Eastern Healthcare Ltd

# Brundall Care Home

## Inspection report

4 Blofield Road
Brundall
Norwich
Norfolk
NR13 5NN

Tel: 01603714703

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

Brundall Care Home is a residential care home registered to provide support to 39 people, some of whom were living with dementia. At the time of inspection there were 24 people using the service.

At the last inspection on 5 July 2016 the service was rated 'Good' overall. At this inspection we found that the service had been unable to sustain the improvements we observed at our last inspection. We identified widespread failings in the service which put people at risk of harm. The service is now rated 'Inadequate' overall.

The service did not have a registered manager. However, the person managing the home at the time of inspection was in the process of registering with us. 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.

At the 5 July 2016 inspection the service achieved a rating of 'Good'. This was following two previous inspections where the service had been rated 'Inadequate' overall and where the Commission took enforcement action against the service. The provider had ineffective systems in place to oversee the service and ensure its compliance. This meant that we found at this visit the improvements that had been made previously had not been sustained.

Risks to people were not always identified and clear plans to mitigate risks were not in place for all the people whose records we reviewed. The manager and care staff did not always recognise risks in the environment, such as items which could cause potential harm. Care planning did not always make it clear how care should be delivered to ensure people's safety.

Care planning around nutrition and hydration was not consistently clear about the support people required. The service did not follow National Institute for Health and Care Excellence (NICE) guidance around the assessment of nutrition and the actions required when people were assessed as at risk of malnutrition. NICE guidance is publically available and provides the reader with up to date information about best practice in providing care to people.

There were shortfalls in the way people's pressure care needs were assessed and care planned. This put people at risk of a deterioration in their skin integrity.

People and/or their representatives were not consistently involved in the planning of care. Care plans and the records we reviewed did not reflect people's views and preferences.

People's records were not consistently personalised to include information about their likes, dislikes, hobbies and interests. Where people were living with dementia, there were not sufficient life histories in

place. Care plans did not set out people's preferences around how they would like their care delivered. This meant that staff did not have the information needed to deliver personalised care.

Sufficient end of life care plans were not in place. The service had not referred to NICE guidance and the Gold Standards Framework to create care plans that set out people's wishes and needs in sufficient detail.

The environment was not safe. There were hazards which could compromise staff's ability to evacuate the building quickly in the event of a fire and some fire exit and evacuation signs were confusing. There were exposed hot water pipes throughout the service which posed a risk of burns if people were to touch or fall against them. We tested a sample of hot water taps and found two did not have valves to stop them reaching scalding temperatures. There were substances and items in some people's bedrooms that could be harmful to people if ingested in error. These included prescription creams.

The audit and management systems in place at the service were ineffective. The manager had not independently identified the serious safety concerns we identified and taken action to protect people. Whilst audits carried out on behalf of the provider had identified some of the shortfalls, prompt action had not been taken to ensure people were protected from harm.

Some parts of the service were cold and this had not been identified by staff or the manager. Staff opened windows around the service and did not have an awareness of how to support people to maintain a comfortable temperature.

Some interactions we observed were not kind and caring. We observed that staff became frustrated with some people using the service and did not demonstrate a knowledge and understanding of people living with dementia. There were no plans in place to guide staff on supporting some people who had behaviours that they found challenging.

People's capacity to make decisions was assessed and Deprivation of Liberty Safeguards (DoLS) applications had been made where appropriate. However, we observed that staff did not always provide people with opportunities to make independent decisions or request their consent.

There were not enough staff to provide people with care and support at the time they needed it. We observed occasions where there were no staff available to support people to mobilise safely which put them at risk of falls. We observed that a member of activities staff had to support care staff to meet people's needs, which took them away from providing activities and engagement for people.

The home was not decorated in a way that helped people living with dementia find their way around the building. We observed people finding it difficult to orientate themselves and requiring staff support to find their way to their bedroom or communal areas.

Staff told us they thought the training provided them with appropriate knowledge for the role. However, discussions with staff and observations meant we were not reassured staff were suitably knowledgeable.

Staff received regular supervision and appraisal. However, this was ineffective in identifying areas for improvement in staff practice.

There were safe recruitment procedures in place.

Medicines were managed and administered safely. However, some prescription creams were not stored

securely.

People told us they knew how to make complaints and felt they would be acted upon.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

Further information is in the detailed findings below.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

Risks to people were not consistently identified, acted on and management plans put in place.

Staff and the manager did not identify risks in the environment. Risks that had been identified had not been acted on which put people at risk.

Care plans did not always contain enough information for staff to provide safe care to people.

There were enough staff to provide care to people when they needed it.

Medicines were administered and managed safely.

### Is the service effective?

**Inadequate**

The service was not consistently effective.

The service did not ensure that people's care was planned in line with best practice guidance.

Care planning did not set out what support people required with eating and drinking in sufficient detail. It was unclear whether action had been taken to protect people from the risk of malnutrition.

Observations of staff practice and speaking with staff demonstrated that staff training had not been effective in all subjects.

Staff did not always request people's consent and support them to make independent decisions.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

People were not involved in the planning or review of their care.

People's preferences and views on their care were not reflected in care planning.

Where people were unable to verbally communicate, there was insufficient information available for staff around other methods of communication.

Not all the interactions between staff and people using the service were caring.

The service did not always respect people's right to privacy.

## Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

People's care plans were not sufficiently personalised and there were no detailed life histories in place for those living with dementia.

The service did not have in place sufficiently detailed end of life care plans for people.

People did not always have access to consistent engagement in meaningful activity.

People knew how to make complaints and there was an appropriate procedure in place for handling complaints.

## Is the service well-led?

**Inadequate**

The service was not well-led.

The provider did not have effective oversight of the service and drive improvement. The service had failed to sustain the improvements they had made at the last inspection.

The manager had not independently identified areas for improvement and was not visible in the service.

# Brundall 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 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 comprehensive inspection was carried out by two inspectors and an Expert by Experience on 20 February 2018 and was unannounced. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the contents of notifications received by the service. Services have to notify us of certain incidents that occur in the service, these are called notifications.

Some people using the service were unable to communicate their views about the care they received. We carried out observations to assess their experiences throughout our inspection.

We spoke with three people using the service, two relatives, four care staff, the operations manager, a company director and the manager.
We reviewed five people's care records, two staff personnel files and records relating to the management of the service.

Inadequate

# Is the service safe?

## Our findings

At our last inspection on 5 July 2016 we rated the service 'Good' in this key question. At this inspection we identified serious shortfalls and failings which put people at risk of potential harm. The service is now rated 'Inadequate' in this key question.

The service was not assessing, monitoring and putting management plans in place to reduce the risk of people choking. One person had been admitted to hospital twice after aspirating food. The service had not assessed the risk of this person choking and did not have a care plan in place giving staff clear instructions on how to minimise risks to the person. The service had been provided with clear instructions to reduce the risk to this person in a 'risk feeding report' from the hospital. This had been placed at the back of the person's care records and not transferred into a care plan. Staff were not aware of these instructions which meant they were unable to take action and reduce the risk to the person.

Where people's needs changed or their health deteriorated, care plans were not reviewed promptly to ensure their needs remained the same. One person had deteriorated significantly following a stay in hospital and we were told they were now at the end of their life. Their care plans had not been updated and still reflected the care they required prior to the deterioration in their health. For example, their care plan stated they required hoisting out of bed to be taken to the lounge. The manager told us that the person now needed to be cared for in bed. The person was now receiving oxygen, but this was not referred to in their care plans and there was no information for staff about maintaining the person's safety whilst using oxygen.

This person's pressure ulcer assessment had not been reviewed since their needs changed and was over a month out of date. The person's skin would be more prone to significant breakdown at the end of their life but there was no clear plan in place to guide staff on the extra pressure care they may now require. The manager told us this person was being assisted by staff to reposition, but this was not documented in their care plan. A moving and handling assessment for this person stated they had leg ulcers but there was no plan in place stating whether there was any support the person needed from staff to keep these appropriately dressed.

In all five of the care records we reviewed we saw that pressure ulcer assessments were out of date and had not been repeated at the frequency specified in best practice guidance. This meant that the service had no way to identify if people's risk was increasing and further measures needed to be put in place to protect people from skin breakdown. Where people had been identified as at risk, the service had not followed publically available best practice guidance to ensure that appropriate management plans were put in place. This meant that staff did not have enough information to support people to maintain their skin integrity.

Some pressure mattresses have settings which control the level to which they're inflated. This is dependent on the person's weight. The service did not have a system in place to check that the settings of these beds remained appropriate when the person lost weight. We found that some beds were set incorrectly. For example, one person's bed was set to a person weighing 90kg when they only weighed 65kg. This meant that its effectiveness in relieving pressure was compromised.

It was not always clear how people assessed as at risk of falls were being supported to minimise this risk. There were not always clear care plans to instruct staff on how to reduce risks and where people had been falling. The manager could not demonstrate that appropriate guidance was sought from other health professionals.

There was ineffective oversight over falls and other incidents in the service. The manager told us there had been no falls in January or February 2018 and there were none noted on their record of falls. However, care records we reviewed and discussions with staff indicated that people had fallen in this time. In addition, the operations manager told us that one person was found on the floor earlier on the day of our inspection. Care records indicated one person had fallen three times in 2018, but the manager was unaware of this and had not taken action to put in place strategies to reduce the risk of them falling again.

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

The environment was not consistently safe. The manager and care staff did not always identify risks in the environment.

A fire risk assessment, carried out by an external company on 4 April 2017, highlighted a number of risk areas that required addressing. These included confusing fire exit signs, signposted fire exits being blocked and a lack of fire procedure notices. During our inspection we found that not all of these shortfalls had been addressed. For example, fire exit signs remained above some doors which were blocked by furniture. Fire procedure notices were not visible in all areas of the home. The manager had been using padlocks to further secure the gates on stairs which meant they took longer to open. They told us this was because one person had been able to open them. However, they had not identified there was a risk this could hinder a quick evacuation in the event of a fire. We were so concerned that we shared this information with the duty officer at Norfolk Fire Service. We also requested information from the service urgently to reassure us that they were taking action in this area. Following our visit a fire officer from the Norfolk Fire Service visited the service and confirmed all necessary works had been completed to make the service safe.

We observed that there were exposed hot water pipes throughout the home, including in people's bedrooms. These posed a risk of burns if people touched them or fell against them. This had not been identified by the manager or provider. However, following our visit the provider sent us evidence to demonstrate these had now been covered to protect people from harm.

We tested the water temperature on a sample of taps. We found that in some communal bathrooms there were no thermostatic valves on two hot water taps. These valves ensure that water cannot reach a temperature which could cause burns to the skin. A health and safety audit carried out in December 2017 highlighted this risk. Whilst some taps had been fitted with these valves, others had not and the service had not identified this risk. Following our visit the provider sent us evidence to demonstrate these taps had now been fitted with the appropriate valves.

We found that there were wardrobes and other large pieces of furniture in people's bedrooms which were not secured to the walls. Some of these were wobbly and the risk of these falling and injuring someone had not been assessed.

There was a lack of oversight over how the risk of legionella was managed and reduced. Legionella is a bacterium which can live in water systems and cause Legionnaires disease. When we requested the last Legionella risk assessment, we saw that the service was awarded the lowest score for management of

legionella risk in July 2017. Urgent work was required to reduce this risk, but in a health and safety audit carried out in December 2017 highlighted that these actions had not been completed. The manager, one of the directors and operations manager were unable to locate documents to evidence that this work had been completed during our visit. We saw records which showed that weekly flushes of little used water outlets were carried out. Following our visit documents were located to evidence that the work had been completed and the risk score had been reduced. However, we were concerned that the provider did not have effective oversight over managing the risk of legionella in the service. The provider had a serious incident at another of their services because of poor Legionella control systems. The lack of systems in place to closely monitor current compliance demonstrated to us that the provider had not fully learned from this incident.

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

During our inspection we identified that some areas of the service were cold. There were windows open throughout the service, including in people's bedrooms and in communal areas. We found one of the bathrooms where people were supported to bathe or shower to be very cold with the window open. In the dining area where most people were seated in the morning the temperature was 17 degrees and the radiators were not on. People were visibly cold and one person asked a staff member for a blanket. Neither care staff nor the manager independently identified that it was too cold, despite being present in this area. We highlighted this to the manager, but prompt action was not taken and over an hour later the room was still cold. We went to highlight this to the manager again who said they had asked the maintenance person to look at this, however, they did not oversee this to ensure this was done as quickly as possible. They did not put in place any contingency to heat this area whilst checks were being carried out on the heating system until we highlighted the issue for a second time. During this time, we saw a member of staff open a window in this area and had to ask them to shut this. Staff displayed a lack of regard for maintaining a comfortable temperature for the elderly, frail people using the service.

There were not always clear plans in place to advise staff on how to understand, prevent and manage behaviour that the service found challenging. We observed that one person displayed frustration and distress when they were not engaged in activity or when they were not sure what was happening at that moment. There wasn't a care plan in place to instruct staff on how to ease this person's anxiety, distress and prevent them from becoming angry. We observed that the person became very frustrated because the activity they were involved in kept stopping and starting but staff did not appear to be mindful of this. Staff did not communicate to the person what was happening and we saw that this resulted in them becoming distressed. For example, the activity they were engaged in was stopped because tea and snacks were being provided. However staff did not communicate this to the person or reassure them that their activity could be recommenced so they became distressed and were calling out at staff. Staff got frustrated by this and did not always respond to the person in a kind, caring manner. Other people using the service started being verbally unkind to the person but staff did not intervene to try and deescalate the situation.

There was a care plan in place for one person which explained how staff could de-escalate the situation to prevent them from becoming distressed and hitting out at staff or other people using the service. However, we observed that staff did not follow this plan when the person displayed behaviours that challenged them during our inspection. The person was verbally aggressive to another person using the service but the staff member told them to be quiet which made them more agitated. The staff member allowed this exchange to continue for an extended period of time before eventually removing the person from the area without speaking to them. There was no life history in place for this person which may have helped staff better understand them and to distract from what was distressing or frustrating them.

Some areas of the service required cleaning or maintenance to ensure the risk of spread of infection was minimised. We observed that in one bathroom the floor was dirty and the floor covering was ripped, meaning it could not be effectively sanitised. The carpets in some areas were soiled and required cleaning. We observed that there were domestic staff working in the service during our visit. However, they were not wearing appropriate protective clothing such as aprons when moving throughout the home and cleaning different areas. In addition, we observed that staff did not always change their protective clothing between tasks and went in and out of the kitchen without appropriate protective clothing on.

Some substances that could cause harm if ingested were not stored securely within the service. This included prescription creams.

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

There were not enough staff to provide people with support when they needed it. The manager told us that there were three members of care staff and one team leader on each day shift. The team leader was responsible for administering the medicines. We were also told that there was a member of activities staff available five days a week. The manager said there were six people using the service who may require the assistance of two care staff to mobilise or for personal care. This meant that if two people required support at any one time there would be no care staff available to provide support to anyone else using the service. The manager was using a dependency tool to identify the number of staff required according to people's needs. However, this had been ineffective in identifying the number of staff required to meet peoples social, emotional and physical needs.

Staff were not always present in communal areas where people were seated. We observed one person struggling to mobilise in a communal area and finding it difficult to sit down. Another person using the service started trying to help them. This person was at risk of falls and the lack of staff presence meant they could not be provided with assistance to minimise this risk. The member of activities staff was participating in care tasks and this disrupted the activities they were supporting people with. People showed frustration at this interruption which happened several times during our observation. The member of activities staff told us that if someone required support and there were no other staff available, they had to assist with this. People told us there were not always enough staff to support them at the time they needed it. A relative told us, "There are times when they are busy and [relative] has to wait a while." Staff told us that they felt more staff were required to meet people's needs, taking into account people's social and emotional needs. The manager told us the service was in the process of recruiting new care staff.

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

Large pieces of equipment such as hoists had been serviced by an external company. A member of maintenance staff regularly carried out checks on other equipment such as wheelchairs and walking frames to ensure they remained fit for purpose.

Records demonstrated that appropriate tests were carried out on the fire detection and alarm systems to ensure these remained in working order.

Despite the shortfalls we had seen during our inspection people told us they felt safe living in the service. One said, "I do feel safe." A relative told us, "[Relative] is very safe here. When I'm not here they check on [person] regularly."

Medicines were managed and administered safely. People told us they received their medicines appropriately. One said, "They [staff] never just hand them to me and leave, they always make sure I take them." Another person told us, "They're pretty good, it's not always exactly the same time but close." We audited medicines against the records on Medicines Administration Records (MARS) and found no anomalies in these records. This reassured us that people were receiving their medicines in line with the instructions of the prescriber.

Inadequate

# Is the service effective?

## Our findings

At our last inspection on 5 July 2016 we rated the service 'Good' in this key question. At this inspection we identified shortfalls and the service is now rated 'Inadequate' in this key question.

The service did not refer to evidence based guidance around best practice when assessing and planning people's care. For example, when people were assessed as at risk of malnutrition, the service did not follow National Institute for Health and Clinical Excellence (NICE) guidelines to advise them on how to reduce the risk to the person and provide them with support to reach and maintain a healthy weight.

There were not always adequately detailed care plans in place around reducing the risks of malnutrition and dehydration. Some of these care plans were generic and the instructions for staff did not reflect the individual needs of people. Where people had a low weight or had actively lost weight, there were no instructions for staff on how to support them to reach and maintain a healthy weight. The manager could not demonstrate that referrals had been made to other health professionals to obtain advice or guidance where people lost weight. There was no evidence that people were supported to have extra snacks and drinks between meals to boost their nutritional intake. We saw a letter from a doctor dated September 2017, in one person's care records, which stated they should be offered fortified drinks and snacks daily. This information wasn't in the person's care plan and staff said they were not aware that this person required extra snacks. Staff told us they did not offer other people at risk of malnutrition extra snacks outside of the scheduled times when tea and biscuits were served. This meant we were not reassured that people were encouraged to eat regularly to boost their nutritional intake and reduce the risk of further weight loss.

The service was not monitoring the weight of people who were at risk of malnutrition appropriately. Best practice guidelines state that a person at risk of malnutrition should be weighed weekly; however the manager was unable to provide records to demonstrate that people had been weighed weekly. One person had lost 2.2kg when they were last weighed in December 2017. They had not been weighed since to ascertain whether they continued to lose weight. Another person had lost 5.8kg when they were weighed on 5 February 2018. Despite this, they had not been weighed since. Two other people considered underweight had also not been weighed for two weeks. The manager told us they had delegated the duty of weighing people to other staff. However, they had not checked that this had been completed and did not have a system in place to oversee people's nutrition and ensure prompt appropriate action was taken if people lost weight. We spoke with the kitchen staff who had a good knowledge of fortifying meals for those with a low weight. However, they told us that they had been asking for the recent weight charts since December 2017 but had not been provided with them. This meant they were unsure whose meals required fortifying.

We observed that the meal time was chaotic and not consistently positive. Staff did not effectively manage the meal time to ensure that everyone received their meal in a timely manner and to ensure that there was a good atmosphere. We observed that one person wished to go to the toilet once they had been seated at the table. They were supported to do this but when they returned to the dining area they were taken to another table. During their meal they wished to use the toilet again, and when they returned they were placed at another table. We saw other people moved around the room periodically during the meal time which

caused confusion and a lack of consistency for people. Staff brought one person into the dining area but there was nowhere for them to sit so staff moved everyone from one table to create space on the other side. There were not enough staff to provide ad hoc support to people when they needed it. One person did not eat much of their meal but staff did not identify this and encourage them to eat. The meal was removed by staff and the person was not offered anything else to eat instead. This meant we were not assured that people were consistently encouraged and supported to eat enough.

There were no care plans in place around supporting people to remain hydrated and reducing the risk of dehydration. One person's care records stated they had recurrent urinary tract infections. However, there was no information about reducing the risk of this by ensuring the person was supported to have a regular intake of fluids.

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

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA) 2005. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). People using the service had their capacity to make decisions and consent to their care assessed appropriately under the MCA. DoLS applications had been made to the local authority and authorised where appropriate.

Records confirmed that staff had received training and mentoring in the principles of the MCA and DoLS. However, staff did not demonstrate a knowledge of the principles of the MCA and DoLS in discussions with us. Whilst we observed that staff supported people to make some decisions, at other times staff did not gain people's consent before assisting them. For example, we saw one staff member move a person in their wheelchair from one area to another without speaking to them. On another occasion we observed a staff member telling one person that they were going to go and sit in the living room, without giving asking them where they would like to spend their time. In discussions staff did not have knowledge of following appropriate processes when someone did not have capacity to make a decision. Staff felt it was their role to make decisions on people's behalves rather than seeking guidance from senior staff or from the person's relatives. The lack of staff knowledge in this area had not been identified by the service and therefore no action had been taken to improve practice.

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

Records confirmed that staff received a range of training in subjects such as dementia, challenging behaviour, food hygiene, moving and handling, MCA and DoLS and fire safety. However, our observations and discussions with staff did not demonstrate that they had a good knowledge of subjects they had received training in. For example, staff practice in MCA and DoLS and supporting people with behaviour that challenged was poor. Formal observations of staff competency were not carried out for existing staff to ensure their training had been effective and to identify and address poor practice.

Whilst medicines had been administered appropriately, staff had not been following best practice when administering from pre-packaged medicines in monitored dosage systems (MDS). Staff told us they felt they had appropriate training for the role, however, some staff commented that they felt they would find face to face training more beneficial than the online training they had received. Whilst the competency of staff administering medicines had been assessed, this had not been effective in ensuring staff demonstrated

good practice.

Staff told us that they received regular supervision and appraisal which they found useful. However, this had been ineffective in improving staff practice and developing the knowledge of the staff team. Whilst staff told us they felt supported, the manager had not held a meeting with staff since they started working at the service in November 2017. This meant that staff had not been involved in discussions about improving the standard of care provided to people.

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

The decoration and design of the service had not been adapted to suit the needs of people living with dementia. Corridors were not decorated in a way which meant they were distinguishable from other corridors in the service. Some bedroom doors did not have decoration which would help people identify which room was theirs. We observed one person disorientated trying to find their way around the service, asking staff where certain rooms were.

We recommend that the service explores current guidance from a reputable source (such as the Social Care Institute for Excellence) to further improve the design and decoration of the service, and consider best practice for people living with dementia.

People told us the food they were provided with was good quality. They told us that they could choose their meals from a menu and if they wanted something else they could request it. We observed that people were given a choice of meals dependent on their ability. Those who had limited verbal communication were shown picture menu's to help them make a choice.

People told us they had access to other health professionals such as GP's and Dentists if they needed it. They told us that a GP attended the home every Tuesday but if they needed to be seen at other times carers would arrange this for them. One person told us, "There's a chiropodist coming to see me this week, that's been arranged for me I think." A relative said, "[Relative] has [their] own GP. A few weeks ago [relative] was really very ill so [carers] called [their] GP. They also called me to let me know what was happening."

Requires Improvement

# Is the service caring?

## Our findings

At our last inspection on 5 July 2016 we rated the service 'Good' in this key question. At this inspection we identified shortfalls and the service is now rated 'Requires Improvement' in this key question.

We identified widespread failings across the service which meant that people did not always receive the care and support they required to uphold their health, dignity, safety and welfare.

The management team had failed to independently identify these failings and take action to improve the quality of the care people received. This meant that the management team did not promote a culture focused around good practice. Care staff were failing to identify and address the poor practice of themselves and other staff members. This meant people were put at risk of harm and received care that did not always meet their needs.

We observed that not all interactions between staff and people using the service were caring. We observed one person approach a staff member and touch their hands. The staff member abruptly pulled their hands back and said, "Don't touch my hands like that." We observed staff becoming frustrated with people's requests for reassurance or support. One person was distressed as the activity they were engaged in kept being disrupted by staff going to offer support to other people. The person kept asking what was going on but we observed staff telling the person to be quiet, rather than explaining to them what was happening and providing reassurance. We observed staff becoming frustrated with another person who was trying to help them with tasks. Instead of offering the person the opportunity to help out, staff told the person to sit down and stop interfering.

Staff did not intervene when people using the service were unkind to other people. We observed one person shouting at another person who was seated at the same table. Staff did not intervene to try and calm the situation and we observed the person became withdrawn as a result. Staff brought another person to a table where someone was sitting reading the newspaper. The person was verbally abusive to them for an extended period of time but the staff member did not encourage the person to move to another area.

People and their relatives told us they had not been involved in writing their care plans and records did not evidence people's involvement. People's views and preferences on their care were not reflected in their care plans. Improvements were required to ensure that care records reflected the tasks people could complete independently. For example, the parts of their personal care routine they could complete themselves and the parts they required staff to support them with. This information could reduce the risk of staff over supporting people and limiting their independence.

There was insufficient information about people's preferences and life histories in their care records. The service was in the process of recruiting new staff who would rely on these care records to inform them about the people they were caring for. Where people were unable to verbally communicate, there was insufficient information about the other ways people may communicate their views. For example, care plans stated the person may communicate via facial expression, but didn't specify what particular expressions could mean.

The absence of information about the person meant we were not assured that staff would have the knowledge required to interact with people in a personalised manner.

We observed that staff knocked on people's bedroom doors before entering and carried out personal care in private. However, one person told us they felt their right to privacy had been compromised due to the removal of locks on bedroom doors. They said, "There used to be locks on the doors but they removed them a few weeks ago. I'm not very happy about that. There are some people here who will just walk into your room and help themselves, that has happened to me. It also means I cannot have any privacy if I want it." The manager told us this was due to a fire risk assessment which said the doors should have the locks removed. However, when we reviewed the risk assessment it stated that the particular door locks which were in place were not appropriate because it was possible for people to deadlock them from the inside, meaning staff could not gain entry in an emergency. The service had not considered other widely available door locks which staff would be able to open if needed.

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

Requires Improvement

# Is the service responsive?

## Our findings

At our last inspection on 5 July 2016 we rated the service 'good' in this key question. At this inspection we identified shortfalls and areas for improvement. The rating in this key question is now 'requires improvement'.

People did not have access to appropriate sources of meaningful engagement. The service had a member of activities staff. However, there were not enough care staff to meet people's needs and we observed that the activities staff frequently went to answer call bells. This meant that the activity they were engaging people in was disrupted which caused people to become distressed and agitated. The activities staff member told us that if care staff were busy and someone needing support, they had to go and help. This meant that people were not consistently engaged in activity.

Staff missed opportunities to support people to be engaged and stimulated. We observed one person trying to help staff with tasks such as making drinks or giving people snacks. Instead of giving the person the opportunity to participate in the task, they told the person to stop interfering. This led to them sitting down and becoming disengaged. The person had a professional background in helping people and when we spoke with them it was clear they still felt that they were working in this role. Staff continually missed opportunities throughout the day to provide the person with the option to be involved in tasks to reduce the risk of them becoming bored or socially isolated.

People's care records were not person centred and did not include sufficient information about people's backgrounds or preferences. For example, there was limited information about people's likes, dislikes, hobbies, interests and aspirations. Some people had limited communication and may not have been able to tell staff their preferences on a day to day basis. For people living with dementia, there was limited information about their life history and background. Staff and the manager didn't always know information people told us about. For example, one person had an unusual nickname and the manager told us they didn't know where they had acquired it. The service was in the process of recruiting a significant amount of new care staff who would be reliant on care records for personal information about people. This meant we were not assured that staff could consistently provide people with personalised care.

The service did not have sufficient end of life care plans in place. Some people had brief care plans, but these were generic and not personalised. The service had not referred to publically available best practice guidance such as the Gold Standards Framework and National Institute for Health and Care Excellence (NICE) guidance when planning people's care. We were told one person was now at the end of their life, however, there was no care planning in place to ensure their wishes were acted upon. For example, care plans didn't reflect where the person would like to end their life to reduce the risk of unnecessary hospital admissions. Care planning did not include information about keeping the person comfortable and ensuring they were free from pain. The manager told us the person had returned from hospital to receive end of life care. However, the manager had not taken advice from the hospital or a doctor as to whether anticipatory medicines should be in place. Anticipatory medicines are provided for people who may be coming to the end of their life. The purpose of these are to ensure that there are no delays in obtaining medicines to make

people comfortable and pain free if there is a sudden deterioration in their health.

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

At the time of our inspection the service had not received any complaints. However, there was a complaints procedure in place which was displayed in a communal area. Relatives told us they knew how to make a complaint and felt they would be listened to. One said, "I would probably talk to the manager or one of the senior carers."

Inadequate

# Is the service well-led?

## Our findings

At our last inspection on 5 July 2016 we rated the service 'good' in this key question. At this inspection we identified widespread shortfalls which put people at risk of harm. The rating in this key question is now 'inadequate.'

On 19 March 2015 the service was inspected and found to be in breach of Regulations 9, 10, 11, 12, 14, 15, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was rated 'requires improvement' overall.

We returned to inspect the service on 9 and 13 July 2015 and identified continued breaches of Regulations 9, 10, 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was rated 'inadequate' overall.

On 5 January 2016 the service was inspected and found to be breaching Regulations 8, 9, 10, 11, 12, 13, 14, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was rated 'inadequate' overall. As a result of the service's continued non-compliance with Regulations and the significant risk to people using the service, we took enforcement action against the service. Following this, the service voluntarily removed their registration to provide nursing care.

On 7 July 2016 the service was inspected and was found to have made the required improvements to comply with the Regulations. The service was rated 'good' overall.

At this inspection we found that the service had been unable to sustain improvements it had previously made. Lessons had not been learned from previous non-compliance and the service was found to be in breach of Regulations 9, 10, 11, 14, 17, and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service is now rated 'inadequate' overall and needs to make significant improvements to safeguard people from potential harm.

Prior to our inspection the provider had identified some of the shortfalls found during our inspection. Minutes of a meeting between the provider and the manager on 14 February 2018 stated that a GP had raised concerns about the service. A number of areas for improvement had been identified by the provider. The minutes stated that the manager should prioritise improvements in care planning. However, during our inspection we found that the manager had not ensured prompt action was taken to put in place appropriate care plans to reduce the risk of people coming to harm.

The manager did not demonstrate that they had sufficient knowledge to identify poor practice and identify shortfalls in the service. They had been carrying out reviews of care planning and felt these were suitable. However, we found that these were insufficient. The minutes of a meeting between the provider and the manager on 24 January 2018 state that the manager said they felt sure the service would be fine at the next inspection. They had not independently identified the significant shortfalls which were identified at our visit. This meant we were not assured of their competence in the role.

The provider's quality assurance system had been ineffective in identifying shortfalls prior to February 2018 and in identifying the deterioration in the service following the inspection in 2016. Lessons had not been learned from an incident at another of the provider's services which occurred as a result of poor legionella control. The provider had not implemented a system to oversee legionella control practices in the services they owned and to ensure that recommended work was carried out to reduce the risk. During our visit the provider was unable to confirm if work had been carried out following a legionella risk assessment in July 2017. Evidence was later provided to demonstrate the work had been carried out, but we were concerned that there was not effective oversight of managing these risks.

There was a poor culture in the service and this had not been identified by the manager or provider. Staff demonstrated poor practice during our visit which evidenced their training had been ineffective. Staff interactions with people were not always kind and caring and staff did not always demonstrate that they kept the needs of people using the service in mind. For example, staff opened windows around the service because they felt hot but did not consider that older people feel the cold. This included the manager, who had a window open in their office with the door to a communal hallway open.

The manager did not demonstrate they were responsive when concerns were raised with them. We told the manager it was cold in a communal area of the service where people were seated. The radiators were off and a thermometer showed the temperature in the room was 17 degrees. People were cold and requested blankets from staff. The manager told us they would get someone to look at the heating. However, over an hour later the radiators were still cold and no one had been to look at these. The manager had not made any interim arrangements to ensure the room was warm enough and did not request that staff move people to another communal area which was warmer. We raised these concerns with the manager again who said they had asked the maintenance person to look at it. We accompanied the manager to find the maintenance person who was on a break. We raised concerns about the temperature in this area and the risks to people sitting there. After two hours the maintenance person identified that a thermostat upstairs had been turned off. We were concerned that it took an extended period of time for this issue to be resolved and we had to raise concerns twice before the manager provided alternative heating arrangements in the room. The manager did not demonstrate that they fully understood the concern and did not personally oversee the prompt resolution of the issue.

The manager was not visible in the service. During our inspection they stayed upstairs in their office unless we requested their input. Staff told us the manager often spent time upstairs in their office. Whilst they said they thought the manager was approachable, they said they would be more likely to raise concerns and speak with other senior staff because the manager was often not present in communal areas. Staff said that the manager had not held a meeting with the staff since they started in November 2017, and that they had not been involved in discussions about the improvement and quality of the service.

People using the service told us they didn't see the manager very often and felt the manager did not know them as a person. They told us they had not had an opportunity to give feedback on the service or have discussions with the manager since they started working for the service in November 2017.

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

We were so concerned following our inspection that we requested urgent information from the provider to reassure us they had an oversight of the risks to people and would take immediate action to safeguard people. The response we received was adequate in reassuring us that action was being taken to make the service safe.