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Windsor Care Home

Inspection report

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13 October 2016

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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

The last inspection of this service was carried out on 9 and 11 May and 4 June 2016. At that time we found the provider was failing to meet legal requirements. The provider had breached Regulations 9, 10, 11, 12, 13, 14, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During the previous inspection we concluded people who used the service were not safeguarded because incidents were not reported or acted upon. People were not fully protected against the risks associated with medicines because the provider did not manage medicines appropriately. People were not protected against the risks associated with infection because of inappropriate staff practices relating to hygiene. People were not protected against the risks of receiving unsafe care because care was not planned and delivered to meet their individual needs or risk assessed to ensure their safety and welfare.

During the last inspection we also found people's dignity was not being upheld. People's capacity to make decisions and their consent were not always sought in line with legal requirements. People's hydration and nutritional needs were not being managed in a way that was safe or met their needs. The service failed to deploy enough staff across the home in order to safely meet the needs of people who used the service. Staff had not been subject to robust recruitment processes and checks. Staff had not completed the appropriate training to enable them to carry out their roles effectively. The provider's quality assurance systems were ineffective and did not make sure people received a safe and good quality service.

We carried out this inspection on 12 and 13 October 2016. The first day of the inspection was unannounced so the provider and staff did not know we were coming.

Since the last inspection the registered manager had left and their registration was cancelled by CQC. A new manager had recently taken up post and was in the process of applying for registration. 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.

During this inspection we found there were continuing breaches in relation to six regulations. Potential risks to people's well-being were not assessed or set out so staff had no guidance about how to manage those risks. For example there were no risk assessments about potential choking for people who had swallowing difficulties.

Medicines were still not managed in a safe way. This was because people did not always receive their medicines in the right way and records had not been completed correctly placing people at risk of medication errors.

People were still not always being supported to meet their nutritional needs in a safe way. Some people

were being given the wrong texture of food which could present a choking risk. People did not have access to drinks whenever they wanted which did not promote good hydration.

During this inspection we found that where people may not have capacity to make decisions around their care, staff had not always completed capacity assessments to check or carried 'best interest' decision meetings with others. For example if people used a lap belt whilst they were in their wheelchair, we could not find evidence of whether they consented to this or documented capacity assessment about whether this was done in their best interests.

There were still significant gaps in training of care staff and competency checks of nurses, although there were plans for improvement in this area. The new manager had begun to plan one-to-one individual supervision sessions for each staff member. However, only senior members of staff had had these so far.

The provider's quality assurance processes were still ineffective. Although audits had been carried out to check some areas of quality and safety, such as care plans and medicines, these had not resulted in improvements.

At the last comprehensive inspection this provider was placed into special measures by the Care Quality Commission (CQC). This inspection found that there was not enough improvement to take the provider out of special measures. CQC is now considering the appropriate regulatory response to resolve the problems we found.

We did find that improvements had been made to safeguarding processes, staffing levels, recruitment of staff and people's dignity. The new manager understood safeguarding processes and had worked with the local authority to look into any concerns. All staff were being retrained in safeguarding and staff who had raised any concerns told us these were being listened to and acted upon. There were sufficient staff on duty to support the 50 people who lived there at the time of this inspection. The provider had agreed to maintain these staffing levels during the process of improvement to the service.

All necessary checks and clearances were carried out for potential new staff and they were only recruited if these were satisfactory. During this inspection we saw staff engaged people in discussions and activities, and supported people in a way that upheld their dignity.

Some people and relatives felt it was a safer place and that improvements were being made to staffing. One visitor said, "There's always somebody around. I feel comfortable knowing she's here."

We found people had access to health care services and staff were more responsive to seeking medical intervention if people were poorly.

The people who were able to express a view about the service they received said that they were happy with the care. One person said, "There are some very compassionate people who do the job with care."

There were some opportunities for people to go out and for community events to come into the home, although this was limited for people who had to spend their time in bed.

Relatives and staff said the new manager was approachable and acted on their comments. Relatives felt there had been recent improvements since the change in management. One relative told us, "There seems to have been a bit of an impetus." They were pleased that "they are not changing the staff around as much". Another visitor said, "It's getting better."

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

Risks to people's well-being were not assessed so staff had no guidance about how to manage or minimise those risks.

Medicines were not always managed safely for people and records had not been completed correctly.

Improvements had been made to the way safeguarding concerns were listened to and dealt with.

There were enough staff on duty and they had been recruited in a safe way to make sure they were suitable for their role.

Is the service effective?

Inadequate

The service was not effective.

Consent to care and treatment was not sought in line with legislation and guidance.

People were not always being supported to meet their nutritional and hydration needs in a safe way.

Staff had more opportunities for staff training and support although this was on-going area for improvement.

Is the service caring?

Requires Improvement

The service was not always caring.

Care records were not always kept in a confidential way by staff.

People and relatives felt staff were caring and friendly. Visitors felt there was a welcoming atmosphere

Staff encouraged and supported people to make their own choices.

Is the service responsive?

Inadequate

The service was not responsive.

People's care records did not always include the right guidance for staff about their specific needs. This did not protect people from the risk of inappropriate or inconsistent support.

There were activities for people to participate in to support their social care needs.

The service had a complaints procedure in place that was accessible to people and their relatives.

Is the service well-led?

Inadequate

The service was not well led.

The provider's quality assurance system was poor, because identified shortfalls had not been so necessary improvements had not been made.

The home did not have a registered manager. People and staff said the new manager was open and approachable.

People, relatives and staff felt they were now asked for their views and could make suggestions about the service.

Windsor Care Home

Detailed findings

Background to this inspection

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

This inspection began on 12 October 2016 and was unannounced. The inspection team consisted of three adult social care inspectors, a pharmacy inspector, a specialist nutrition nurse 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. A second, announced visit was carried out on 13 October 2016 by two adult social care inspectors.

Before the inspection we reviewed information we held about the service. This included previous inspection reports and statutory notifications sent to us about the events and incidents that happened at the service. Notifications are changes, events or incidents the provider is legally required to let us know about. We had regular contact with the commissioners of the relevant local and health authorities and the local safeguarding authority to obtain their views of the services delivered at this home. We also contacted the local Healthwatch groups in each of the three local authority areas to obtain their views. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with six people who used the service and 11 relatives who were visiting the service. We observed a lunchtime meal and experience in two dining rooms. We undertook general observations of how staff interacted with people as they went about their work.

We spoke with the manager, deputy manager, three nurses, two seniors and six care workers, a cook and a domestic worker. We also spoke with the provider and a care consultant who had been contracted by the provider to help improve the service at the home.

We looked at nine people's care files, as well the nutrition assessments for five people and the medicine records for 12 people. We viewed the recruitment records relating to three new employees, training records

relating to 83 members of staff and quality monitoring reports carried out by management since June 2016.

Inadequate

Is the service safe?

Our findings

At the last inspection in June 2016 we found people's care needs were not always appropriately assessed, managed or reviewed in an effective way. Since then the care needs of people had been reviewed and their care records were being rewritten. However during this inspection we found people's records did not always include assessments about significant areas of risk. For example some people had difficulties with swallowing but there were no risk assessments about their risk of choking.

Where risk assessments were in place these were written in a brief, generic style that did not provide staff with information about identified risks and the action they needed to take to minimise the risks. For example, one person had a risk assessment that stated the hazard was 'Alzheimer's', but did not detail any specific risks from this diagnosis. In other risk assessments there were brief descriptions of hazards such as 'unable to weight bear' but there was little detail of the control measures the staff should use to reduce the risk.

Some areas of the risk assessments were contradictory. For example the home was using two different types of nutritional assessment; one was a 'nutritional risk assessment' and the other was a malnutrition assessment support tool. In some cases these assessments identified different levels of risk for the same person. Risk assessments were not kept under review. For example, one person's risks assessment identified them as being at a high risk of falls. However this had not been reviewed in over six months.

In discussions one person's relatives said they received differing accounts of their family member's needs from different staff so were concerned staff may not always be following the correct plan of care. Some of the care records we looked at contained contradictory information. During this inspection we asked the manager to arrange for three people's care files to be updated immediately and for the staff team to be instructed in the changes. This was because there was a risk that those people might receive inappropriate care because their care records were wrong. This was addressed overnight and we saw these care plans had been updated to reflect those people's specific needs.

At the last inspection in June 2016 we found the arrangements for the management of people's medicines were not always safe. During this inspection we found the arrangements for the management of medicines were still not safe.

Records relating to medicines were not completed correctly placing people at risk of medication errors. Medicine stocks were not properly recorded when medicines were received into the home or when medicines were carried forward from the previous month. This is necessary so accurate records of medicines are available and staff can monitor when further medicines would need to be ordered. We also found gaps in the records we looked at where staff had not signed for the administration of medicines. It was therefore not always possible to confirm if staff gave people their medicines as prescribed.

We also saw that some creams were applied by care staff. Although the home had a policy stating clear information on where to apply and the frequency of application should be available for staff, we saw this

was incomplete and the recording of the application of these products was poor. Staff told us that one person had red sore skin however we saw no records of application of the person's prescribed barrier cream.

When we checked a sample of medicines alongside the records for 12 people, we found that ten medicines including oral medicines, inhalers and nutritional supplements did not match up. This meant we could not be sure if people were having their medication administered correctly. Five medicines for three people were not available in the home. This means that appropriate arrangements for ordering and obtaining people's prescribed medicines was failing, which increases the risk of harm. Where people could have medicines, such as painkillers, in variable doses (one or two tablets) it was not always recorded how many they had been given.

For a medicine that staff administered as a patch, a system was in place for recording the site of application; however, staff had not fully completed this for one person whose records we looked at. This is necessary because the application site needs to be rotated to prevent side effects.

Some people had medicines administered covertly. This is when medicines are given in food or drink to people unable to give their consent or refuse treatment. We saw that the GP had authorised covert administration (adding medicines to food) for people who did not have capacity and were refusing essential medicines. However, the information on how this would be done was not clear and there was no information to confirm that guidance had been sought from the pharmacist to make sure that these medicines were safe to administer in this way. This information would help to ensure people were given their medicines safely when they were unable to give consent.

Most of the people who used this service had their medicines given to them by the staff. One person was self-administering some of their medicines. However, a risk assessment had not been undertaken to ensure they were safe to do so.

All the above matters were a continuing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines kept at the home was stored safely. Appropriate checks had taken place on the storage, disposal and receipt of medicines. This included daily checks carried out on the temperature of the rooms and refrigerators that stored medicines. Staff knew the required procedures for managing controlled drugs. We saw that controlled drugs were appropriately stored and signed for when they were administered.

At the last inspection of this service in June 2016 we found the service was not safe for the people who used it. This was because the service had failed to take appropriate action to investigate and refer suspected abuse to the appropriate body.

During this inspection we found improvements had been made. The manager had acted upon any concerns relating to the protection of people who used the service. They were clear about their responsibility to report any concerns to the local authority and had done so in line with safeguarding adult protocols. For example, since the manager took up post in September 2016 they had reported incidents involving an altercation between two people who lived at the home and medicines errors. In this way the manager was working in collaboration with the local authority safeguarding team and commissioners to deal with any concerns.

The staff we spoke with said this was an area that had significantly improved since the last inspection. They felt able to speak about any issues with the new manager and were now confident that these were dealt with. For example, a care worker said, "There have been changes for the better. The manager listens to you

and acts. I raised concerns in the past and nothing got done about it, but he listens and does things." Staff were aware of safeguarding and whistleblowing procedures. Two thirds of the staff team had had refresher training in safeguarding since the last inspection and there were plans for remaining staff to update their training in safeguarding.

At the last inspection in June 2016 we found there were insufficient staff deployed to meet the needs of the people who lived there at that time. Since then some people had moved to other services and the number of people with very complex nursing needs had reduced. The home had maintained the same staffing levels which meant there were fewer people with less complex needs to care for.

Most people and relatives we spoke with felt there were enough staff on duty to support people. For example, one visitor said, "There's always somebody around. I feel comfortable knowing she's here." One person felt they sometimes had to wait for assistance depending on what else was going on at the time.

One relative said, "The girls really care, I think [my family member] is safe. Obviously we know what went on (referred to previous inspection report) but the care is great. The reason we like it is there's always staff around. There are two staff in this lounge and if you go to the other area staff will be there too."

During the inspection visits there was a timely response to call bells, although there were few occasions when they rang. Throughout the inspection we saw staff supported people in a calm and unhurried way. We saw staff were present in lounges and other communal areas where they could supervise people's well-being.

The staffing rota for a four week period showed there were usually two nurses, two senior staff members and 12 care workers on duty through the day to support the 50 people who lived at the home. At this time staffing was not calculated on a specific staffing tool as it had been agreed with local commissioners to maintain these staffing levels to facilitate improvements to the service, including care records. The manager described a staffing level tool that was intended to be introduced following a review of each person's dependency levels, although work on this had not commenced. At this time the staff levels were consistent and in line with local authority commissioners' requests.

At the last inspection in June 2016 we found recruitment practices were not robust or effective. This was because some staff had been employed without satisfactory checks of their conduct or identity.

During this inspection we found improvements had been made. Since the last inspection a small number of new staff had been recruited or were going through the process of recruitment. New staff had not begun to work until all necessary checks and clearances had been received and were satisfactory. We saw references, Disclosure and Barring Service checks (to check if a person had a criminal record or was unsuitable), previous conduct and identity were checked before new staff commenced in post. New staff were provided with an induction period before they worked unsupervised.

Improvements had been made to the recruitment process to ensure an applicant's experience in care and motivation to work in care was explored at both application and interview stage. Nursing and Midwifery Council checks on all nursing staff had been completed to ensure their registration was in date.

At the last inspection in June 2016 we found infection control measures were not adequate. This was because staff did not change their personal protective equipment (PPE) when going from bedroom to bedroom or after supporting different people. During this inspection we saw staff wore and disposed of PPE in the correct way. There were no odours anywhere in the home and all areas we viewed were clean.

We found sufficient stocks of PPE were available around the home for staff to access and use. Staff were able to describe the types of infection control used in the home. One senior care worker told us, "We have notices about hand washing, we have red bags for soiled laundry, all carers use PPE, it's part of our job." Ancillary staff had a schedule of cleaning they followed and they had a colour-coded rota so they knew which areas of the home they were working in each day. This meant all areas of the home were cleaned in a timely manner.

Inadequate

Is the service effective?

Our findings

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

At the last inspection in June 2016 we found the provider had breached a regulation relating to people's consent. This was because the previous manager and staff did not understand or act in accordance with the principles of the MCA and the Deprivation of Liberty Safeguards (DoLS), which meant they failed to act lawfully to support people who lacked capacity to make their own decisions.

During this inspection we found that where decisions had been made on behalf of people around their care, staff had not always taken steps to complete capacity assessments or 'best interest' decisions within a multidisciplinary team framework. For example, a mobility and falls risk assessment was in place for one person which stated they need to wear a lap belt and calf strap whilst they were in their wheelchair. There was no evidence of a documented capacity assessment or best interest decision having taken place in relation to the use of this potentially restrictive practice.

Another person used bed rails to prevent them from falling from bed. A bed rails risk assessment was in place and had been reviewed on a monthly basis. A capacity assessment had been completed by two senior care staff, however there was no date recorded to review the decision. A recent best interest decision was in place but there was no detail to see if any other, least restrictive, options had also been considered.

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

At the last inspection we found people's hydration and nutritional needs were not being managed in a way that was safe or promoted their health and wellbeing. During this inspection we found there had been some improvements. For example, people's care records now included the guidance from dietitians and speech and language therapists (SALT) about how to support people. A new chef had recently been appointed who understood the different textures of food that people needed. However there were still concerns that people were not always being supported to meet their nutritional needs in a safe way.

We found staff had given wrong advice to relatives about the consistency of food they could give to their family member, for example yoghurts. This was incorrect because the person needed a thickening powder

added to drinks and food needed to be smooth and unable to pass through a fork to ensure they swallowed it safely. The person needed to be sitting upright in their bed or chair when eating and drinking but staff had left a yogurt for the relatives to give to the person without raising the bed. Also, the yogurt was not safe to be given as it did not meet the thick puree descriptor of being unable to pass through a fork. The inspection team asked staff to do this. The person was also being given a tablet in their thickened drinks, but this altered the texture of the drink so could present a choking risk.

The person's care plan was not clear about this as their other medicines were in powder form. We told the manager about this concern because staff may not have been supporting the person in a safe way. On the second day of inspection the care plan had been rewritten, staff we talked with were able to describe the right way to support the person and the GP had agreed to provide the medicines in a suitable form.

Another person's care file included the SALT and dietitian recommendations which stated they should be provided with a pre-mashable diet, for example finely minced food or in extra thick sauce. On the day of this inspection the person was given the wrong texture of food (fork-mashable) which had made the person start to choke. Staff immediately supported the person who quickly recovered from the incident.

For people who needed to have their food and fluids monitored the records of their intake were poorly filled in. For example some charts showed gaps of over four hours through the day with no recording of whether any drinks had been given. There were no target amounts set out in care plans or on fluid charts so it was not possible to know whether each person had had the right daily amount of fluid they needed. There was no indication of what staff did or should do if the person did not drink enough. One person's catheter care plan stated, 'Staff to ensure [person's] fluid intake is meeting their daily targets.' We found no record of the daily target so were unable to assess if the person was being supported appropriately.

Tea was served mid-morning and mid-afternoon. During the morning of the inspection tea was given out in an upstairs lounge with no biscuits or snacks. The care staff stated they were unable to go to the kitchen as they could not leave the lounge unattended. There were no jugs of water or juice in the lounge. We saw a water cooler in one ground floor lounge which was disconnected. Two other lounges had drinks dispensers which were empty.

There was a small kitchen area in the lounge where staff could made drinks for people but this appeared to be only at set times. For example when a resident asked for a cup of tea they were told the tea would be coming round soon. During meal times there was no juice or water served or offered. Tea was only offered once the dishes were cleared away. This did not encourage or promote good hydration.

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

At the last inspection in June 2016 we found that few staff had necessary training in basic health and safety or other mandatory training such as safeguarding. During this inspection we found that some improvements had been made. Around three-quarters of the full staff team had attended safeguarding training; half the care staff team had attended updated training in first aid; and just under half had attended updated moving and assisting. Some staff had also attended training in infection control and health and safety.

Although this was an area that was improving there were still significant gaps in training of care staff and competency checks of nurses. For example, some people were living with dementia but the training matrix showed that only three staff had had training in dementia awareness.

There was no evidence in the training files of the seven nurses of their assessed competency for areas such as catheter care and tube feeding. Only two nurses had attended a pressure ulcer management and prevention session, and a training session around epilepsy. Documents for medicine competencies of nurses had not yet been completed.

A supervision matrix was in place which showed some staff had had supervision from July 2016 onwards. The manager explained they were focusing on completing supervisions with the nurses and senior care staff who, when competent, would go on to supervise the care staff. This was an area that was still being addressed. This was because most staff had not received supervision or appraisals, so they were not being offered support in their role.

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

The manager explained that arrangements had been made with a new training company to deliver mandatory training in the first instance and there would be plans to introduce further training based on individual staff needs for example in dementia care, challenging behaviour and specialist areas of health needs such as epilepsy and diabetes. The manager told us, "All staff are doing the self-audit for the Care Certificate (a national set of learning outcomes for staff working in care) to assess their training needs and identify any gaps in their training."

The staff we spoke with during this inspection were motivated about the training they had received so far and further training opportunities. For example one staff member told us, "We are getting more training, which we have asked for. I want refresher training. I'd like to know about palliative care and challenging behaviour."

Since the last inspection over two-thirds of the senior care workers and care workers had attended training in MCA and DoLS. The staff we spoke with had a good understanding of the principles of the Act and the reasons for it. For example, one care worker told us, "DoLS is about people who say "no, no, no" but need things done. It allows us to work in their best interest. We always explain things but sometimes it just has to be done." Senior care worker were beginning to complete capacity assessments where required. This was an area of on-going development.

We found people had access to health care. Care records contained details of referrals to other health care professionals. For example, GPs, speech and language therapists and district nurses.

We asked the staff how people's health needs were supported. One nurse described how they had requested a referral from the GP for an urgent care call because they felt someone had an infection. Another told us, "We have a daily handover, so information can be passed over if someone is not well." We saw records of one person not being well in the night. The service had been responsive, checking their temperature and organising emergency support.

Requires Improvement

Is the service caring?

Our findings

The people who were able to express a view about the service they received said that they were happy with the care. One person said, "There are some very compassionate people who do the job with care." They described caring staff as the ones who "make you feel how you want to feel".

Most visitors felt that the staff approach to their relative was very good. One relative commented, "They're smashing - they are really good. They all say they love [my family member]." One visitor told us, "(Staff are) all very caring - there's a good rapport between them (and my family member)." Another said, "Some are exceptionally caring and good with my [family member]."

Other visitors' comments included, "staff are nice" and "the staff are so brilliant". One relative felt that a particular care worker was "very hands-on". They told us, "(She) talks to the client in a way they want to be spoken to. She's very caring and professional." They went on to name other members of staff who they thought were good. They said, "I find them all to be the same - I know that they would look after (name) really well". However some visitors felt the caring nature of staff and effectiveness of care varied between staff. One said, "It depends on which member of staff."

Relatives were able to share in the care of their family members. For example one person and their spouse were sitting together on a couch having lunch from a side table. The spouse received their lunch every day at the home because it encouraged the person to eat their meal too. Another relative gave an example of how they felt involved and had devised checklists (to ensure their relative was comfortable). They showed us how staff had responded positively to their involvement by using the checklists. They had added an information sheet to the care plan suggesting reasons for any distress and how to address these.

Staff told us there had been improvements since the last inspection to the opportunities for social interaction with people. A nurse commented, "There's more time to spend with residents so we can have a chat and a laugh now." We saw some good examples of staff interaction with people through the day, although during the mealtimes there was less engagement as staff were busy taking meals to other people in their rooms. This meant some people did not get much encouragement with their meals, although people who needed physical assistance with their meals were supported with this.

One visitor gave an example of how their family member was encouraged by the care workers to make choices. They said, "They choose her clothes together." One person told us that if they didn't want to do something staff would respect that and "put it off today".

People were offered choices through the day such as activities and meals. People chose from two main dishes at the time of the meal. We were told by staff that people could have food that wasn't on the menu and staff did try to offer this where people were able to decline both main choices. The menu boards were incorrect on the day of our inspection and the meal choices were written in red pen which was difficult to read. Also in one small dining room we saw tables were set with a placemat and serviettes on the table but there was no cutlery, crockery, condiments, or drinks on the table. There was no decoration to make to the

tables look appealing.

We saw examples of care practice that upheld people's dignity. For example, one person was provided with a spoon for their meal as it supported and encouraged them to eat independently. We saw the person was offered assistance in a dignified way to clear up some of fallen food.

One person said that staff protected their privacy. Another person said that staff "explain everything and make you feel at ease". A visitor described how privacy was maintained in relation to their family member's personal care. They told us, "They close the curtains and ask me to leave." They also said that they speak to them privately on matters of care and added "I think they do treat [my family member] with respect."

The visitors we spoke with said they felt welcome in the home. One relative said they were made to feel comfortable and were offered to "stay for lunch and tea here". Relatives felt that care home staff kept in touch with them and notified them if their family member was not well.

It was good practice that staff spent time with people in lounges to complete records. However there were occasions throughout the two days where staff left records unattended whilst they supported people out of the lounge which could compromise the confidentiality of those records.

Inadequate

Is the service responsive?

Our findings

At the last inspection of this service in June 2016 we found the provider had breached a regulation relating to the personalised care and treatment of people who used the service. During this inspection we found there were continuing shortfalls because care records did not always reflect the current needs of people or contained inconsistent information.

One person was prescribed a medicine that could be used for agitation and anxiety. There was no care plan or guidance in place to assist care staff in their decision making about when it would be used. This meant different staff may support this person in an inconsistent way.

Another person was prescribed 'as and when required' medicines for support to manage behaviour that challenged. A written protocol was in place however this contained little detail about how and when to support the person. For example, it stated the person could have up to 4mg a day for severe anxiety and severe agitation. There were no descriptors for the level of anxiety and agitation, no information on strategies to try before medicines and no detail on the time to wait between doses.

One person's care plan stated staff needed to offer assistance with food. There was no description or personalisation about how much support they required and how to assist them. One person had a care plan about continence care but this did not specify the aids the person needed to support them to manage their continence needs. Another person had a catheter but their care plan about continence needs did not refer to this equipment. A hygiene care plan described the areas where a person was independent and could support themselves but stated 'Is fully reliant on staff to bath/shower' with no description of how staff should provide the care.

There was limited activity or social interaction for people who spent time in bed. For example we looked at the social isolation care plan for one person who spent much for their time in the bedroom. The last evaluation of the care plan was recorded in August 2016 and there were no references to any occasions where the person had been brought out of their bedroom. This indicated a lack of understanding about the importance of social care.

Some people's care plans stated they should be weighed weekly but this was a generic statement in many care plans even where people did not have specific nutritional needs. This meant there had been a blanket approach within the home rather than a personalised assessment of the individual needs.

The people who could express a view could not recall seeing a care plan which indicated they had not been involved in planning their own care. Some relatives felt involved in care planning and some had seen the care plan. Other relatives said they were concerned about the lack of adherence to specific instructions on care plans, for example in relation to hospital admission, positional changes or food textures.

The incomplete or contradictory information in people's care plans meant that we could not be sure that people received personalised care that was specific to their individual needs. This was beginning to improve

through review and re-writing of care plans but there were still on-going shortfalls to be addressed.

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

The manager had recently introduced core staff teams to each area of the home so that staff could become more familiar with people's individual needs and preferences. One staff told us "It's much better now we are working on the same unit. It is more consistent for people. I can tell staff who have been off what has been happening."

In discussions staff we spoke with understood people's needs and were able to explain how they supported them for example with their mobility, nutritional and behavioural needs. For example one staff member told us, "When [person] is agitated I know they are tired, so a lie on the bed for an hour really helps. [Person] does have (sedative medicine) but rather than give that they have an hour's sleep and they are fine." It was important that this knowledge was fully reflected in care records so all staff had this information and worked consistently with the person.

One person felt that staff had got to know them well. They said "Oh indeed, they get to know what you like and dislike." Another visitor said they had completed a form of their family member's preferences and "what wasn't on the form they find out from (the person)". They added, "If (name) is down they talk to them and encourage them."

The manager was introducing the 'This is Me' document for each person which included a personal profile and life history of the person so that these would be easily accessible in care files for staff to read.

The home employed an activities member of staff who arranged games, social events and leisure activities within the home with the support of care staff. The activity programme was on a four week cycle and included knitting, baking, board games, skittles, reminiscence, book clubs (including reading to people), jigsaws and gardening.

A second activities staff member had recently been appointed and was to take up post in the near future. Both activities staff members had lots of ideas of how they wanted to improve activity provision within the home. We saw care staff were more involved in supporting people in activities in the communal lounges such as one-to-one games.

There were some opportunities for people to go out and for community events to come into the home. The activities coordinator told us, "We have church services, the Jehovah Witnesses come in, and a local vicar at a weekend. We have recently been to the Customs House theatre and the Sunderland Dog racing. We'll be going to a pantomime and have singers come in. The miniature pony came in and is coming back and we are doing a Halloween party and getting relatives and people's grandchildren involved."

Some visitors felt there was little to stimulate those people who were confined to bed. One visitor commented, "Some days you come in and my [family member] is in the dark and there's not a sound in their room." Another relative also felt their family member would be socially isolated if they did not visit because staff did not spend time in the room other than for brief checks. When asked about supporting those people with activities the activities co-ordinator said this usually included talking to people and perhaps using a photo album as talking point.

There was information for people and their relatives in the service user guide about how to make a

complaint. The manager was proactive at dealing with any comments or concerns. People now had opportunities to raise issues at monthly residents/relatives' meetings. People and relatives said they had more confidence that these were listened to.

Recently the manager and care consultants on behalf of the provider had responded to some historic complaints that had not been managed well in the past. There was a complaints log which recorded the details of each issue raised, the investigation, any actions taken and the outcome was now reported to the person who had raised the concern. There had been 10 recorded complaints since the last inspection. These included issues about records, a person's appearance and personal hygiene. We saw these complaints had been addressed.

Inadequate

Is the service well-led?

Our findings

At the last inspection in June 2016 we found the provider had a breached a regulation relating to the governance of the quality and safety of the service people received. During this inspection we found the quality assurance systems used were still ineffective because they failed to address identified shortfalls.

We saw audits had been carried out in August 2016 regarding medicines management, health and safety and kitchen safety. We found the audits were not satisfactory as they did not include action plans or timescales to address the identified shortfalls. This meant it was not possible to determine what remedial action was required and when. As a consequence the shortfalls had not been addressed.

Audits of care plans had been carried out by the provider and by local commissioning officers on 7 September and 13 September 2016 respectively. The audits identified several gaps in completion of records but many of these had still not been addressed one month later. The care plan audit by the provider had not identified that individual people's care records were contradictory or did not match their needs. For example, one person's care plan stated they were 'compliant with their medicines'. However the person was not in a position to show compliance as their medicines were given covertly in food so they were unaware they were taking them.

In addition the audits by the provider had not identified the lack of risk assessments for some significant areas of people's individual needs. For example there were no choking risk assessments in place for people with swallowing difficulties. The care plan audit had not identified that where risk assessments were in place these were not fit for purpose as they did not set out the control measures to be used to mitigate the possibility of risk. Some of the anomalies in care records found during this inspection were not identified on the provider's audit tool.

The provider had compiled an action plan to address issues raised at the last inspection and issues identified by commissioning officers of the local authority. However the action plan was inaccurate as it referred to actions by staff who were no longer employed at the home. Also some areas were identified as having been addressed however these still required improvement (following this inspection the provider prepared a new action plan based on the on-going areas that required attention).

In this way the quality assurance system was still not effective in monitoring the safety and quality of the service care that was being delivered.

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

At the time of this inspection a new manager had been in post for three weeks and had applied for registration with CQC. The new manager was introducing new systems to support improvements to the service. For example, they were introducing a keyworker system for accountability of nurses and senior staff. It was planned that nurses and senior staff would supervise a team of staff to care for a small group of

people so they could become familiar with their needs. It would also mean that staff had a named line supervisor who they were responsible to. The manager had also introduced 'policy of the month' and had focused on safeguarding and DoLS one month and currently on bullying and harassment.

A new deputy manager had also commenced work at the home two days before this inspection. They had begun to assess staff competencies in the home. They told us, "Care records need to be far better than they are. The nurses and seniors need guidance. They need more support from management and to know that, if needed, they can ask for help. Staff have recognised there are training needs."

All the nursing and care staff we spoke with told us they felt that the new management team was making improvements to the service. One staff member said, "We are getting consistent messages from the manager. I'm more confident in him, he takes us seriously and confidentiality is kept. Communication is better." They added, "Morale is slowly picking up, we've been beaten and battered but we are getting there. We are worried if we are doing it right and want it to be person centred, we want the best for people."

A senior care worker told us, "The new manager is really good; we have a brilliant manager now, and it seems a good deputy as well. Support is brilliant. The new manager is doing supervision and appraisals. We can speak to them about anything, it's going to take time but we'll get there."

A care worker said, "There's been changes for the better. [Manager] listens to you and acts. I raised concerns in the past and nothing got done about it but he listens and does things. We have team meetings. We have support now and direction."

Staff told us there had been an improving culture within the home. They now felt able to approach the manager about issues and felt these were treated in confidence. Staff were able to describe concerns they had raised and said these had been dealt with appropriately and swiftly. One staff member told us, "Things are much better, I trust [manager], I can raise things with him and he acts and does things. Things definitely much better, I'm much happier now, I love my job and I come to work with a smile on my face now, I love it."

Relatives also felt there had been recent improvements since the change in management. One relative commented, "There had been an obvious lack of direction and management but the care is there." Another relative told us, "There seems to have been a bit of an impetus." They said they were pleased that "they are not changing the staff around as much". Another visitor said, "It's getting better."

Residents/relatives' meetings had been held on a monthly basis. The meeting was repeated at two different times on each date to allow more relatives to attend. The previous inspection report and rating of the home had been discussed with relatives and information shared with them about the provider's plans to improve the service.

Relatives felt their suggestions were now being addressed. For example, one relative described how the management had responded to a request of change of rooms and felt they had been listened to. Another visitor said they had asked at a recent resident/relatives meeting for staff to wear name badges. They felt the management team had listened to this and responded quickly.