

in line with the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. They also undertook an induction into the home and shadowed experienced workers. The provider had obtained evidence that temporary agency staff had received up to date training in key areas. The provider had a training programme designed to support staff with regular training in the areas they needed and to help them understand people's health conditions and needs.

At the inspection of 27 September 2017, we found that the environment was not designed in a suitable way to support people living with dementia. We made a recommendation in respect of this.

At the inspection of 22 May 2018, we found the provider had started building work to improve the environment. They had plans to create new communal areas based on themes which reflected people's interests. At the time of the inspection, this work had only just commenced, and whilst there was some signage and information to support people to orientate themselves, further improvements in this area were needed. In addition, we found that the garden was largely inaccessible with long, overgrown grass and limited seating. One visiting relative commented, ''They should be ashamed at the state of the garden, uneven paving and overgrown weeds.'' The manager told us that work to improve the garden was due to commence shortly after our inspection.

People had personalised their bedrooms with their belongings and many of these reflected the personalities and interests of the occupant. The building was equipped with hand rails along corridors. Communal rooms were light and well ventilated, with comfortable seating and access to a call alarm system from all rooms.

There was some information on display for people, for example, menus. Although these were not always accurate and some menus on the day of our inspection showed a different plan to the meals provided. There was limited information about planned social activities and events, access to other services or information which might be of interest to people living at the service and their visitors. However, the complaints procedure and information about recognising and reporting abuse were displayed. In addition, the provider had put up notices about the building works which included photographs and the names of the contractors carrying out the work.

The staff did not always make sure that people had enough to drink and did not take appropriate action when records indicated that people had consistently failed to meet hydration targets each day. We observed that throughout the inspection some people remained in their bedrooms and some people were seated in communal areas. Everyone had access to a cold drink at all times. However, people were not encouraged to drink these. In most cases, people did not drink at all and we noted that the drinks remained untouched for most of the day.

People needed support with drinking to prevent them from becoming dehydrated and whilst some of these people were given fresh drinks at lunch time, the staff did not note or record that the drinks they were taking away had not been touched. People in some parts of the service were not offered any hot drinks. No other form of liquid refreshments, such as fruit, frozen lollies or milkshakes were offered to people.

Some people had their fluid intake recorded. These records showed that some people regularly had less than 800ml of fluid a day. Whilst this risk had been identified for these people, care plans did not include strategies to increase people's fluid intake. Therefore, people were at risk of developing health problems related to low fluid intake and dehydration.

The staff had assessed the nutritional risks for everybody, however we found that the risk assessment for

one person had been wrongly scored. The actual level of risk for this person was high because of their age, fragility, history of weight loss and health conditions. However, the member of staff completing the risk assessment had calculated the risk as medium and therefore specific plans to support this person with their nutrition had not been developed.

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

The majority of nutritional assessments had been completed accurately. The staff reviewed these each month and people were regularly weighed. Changes in people's weight had been responded to by the staff making referrals to relevant nutritional professionals.

People gave us mixed feedback about the choice and quality of food, with some people telling us they enjoyed this but others did not. Some of the comments people and their relatives made included, ''I do not like the food and I have told them that'', ''I do not think they understand about food allergies because there is not much variety when you have a restricted diet'', ''There is enough food, I do not think the quality is that good but [my relative] will eat anything'', ''There is always food and snacks when I want them'', ''The food is mediocre, normally there is a menu but they haven't given us one for a couple of days this week'', ''The food is quite good'' and ''I can't grumble, it's alright.''

Some people received nutrition and hydration through a Percutaneous Endoscopic Gastrostomy (PEG) system. There were detailed care plans and regimes for supporting people with these. The staff followed these and their needs were being met.

The provider had undertaken assessments of people's needs and choices before and when they moved into the service. These assessments were sufficiently detailed and gave enough information to plan people's care. The provider followed national good practice guidance and tools to identify the level of risks and determine the type of interventions people needed. People had been involved in creating the assessments, therefore the assessments included information about their choices and preferences.

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

The provider had undertaken mental capacity assessments in relation to decisions about people's care. These were well documented and were linked directly to care plans. There was evidence that the provider had taken steps to enable people to make decisions. For example, they had arranged for someone to interpret on behalf of a person who did not speak English. Where people lacked the mental capacity to make decisions, the provider had made decisions in people's best interests by speaking with their legal and personal representatives, and these discussions were documented. The provider had made appropriate applications for DoLS when needed.

People were supported to access the health services they needed and their health and wellbeing was monitored. Information about people's health conditions was appropriately recorded. Nurses worked at the

service 24 hours a day and attended to people's healthcare needs. We saw that they had made referrals for additional care and support when needed and had made sure people were seen by external healthcare professionals. The GP surgery regularly visited the service and there was effective communication with the surgery and care home staff. Each person's care file included details of all health appointments and we saw that recommendations from external professionals were followed and included in care plans. The staff had responded promptly when people became ill and this was recorded.

The healthcare professional who was visiting the service on the day of our inspection told us that they thought the staff worked hard to meet people's healthcare needs and they had good communication with them.

Requires Improvement

Is the service caring?

Our findings

At the inspection of 27 September 2017, some people told us they had experienced the staff being rude. We also observed that some of the care provided did not show people respect or consider their individual needs and wishes.

At the inspection of 22 May 2018, we again observed some staff behaving in a way which did not show due respect towards people. For example, one member of staff mimicked the voice of a person they were describing, in a way which was not respectful and did not show understanding of the person's wishes. Two members of staff also described how they supported people in a way which met the convenience of their way of working rather than the needs and preferences of people. For example, they explained that one person liked to stay up late but that they always made sure the person was in bed by the time the night staff came on duty, even though the person did not want this. They also talked about how one person liked to be independent and do things for themselves, although they explained how they intervened to do things for this person rather than allowing them to take a long time. We observed this, when the person explained they did not want help cutting up their food, however a member of staff did this for them anyway.

The staff tended to focus on the tasks they needed to perform rather than people's choices and preferences. For example, a trolley containing food for lunch was bought to the ground floor just after 12pm. The food could be smelt and the staff explained to us (and people using the service) that the food had arrived. One person repeatedly told the staff how hungry they were. However, the staff did not provide any food for this person until 12.30pm. We discussed this with the staff and asked why they were not serving the food for this person, who was able to eat independently. They responded by saying that they did not serve lunch until 12.30pm but could not give an explanation for this.

People were not always given choices. For example, before lunch the staff placed paper protective aprons on all of the people seated for lunch in the ground floor dining room. No one was asked if they wanted to wear this and the staff did not explain what they were doing. Additionally, in two of the dining rooms, and for people in their bedrooms, lunch was served to everyone without the staff giving them a choice of meal or explaining what the meal was once it was served. People were served gravy on their meals without being asked if this is what they wanted and were bought drinks without being asked what they would like to drink.

People using the service and their relatives gave us mixed feedback about their experience with the way the staff treated them. Some people's comments included, ''They don't treat me with respect, they just get on with what they need to do and do not talk to me'', ''When they answer the call bell they just say, 'what do you want?' they are not very caring'' and ''When they bring me my food they put it down and leave it, sometimes I cannot reach it.''

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

However, some people told us that the staff were kind and they were happy with the support they received.

Their comments included, ''All the staff are very nice'', ''They are very good'', '''Some carers are good and others are not so good'', ''Some of the staff are kind'', ''Individual carers are lovely and I have never seen anyone being unkind'', ''They seem to do everything with a good heart'', ''The staff seem very pleasant'' and ''The people here are good at their jobs, they never pull a face or anything.''

We also observed some positive interactions where members of staff spoke with people in a kind and caring way. For example, in one part of the home people were asked what they wanted for lunch and given a choice of two meals. We observed one member of staff having a little dance with a person whilst taking time to explain about lunch. In other examples, we saw a nurse taking someone's blood pressure. They explained to the person, "I am going to take your blood pressure. This might feel a bit tight. I am sorry" then reassured them by saying, ''Do not worry it is all perfectly normal''; And we overheard a member of staff complimenting how a person looked when they assisted them to put their cardigan on. Some of the staff supporting people during meal times did this in a calm way, speaking gently to them and making good eye contact.

Most people told us that they had been involved in planning their care or that their relatives had. We saw evidence of consultation with people in their care plans. There was information about their preferences and when they had made specific decisions. One person explained, ''I am involved in making decisions and they ask me about the care plan.'' However, no one we spoke with told us they had been asked whether they had a preference for same gender care workers. Their comments included, ''I don't mind if I have male or female carers but I wasn't asked'' and ''It has never been discussed with us about whether we want male or female carers.''

People who followed a faith told us that they had access to religious leaders and services to meet these needs. People's religion, background and basic information about their culture were recorded in their care plans. One person could not speak or understand English. A small number of staff working at the service could speak the person's language but for the majority of time they did not receive support from staff who could understand them or who they could understand. There was no evidence that the staff used communication aids, such as pictures or learning basic words from the person's language and they told us that they communicated mostly by pointing. We discussed this with the provider so that they could think about ways to enhance their communication with this person. Following the inspection, the provider contacted us to let us know that they had made progress in this area, such as updating this person's care plan with information about their communication needs and providing staff with key phrases so they could use these when speaking with the person.

People told us that the staff respected their privacy and provided care behind closed doors.

Requires Improvement

Is the service responsive?

Our findings

At the inspection of 27 September 2017, we found people's care needs were not always planned for or recorded. People were not always supported in a way which met their needs and reflected their preferences.

At this inspection on 22 May 2018, we found this was still the case.

People using the service and their relatives told us that their basic care needs were being met, but most people felt that there was not the level of support they wanted or expected. Some of their comments included, ''They only do the basics'', ''If I ask they help me'' and ''The staff do not seem to understand the basic simple things.''

People told us that they did not have access to regular showers or baths and were not offered these. One person commented, ''You don't get offered a shower, it is terrible.'' Another person told us, ''I want a shower twice a week and I have told them this but I don't remember when I last had one, no one asks you if you want one.'' The records of care provided confirmed that people were not regularly offered or given baths or showers. The staff explained that most people were supported to wash or received bed baths. This did not reflect everyone's choice. We discussed this with the manager and provider's representatives. They told us there was no specific form for recording when person care was given or baths and showers were offered and that these interventions should be recorded in daily care notes. The provider explained they had identified that this was not always happening and had started to take action to improve this.

People using the service told us that they were not offered things to do or ways to spend their time. Many people we spoke with told us they felt lonely and did not have anyone to talk to. Some of their comments included, ''I am not happy with my care because the only person I talk to each day is [my relative] when they visit me'', ''The staff never have conversations with me. Sometimes they ask me about my [ex-partner] but I do not want to talk about [them]'', ''The staff do not talk to me much'', ''I never talk to anyone'' and ''The nurses talk to me if there is a problem but not about anything else.''

Our observations were that the most people did not have opportunities to engage in conversation or sustained interactions. People who remained in their bedrooms were checked by staff each hour, but these checks did not include interactions, or only brief greetings. Most of the people seated in communal areas were not involved in any conversations or activities for the duration of the day. The television was turned on in all three lounges but people were not offered a choice about what they wanted to watch and most people spent their time asleep or looking elsewhere in the rooms. At least one member of staff was present in lounges at all times, but for the majority of time the staff did not speak with people other than when attending to a task. No one was offered any activity to do other than having visitors . People using the service and their relatives confirmed this was the norm with comments that included, ''It is outrageous, there is never any activities and there have not been for six months, the staff tick a box to say they have provided an activity but they have not'', ''I wish there was somewhere they would take people, like a local park'', ''I just want to go out sometimes'' and ''It doesn't really matter we get used to it.'' One relative commented, ''Someone once read a newspaper to [person] which I think was great.'' However, this was not

a regular occurrence.

Records of care provided confirmed that people did not take part in a range of social or leisure activities which met their needs and preferences.

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

The manager told us that they were aware that improvements were needed in meeting people's social and emotional needs. The provider was actively trying to recruit a member of staff to take a lead in providing social activities. The manager told us they would also speak with the staff to make sure they engaged with people and found ways to provide them with something to do and people to speak with.

People's care needs had been recorded in care plans. However, the records were not always clear. The care plans still included information written by staff working for the previous provider as well as more recently recorded information. Therefore, it was not always easy to identify people's current care needs. This was particularly a concern because of the high number of temporary and new staff supporting people who relied on the records to understand people's needs. The provider had started to address this by creating short guides outlining people's main care needs, which they placed in bedrooms. These were not in place for everyone at the time of the inspection and did not always give information about people's preferences. However, the manager explained that this work was in progress and they hoped to have these up to date short care plans in place for everybody soon.

Additionally, the provider was rewriting all care plans so that the information was recorded on their paperwork only and included only current needs.

People using the service and their visitors knew how to make a complaint and felt that these would be responded to. Information about making a complaint was displayed and people were given a copy of the provider's complaints procedure. One person explained to us, ''I have not made a complaint, but if I needed to I would speak with the sister in charge.'' A relative told us,' 'I made a complaint once and they looked into it. I try to work with the staff if there is something wrong.'' The provider kept a record of all complaints and how these had been investigated and responded to. There was evidence that information from complaints was considered as part of the provider's audits and action plans for improvements.

Some people were receiving care at the end of their lives. There was evidence of close work with external palliative care teams who offered support for people and their families and advice for the staff.

The provider had clear records showing the discussions that had taken place with people using the service, their representatives and other professionals about specific wishes at the ends of their lives. This information included where people had made a choice that they did not wish to be resuscitated in the event of them becoming very ill. The staff had easy access to this information so that they would be able to see quickly if a person wished to be resuscitated so that they could provide this care if needed.

Requires Improvement

Is the service well-led?

Our findings

At the inspection of 27 September 2017, we found the provider's systems for monitoring and improving the quality of the service were not always effective.

At the inspection of 22 May 2018, we found this was still the case. Whilst improvements in some areas were noted, the provider had failed to meet the requirements notices `made at the last inspection. In addition, the had not always identified, assessed and mitigated the risks to people's safety and wellbeing.

During this inspection visit we identified a number of breaches of Regulations. People were placed at risk because the provider's checks on the safety of the environment and equipment had not identified or mitigated risks that were present on the day of the inspection. In addition, assessments of individual risks did not always include plans to support people to minimise the risk of harm. People did not always receive their medicines as planned because the staff were not always applying prescribed topical creams. There were insufficient plans to support people who were at risk of dehydration.. The staff were not always meeting people's needs or treating them with dignity and respect. The systems for monitoring, supervising and guiding staff were not always being implemented effectively to prevent this from happening.

This was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider discussed with us that there had been a negative impact of several changes of management at the service and this had meant that improvements had not taken place as quickly as they had planned. The provider had an action plan for meeting the outstanding actions and they kept this under regular review, taking into consideration the time it would take each new manager to settle and start to make improvements.
The provider's action plans for improvement demonstrated that they were taking action to address the outstanding breaches of Regulation and had plans for improvements to be made.

Some of the people who we spoke with were not happy with the service. Their comments included, ''There is nothing good about living here'', ''Going to bed at night is the best thing about being here'', ''Nothing will ever get better because there is no one here to listen'' and ''I hate it here, the only good thing is the television.'' One relative also commented, ''I am disappointed that the provider has not made improvements.'' However, other people told us they liked the service and felt the staff were good. Their comments included, ''They are very good to me and I am happy'', ''I like being here'', ''We are extremely happy, this is by far the best home'' and ''They are really quite good here.''

The staff who we spoke with told us they liked working at the service and felt supported by managers. One of the permanent members of staff told us, ''It's hard but I like it, we have a lot of training. If we are worried about something we can speak with the manager or nurse.'' One of the temporary agency staff explained, "I am loving it here – it is totally different from working in hospitals. Here you can build a rapport with people and see them every day. I am supported by the manager and she seems very nice.'' Another member of

agency staff said, ''It's good working here. The permanent staff are friendly and helpful. They gave me an induction when I came here the first time. All staff are caring and respectful here. If I saw something bad, I would inform the nurse or the manager."

The manager had been in post for two weeks at the time of our inspection. They told us that they had started the process of applying to be registered with the Care Quality Commission. They had previously worked at other care homes and were a qualified nurse. People using the service, visitors and staff spoke positively about the manager. Some of their comments included, ''I think the new manager seems very good, but she is the fifth one so far since [my relative] has been here so I do not expect her to stay'', ''You can tell the difference [the manager] has made in a short time'' and ''The manager is good and approachable.''

We noted that the manager demonstrated a good knowledge of individual people and their needs. They addressed people by their names and showed that they knew the person and how they liked to be spoken with. They were caring and kind when approaching people.

The provider's senior managers regularly visited the service to undertake audits and help with improvements. For example, the provider's quality and compliance inspector along with the regional director carried out a full audit of the service each month. They recorded where improvements were needed and helped the manager to develop an action plan in respect of these. We saw the provider's action plan and this was comprehensive and had captured most areas of concern which we identified. Other managers working for the provider were helping to update and improve records.

During the inspection we identified that care records were not always clearly recorded and some information was out of date. The regional director told us that the provider used an electronic system of care planning which they were hoping to introduce to the service. However, there had been delays in the implementation of this because of various reasons, including staffing shortages, and therefore they were in the process of updating paper records before the transfer to the electronic system.

The local authority quality team carried out regular monitoring visits of the service. They told us they felt there had been improvements in most areas and they were confident in the provider's continued improvements. They told us that their main area of concern was the lack of social and leisure activities.

The staff working at the service and for the provider carried out a number of regular audits which included, infection control, safeguarding, accidents and incidents, care records, staff records, mealtime experiences and health and safety. These were recorded and concerns had been identified and acted upon. The change over of managers had resulted in a period of time with less audits than the provider intended. This was partly the result of no handover period between managers. However, the new manager told us that they had a plan to ensure that regular checks and audits took place in the future.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not always provide care and treatment to service users which was appropriate, met their needs or reflected their preferences. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not ensure that service users were always treated with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not always provide care and treatment in a safe way for service users because they had not always assessed the risks to the health and safety of service users or done all that is reasonably practicable to mitigate these risks. Regulation 12(1) and (2)(a) and (b)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs

The registered person did not ensure that the hydration and nutrition needs of service users were always met.

Regulation 14 (1)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not operate effective systems and processes to assess, monitor and improve the quality of the service or to identify, assess and mitigate risks relating to the health, safety and welfare of service users. Regulation 17(1) and (2)(a) and (b)

The enforcement action we took:

We have issued a warning notice telling the provider they must make the necessary improvements by 30 September 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had not ensure that persons employed by the service provider received appropriate support, professional development, appraisal or supervision as necessary to enable them to carry out the duties they were employed to perform. Regulation 18((1) and (2)(a)

The enforcement action we took:

We have issued a warning notice telling the provider they must make the required improvements by 31 August 2018.