St Marks Care Home Limited

St Marks Residential Care Home

Inspection report

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Date of inspection visit:
06 February 2017
09 February 2017

Date of publication:
06 June 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place over two days, 6 and 9 February 2017. St Mark's Residential Care Home was previously inspected over three days in February and March 2016 and was rated requires improvement with breaches of regulations in The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to providing person centred care, staffing and good governance. Following that inspection the provider sent us an action plan to tell us what improvements they were going to make. You can read the report from our comprehensive inspection of March 2016 by selecting the 'all reports' link for 'St Marks Residential Care Home' on our website at www.cqc.org.uk

St Marks Residential Care Home provides personal care for up to 17 older people, some people living with dementia. There were 16 people living in the service when we inspected.

The service has a registered manager, who was also the provider. The manager was also registered to manage another care home for older people in Clacton. 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.

Improvements had been made in the staffing levels, however further work was needed. We have made a recommendation to support the provider in the deployment of staff. This is to ensure the service consistently has sufficient staff, with the right skills and knowledge to monitor and support people with complex needs.

Training was being provided for staff, but it did not always provide staff with the knowledge and skills to effectively carry out their role. The majority of training was provided by the registered manager. We identified concerns about staff's understanding of current good practice and the ability to put training into practice. For example, where staff did not demonstrate knowledge of safe care and best practice in areas such as moving and handling, dementia care and infection control.

Further improvements were needed to support people with their mental and emotional needs by ensuring they had access to activities that provide mental stimulation. We recommended that the service explores the relevant guidance on best practice to enhance people's wellbeing through meaningful occupation.

People complimented the quality of the food. However, we found people were not always supported to ensure that they had enough food and drinks to support their health needs. Records were incomplete and not assessed, we could not be assured that people had been given enough to eat and drink. Where people of low weight turned down food, or had a low appetite, this was not always being effectively managed. This put people at risk of losing, or not maintaining their weight.

Staff's practice was not always shown to be caring or respectful. We saw some good interactions, and

people told us they liked the staff. However, some support given focused on the provision of tasks and was not always person centred or individualised. It did not promote people's wellbeing or ensure that people felt valued. We have made a recommendation to support staff in promoting dignity in care.

Improvements were seen in the development of people's care plans. They were more individualised and reflected people's wishes and preferences. However, some areas needed to be developed further, and in a way that reflected best practice. This is to ensure staff were being given clear guidance on meeting a person's needs, that ensured their safety and wellbeing. For example supporting people's mental health, and managing pain relief.

People were not always supported to have maximum choice and control of their lives and staff were not always supporting them in the least restrictive way possible.

People told us they felt safe, and there were systems in place to ensure people were being provided with safe care. However, further improvements were needed in the management of infection control and risk, to ensure staff were following safe practice, for example when assisting people to move safely.

The quality assurance systems had improved, however were still not robust enough to independently identify and address shortfalls as part of driving continuous improvements and embedding them in practice. Feedback we had received regarding the registered manager, described them as caring, but needed to be more proactive in instigating changes in a more timely manner.

During this inspection we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staffing levels were not always sufficient to meet people's needs.

Medicines were not always managed safely.

Improvements were needed to ensure staff were consistently monitoring any potential risks during care delivery which could impact on people's welfare.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received training but they did not always put into practice what they had learnt. We found shortfalls in staff's knowledge of supporting people living with dementia.

Not all people were being effectively monitored and supported by staff to ensure they were given enough to eat and drink to support their health and welfare.

People were supported to maintain good health and had access to appropriate services which ensured they received on-going healthcare support. Improvements were needed to ensure that guidance from other professionals was followed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Improvements were needed to ensure all staff's interactions were respectful, caring and compassionate so all people felt listened to and valued.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans had been revised but did not always provide clear guidance for staff on meeting people's needs.

Improvements were needed to ensure all people had access to stimulating occupation / activities, linked to latest research, which met their individual needs.

Complaints procedures were in place and displayed.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Improvements were needed in the quality monitoring systems to ensure they are robust enough to independently identify and address shortfalls, and embedded to drive continual improvements.

Improvements were needed in the leadership of the service. This is to ensure they have good oversight of the service to be able to address concerns before they escalate / impact on the quality of people's care.

St Marks Residential 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 unannounced inspection took place over two days, 6 and 9 February 2017. The inspection team consisted of two inspectors on the first day, and one on the second day.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service: what the service does well and improvements they plan to make. We reviewed information we had received about the service such as the provider's improvement plan, safeguarding referrals and notifications. Notifications are information about important events which the provider is required to send us by law. We also looked at other information that we held about the service and made contact with the local quality monitoring team and fire safety officer who had visited the service.

We observed the care and support provided to people and the interaction between staff and people throughout our inspection. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with nine people who used the service, two relatives and six social and health care professionals.

We looked at records in relation to six people's care. We spoke with the provider / registered manager and six members of staff including the deputy manager, senior care, care, and catering staff. We looked at records relating to the management of the service, staff recruitment and training, and systems for monitoring the quality of the service.

Requires Improvement

Is the service safe?

Our findings

Our inspection of February and March 2016 found that improvements were needed to ensure there were always sufficient numbers of suitable staff available to keep people safe and meet their needs. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations. The provider wrote to us and told us about the improvements they had made.

At this inspection we saw where the improvements had been made in the staffing levels. The staff roster dated 30 January to 5 February 2017 showed the service had recruited a part time cook who worked Monday to Friday 10am to 1pm and a domestic four hours a week. A volunteer had also been recruited to co-ordinate activities six hours a week. When not on duty, care staff covered these roles. In addition to these staff one senior and two care assistants supported up to 17 people throughout the day.

The registered manager felt that the staffing levels were sufficient to ensure people were being provided with safe care. That staff also had, when on duty, the additional support of the management team. It was during these times, when problems were occurring, which were impacting on the quality of service people received.

Feedback from visitors to the service and our own observations showed that problems were occurring, when catering, activities and domestic staff were not on duty, and staff were covering these roles, it was impacting on the quality of service people received. This included weekends and evenings.

A relative felt having a consistent staff presence in the lounge, would reduce the risk of falls, where people have tried to get up unaided. One person said, "They [staff] don't have a lot of time to help me." They confirmed that when they rang their call bell that staff usually came straight away, but when busy, "Sometimes not."

When the cook was not on duty, although they did as much preparation as they could, care staff were still involved in catering / domestic tasks. For example we observed where staff were busy trying to make the evening meal and provide personal care. One member of staff who was making sandwiches, had to leave the task part way through to assist a person to the toilet, before continuing to make the sandwiches. Throughout this period we heard a person calling out for their tea, saying, "This is unbearable…I am so upset," until their tea arrived. Staff were responding to people's requests for assistance but had little time to engage with people.

The registered manager used a dependency tool to support them in setting the staffing levels. As they were confident that they had enough staff, taking into account what we saw and the feedback we received, further review of the staffing roster is needed. This is to ensure they have enough staff on duty throughout the week and supported in a consistent, safe manner.

We recommend that the service uses an observational tool from a reputable source to support them in the deployment of staff, such as the Adult social care outcomes toolkit (ASCOT).

The provider's action plan of June 2016 told us that they had two staff on at night. This was to address our previous concerns that one waking night staff was not enough to meet the needs of people at the service. However at this inspection, records and feedback we received showed the increase to two waking night staff had only just been implemented. Commissioners for the service told us they had recently stressed the importance with the provider of having two waking night staff to provide support and reassurances had been given that the post was being recruited to. The staff roster for the week of our inspection showed action had been taken, with two waking staff on at night.

Improvements were needed to ensure people were consistently supported in a clean and hygienic environment. Some areas we looked at showed a lack of thorough cleaning. For example, where staff had made a person's bed, we found under the bottom sheet, a dirty mark and debris on the air bed mattress underneath. There was also debris under the bed, dust on top of skirting boards, and food debris and sticky marks on their table. The commode pot, mobility aid, commode and toilet brush all showed evidence of dust or body fluids where they had not been cleaned properly.

The assisted bath chair in the shared bathroom had a build-up of scum underneath the seat, hoist slings were stored next to a toilet, and a bar of used soap was in the sink making it a potential breeding area for bacteria and for passing on infections between people. When we pointed these shortfalls out to the registered manager, they took action straight away. They also reminded staff of the importance of ensuring people were supported in a clean environment. However, we could not be assured, linked to the deployment of staff, if the improvements we saw on the second day we inspected, would be sustained.

Staff's awareness of potential risks to people needed to be embedded in their everyday practice to ensure they are constantly monitoring for any potential risks and taking appropriate action where needed. For example, a health professional spoke of finding a person on a deflated pressure cushion, because staff had not plugged it in. In a person's bedroom, an electrical adapter was sitting on top of their heated radiator. This had not been considered by staff as a potential risk. Where staff had completed body maps and noted bruising on people, records did not demonstrate that any effective investigation had been carried out to identify the cause.

Improvements were required in the management of medicines. We found shortfalls in the service's record keeping, administration and staff's knowledge of pain management.

Three people's records showed that staff had recorded the name of the medicines people had brought in with them, but not the amount. Where people were on prescribed nutritional supplements, new monthly paperwork did not provide information on any stock left from the previous month. This information should be used to support staff in knowing how much stock they held for people. This meant that effective audits could not be carried out to check that people had received their medicines as prescribed. We brought to the attention of staff that a person did not have enough to last the month, ensuring they were reordered in good time and reducing the risk of them running out.

When people were prescribed medicines on a when required basis, there was written information available to show staff how and when to administer some of these medicines; however, this information was not available for all medicines to be given this way. This is to ensure that staff are aware of how they should be used, so they can be used effectively. Pain assessment tools were not being used for people prescribed pain-relief medicines and who were unable to communicate about their pain-relief requirements to enable staff to give them their medicines consistently and appropriately.

People's care plans provided information on topical applications, such as creams and included why they

were prescribed, and where they were to be applied. However, the systems in place to record the daily management of these were not effective enough to evidence that staff were doing this. Where staff had not signed the 'cream charts' we could not be assured that they had been applied. Not all people's cream charts were up to date or could be found.

Staff told us they carried the medicines keys on their person. This ensured only those trained to administer medicines had access to them. However, when we asked to look at the medicines systems, staff retrieved the keys from an unlocked cupboard in an area which could be accessed by others.

We looked at the systems in place for the safe use of medicines regulated by government (controlled drugs). A staff member talked us through the safe procedures they followed, including a second staff member witnessing to confirm they had given the right amount to the right person. A running total was kept to confirm how much stock was held for each person. We cross checked the medicines held for two people and found a discrepancy of 10mls in one person's liquid pain relief which the registered manager could not account for. It had not been picked up by the internal checks and reviews. This raised concerns that staff were not always following safe practice in checking the correct amount had been given, which could put a person at potential risk.

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

Records showed that staff received safeguarding training as part of their induction to ensure they had awareness of what to look for, and what action to take if they had concerns about a person's welfare. Two staff confirmed that they had received the training, and that they would report any concerns about a person's welfare to the registered manager. However, discussions with one staff member identified that further insight was needed to ensure that they were fully aware of the different types of abuse and, as we had found during our last inspection, an awareness of the external agency responsible for safeguarding, and how to contact them. This showed that that although staff had received training, improvements were still required to ensure staff had a good working knowledge in recognising abuse, and who to report concerns to externally as well as internally.

Records showed that risks associated with a person's daily activities were being assessed and staff given guidance on how to support people in a safe manner. This included where applicable, risks associated with people's mobility, falls, skin breaking down, choking and diabetes. Where required, staff had sought the advice of health professionals to reduce risk, including the falls prevention team and speech and language therapist.

Improvements were needed in the service's recruitment processes. The recruitment records for two recently employed staff provided information to confirm their identity, and that character/ previous employment references had been obtained. Records showed that initial 'Adult first checks' had been carried out to confirm that there were no immediate concerns over their suitability to work with vulnerable people. However, the registered manager was unable to confirm if the full disclosure and barring check had been received and was not aware of the additional checks that should be undertaken in the period between the adult first checks and full DBS. They were also unable to locate the interview records. Therefore we were not satisfied that the provider had safe, effective recruitment procedures in place to ensure that staff appointed were of good character and had the skills required for their role.

Requires Improvement

Is the service effective?

Our findings

Staff were not always carrying out their roles and responsibilities effectively, which put people at risk of their care and support needs not being met. The quality and effectiveness of the care people received varied.

Feedback from people, health and social care professionals, and our own observation, showed that staff were not always putting their training into practice and acting on the advice and guidance given by health professionals. Where staff had acted on the advice given, a health professional provided examples of where it had led to improvements in the people's health and well-being, but the service had needed a lot of support.

Another health professional had to reconfirm with staff the level of support a person should be given with their personal care, after their previous instructions had not been fully actioned. They felt that where staff used English as a second language, they may not always understand what was being asked of them but also felt that staff lacked knowledge of certain conditions. Another commented that the staff, "Need more training around dementia." Records showed that staff received three hours training in dementia. This was not sufficient to provide staff with the knowledge and understanding of dementia to be able to provide effective, person centred care. One person's care records showed instructions given to support their pain management, but we found a lack of understanding from staff on how to effectively implement the instructions given to ensure the person's comfort and well-being.

Records showed that new staff had been given an induction and all staff were receiving on-going training in core subjects to keep their knowledge updated. This included safeguarding, moving and handling, health and safety, medicines administration, infection control, dignity and respect, nutrition and dementia. As we found shortfalls in staff's knowledge and practice in these areas, it raised concerns over the effectiveness of their training. This was because staff were not always putting it into practice, which impacted on the safety and welfare of people they were supporting.

The majority of training was provided by the registered manager. We were not assured that staff's practice was assessed effectively to ensure they were correctly implementing the training they had received. For example, Where a person was assessed as requiring a hoist, we noted small marks on the front of their legs; they told us it must have happen when the staff had, "Picked me up," to transfer them to bed, instead of using the hoist. When we pointed this out to a senior member of staff, they told us that staff had been instructed to use a hoist and would never lift the person. However, they were unable to explain why a handling belt was kept in the person's bedroom, removing it saying it should not be used.

On another occasion, we observed a person who was very unsteady on their feet, being moved from their chair to a wheelchair. The staff member placed their arm underneath the person's shoulder to assist them to stand. This is a move that is not recommended as it can cause injury to the person's shoulder. As the staff member had not placed the chair in the correct position, this resulted in them trying to manoeuvre the wheelchair behind the person, nearly catching the person's walking frame in the process. We were concerned because the person was showing signs of anxiety during the transfer, and so we stood beside

them to reduce the risk of them falling.

Another example of where staff were receiving training but not putting it into practice was when assisting a person to eat. They placed large amounts of food on a dessert spoon, undertaking the task in a quick manner and not giving the person enough time to chew and swallow their food. The staff member did not seem to be aware of the risk of choking, as identified in the person's care plan.

The provider's information return (PIR) informed us that the service trained and developed their staff and, 'makes sure they put their learning into practice to deliver outstanding care that meets people's individual needs'. This was not our observation; staff were not always demonstrating that they had the skills and knowledge, and that they were putting their training into practice.

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

People told us they were supported to access healthcare services; which their care records confirmed. During both days of the inspection, health professionals were visiting people to support their health care needs. However, improvements were needed to ensure that their guidance was followed.

Improvements were required in monitoring people's nutritional needs. Where people had been assessed at risk of malnutrition, staff needed to be more effective in checking and encouraging people to eat and drink to ensure their health and welfare. This included keeping accurate records to support staff in knowing how much, or how little a person had to eat and drink. The registered manager told us that they would be taking action to retrain and supervise staff to ensure accurate records were maintained.

Staff also needed to be more proactive in acting on the recommendations given by the dietitian in using high calorie foods to promote weight gain, rather than just relying on prescribed food supplements. For example, where guidance had been given for one person was to encourage homemade smoothies and high calorie snacks times three per day between meals and fortified diet. The daily records didn't always evidence that this was happening.

People told us they enjoyed the quality of the food. One person told us, "Food is good, they come in the morning and ask what you would like, [staff member] is a good cook." Another person remarked, "It is wonderful food." One person told us that staff would mince up their meat for them as they found it easier to swallow, "It's nice minced up." Another person on finishing their meal told us, "I enjoyed that."

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

People can only be deprived of their liberty 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the service had submitted DoLS applications to the appropriate supervisory body. The registered manager was aware of their responsibilities in ensuring the conditions of any approved authorisations were met.

The registered manager had told us in their provider information return (PIR) that they had provided staff with training on the MCA and staff confirmed this. We found gaining consent from people was not embedded as part of practice. We did observe some good practice such as a member of staff asking if they could assist a person with their meal, and the person smiling back, indicating their consent. However, we also observed another member of staff remove a cushion a person had put on their table in front of them, without speaking to the person or getting their permission. This left the person with restricted sight, trying to locate the cushion after the staff member had left the room.

Care records provided information for staff where a person lacked capacity to express their needs, and how staff needed to act in a person's best interests to ensure their safety and well-being. For example where a person was unable to use their call bell, we saw staff regularly checking on their welfare. However, where staff said they had made a best interest decision for a person to remain on bed rest linked to their safety, we found not all avenues had been explored to ensure it was the least restrictive option, and supported the person's wellbeing. To support them in doing this, the registered manager said they would be seeking further advice from health professionals.

Requires Improvement

Is the service caring?

Our findings

Improvements were needed to ensure all interactions with people were caring, meaningful, and supportive of developing caring relationships where people feel valued. The provider's information return (PIR) told us that the service had a 'visible person centred culture'. Our observations identified what we were being told wasn't embedded in the culture of the service, and in all staff's practice.

One person told us they did not feel restricted by the service's routines, and spent the day as they wished. This included choosing when they got up, went to bed and what they wanted to eat. They also told us that that they regularly had visitors who they, "Go out," with.

We found the quality of people's experiences was variable, depending on their level of independence and mental capacity. Where staff had the skills and time to interact with people, we saw positive interactions which supported people to retain their independence, have a voice and feel valued. One person told us, "Staff are pretty good…it is a good home." Another said, "You take the rough with the smooth here, you have to have patience to do this job, they [staff] do an amazing job, a lot of them are [from abroad]." We saw their interactions with staff were good, as they discussed different topics, for example discussing a news item shown on the television. They informed staff what they were going to do and staff respected this, which promoted them retaining their independence.

However, where people were living with dementia, and / or were physically frail their experiences were not always as positive. Where a person was supported in bed, their care records showed that they wanted 'staff to engage in conversation about my past to stimulate my memory' including when assisting them to eat and drink. The conversations we heard at lunch time were limited more to instructions, and the task being undertaken such as, "[Person's name] do you like?" The care staff member repeated the person's name several times when trying to prompt them to eat, but no meaningful conversation was heard, "Do you like… water for you…drink a little more…yeah well done." The 'Map of my Life' provided a lack of information to support staff in knowing about the person's life to stimulate memories. Records also showed that the staff member was not following the person's wishes, as they were not addressing them by their preferred name.

A professional described staff as, "Caring." Another who visited the service regularly said that the staff were, "Nice, polite and helpful." The PIR told us that staff were, 'motivated and inspired to offer care that is kind' We saw some kind and caring interactions where staff sat and listened to the person, or provided reassurance using both verbal and non-verbal gestures; and some that weren't. For example, whilst providing reassurance to a person, staff asked after their welfare, and used appropriate touch, such as resting their hand on the person's arm whilst talking. The focus of their interaction was on the person. However, for another person being assisted with their meal in silence, the staff member was distracted and turning their head to look at the television. They then got up to speak to another person, before returning and 'taking over' and assisting the person, without noticing that the person was managing to eat independently. These actions were not supportive of making the person feel valued, or promoting their independence.

During the afternoon, a person told us that they didn't have their hearing aids in, and thought they could have been lost. However we had seen them in the person's bedroom. The PIR said that staff used,' creative ways to make sure that people have accessible and different methods of communication'. They did not provide any examples. Our own observation and discussion with a relative showed that had not provided basic care by ensuring a person's hearing aids had been put in. When a person asked a staff member, "What day," it was, they replied, "Thursday." We saw a calendar block gave the date and month, but no day.

Although the provider told us that staff had an in-depth appreciation of people's individual needs around privacy and dignity, improvements could be made in this area. For example, storing people's continence pads so they were out of sight of their visitors. Where specialist continence knickers were being used to hold a person's pad, these were not always being named to ensure they were used by the same person. When we were talking with a person in their bedroom, staff entered without knocking. A culture had developed with the hairdresser cutting and styling people's hair in the main lounge, visible to others and consideration had not been given as to providing a more private space. At lunch time a carer asked a person, "Want a bib?" which was not age appropriate.

We recommend that the service uses a reputable source to support them in promoting dignity in care and consideration of the role of dignity champions. For example the Social Care Institute for Excellence and Dignity in Care.

Requires Improvement

Is the service responsive?

Our findings

Our inspection of February and March 2016 found that improvements were needed to ensure people received mental stimulation to enhance their well-being. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations. The provider wrote to us and told us about the improvements they had made.

This inspection found that work had been undertaken by the management to drive improvements in this area. There was now an activity coordinator organising activities three mornings a week. They were working on the first day of our inspection. One person told us they had taken part in the morning's activity, "Was playing scrabble this morning," which they had enjoyed. Another person told us that they tended to watch the television, but didn't have the controls to be able to put the sport on which they preferred. But hadn't said anything because, "There would be an argument." The positioning of the television meant that not all people would be able to view it.

On the second day, we did not see any activities going on, the majority of people spent their day in the lounge. The information board did not provide any information on any organised activities for that day. A poster provided information the daily activities arranged for August. Staff confirmed it was out of date, and said that they were still doing the range of activities listed. This included people being able to request a carer to support them to go out. One person named the staff member who took them out, "Will take me out as long as I can give notice…we can go into the garden in the warmer weather…I wish I could go out more." They told us that they enjoyed playing a board game with the member of staff, "I have taught [staff member] how to play." This supported the person to feel valued, by passing their knowledge onto the staff member.

We found the service needed to continue working on developing in this area to ensure all people were being provided with mental stimulation to enhance their well-being, especially people living with dementia, and / or those who spent the majority of their time in their bedroom. This was because there needed to be more quality engagement from staff to prevent the risk of people feeling socially isolated. People's care records provided staff with guidance on the supporting people's social and emotional needs. For one person living with dementia, it included 'I like watching TV sometimes' and 'I enjoy chatting to staff and laugh sometimes'. There was no information on the type of television programmes they enjoyed to support staff in facilitating this, as they were unable to do this for themselves. The quality of the conversations we heard showed a lack of understanding in how to engage to promote the person's well-being.

We found the quality of the conversations and providing social interaction between staff and people using the service were better for those without dementia. This showed that staff needed further training and guidance in this area. For example where people were involved with staff in conversations, playing board games, the person living with dementia was not being provided with any stimulus.

We recommend that the service consults with people and uses a reputable source to support them in identifying activities which people are interested / able to participate in. For example the Social Care Institute for Excellence, Alzheimer Society, and the National Institute for Health and Clinical Excellence.

Since our inspection of March 2016, the service had implemented new care records to provide staff with guidance on the person's assessed needs, and the level of support the person required from staff to meet them. For example, support with washing and dressing. Staff were informed what the person could do for themselves, and where staff needed to assist. Staff told us that the information was being reviewed monthly with the person, or where applicable their relative. Staff were asked to sign the review to ensure they were up to date with any changes.

People's care records provided lots of information in separate sections. The information contained was not always easy to follow or linked up to support staff in having a more person centred approach. For example, where a person was known to become distressed due to pain when staff touched their body, 'staff to ensure that I have adequate pain relief before they move me' this was recorded in the mental health and behaviour care plan, but not the person's washing and dressing plan. This meant that the person could be wrongly described as being 'aggressive', and given medicines to manage this, where their behaviour was linked to staff not being responsive to their needs.

Further work was needed in linking and providing detailed information for staff to support them in understanding how a person's mental and physical health could impact on their ability. Staff needed to check that information made sense and could not be misinterpreted. One person's care records stated they had 'declined' personal care on continuous days. However, staff told us it meant that the person had, "Declined their help, as they liked to be independent."

During the inspection, it had been raised by a visiting health professional that staff had not been giving the person the right level of support with their hand hygiene, to prevent the risk of infections. When asked, staff were unable to locate the risk assessment and guidance around the hand care. A staff member said that they thought there had been one, but this could have been filed with the person's old care plan. This had not been picked up by staff. They provided reassurance that the current person's care plan would be updated to include this.

The service's complaints policy was displayed, and forms made available for people to complete if they had a concern. Records showed that two concerns had been received and acted on. This included where a concern had been raised about the 'portion of food not being big enough'. Action had been taken to gain people's views, and found people to be 'happy with the portions'. The management said any concerns would be listened to and acted on as part of driving continuous improvement.

Requires Improvement

Is the service well-led?

Our findings

Our inspection of February and March 2016 found that improvements were needed in the overall governance of the service. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations. The provider wrote to us and told us about the improvements they had made. At this inspection we found improvements were slowly being made, but further work was needed to drive continuous improvements.

The provider was the registered manager and also managed another nearby residential home for older people, which they also owned. The staff roster showed that they were supported by three deputy managers who also covered as senior care, and provided administration support. On the second day of our inspection, one of the deputy managers was providing management cover for both services as the provider was out of the country. We observed that the registered manager was committed, as although absent, they kept in contact with the deputy manager throughout the day to provide support and receive feedback.

The first day of the inspection the provider had acknowledged they were late returning their provider information return (PIR) and provided us with a satisfactory reason why, and were granted an extension. This meant that we received the PIR five days after we inspected. It provided information on how they were ensuring people received a safe, effective, caring, responsive and well led service. The PIR used positive wording to describe what they were doing; creative, current best practice, innovative systems, imaginative and person centred. However what we were being told didn't always reflect what we had found. We were not assured that the provider had effective oversight of what was happening in the service to drive improvements.

For example the provider told us that they trained and developed their staff in a way that 'makes sure they put their learning into practice to deliver outstanding care that meet people's individual needs'. This was not our observation. Best practice, for example in dementia care, was not consistently being delivered to promote people's mental stimulation and activity.

We were told visiting professionals said that the service focused on providing person-centred care and it achieved good results. However, people's records showed where professionals had to request action to be taken, as staff had not put it into place to support people's care needs, such as instigating re-positioning sheets. Information we held on the service, our own observation and feedback from health and social care professionals, identified that this was not always the case.

We saw that the provider had used the PIR 'what improvements do you plan to in the next 12 months' section to include how they were going to address shortfalls identified during the inspection. For example to address the identified shortfalls in monitoring people's fluids and dietary intake, each member of staff would be 'retrained, assessed and supervised on how to maintain and accurate fluid and diet chart'.

Although it showed what action they would be taking, their responses still showed a lack of oversight, as to why the improvements they had already made including increased training, audit checks, management

cover and staffing levels had not resulted in further improvements. Consideration was not being given, especially where English was a second language for the majority of the staff, on focusing on the quality and staff's understanding of the training, to enable them to put it the learning into practice and having more robust checks in place to ensure this was happening. Without this it will not be supportive of driving continuous improvement.

We saw that the local authority quality team had been providing additional support to this provider helping them to develop systems to monitor and raise the quality and safety of the care. There were some quality assurance systems in place and some of these were informative. For example there were checks on if people had baths, checks on people's weights and we saw they collated information on accidents and made referrals to the falls service. However, there needed to be a more robust auditing of practice and competency in order to drive improvement at the service. For example the PIR stated 'The service seeks out current best practice and uses this to drive improvement'. This is not what we found in relation to providing dementia care. Similarly the provider's action plan told us the measure they were putting in place to sustain improvements they had made, 'Staff will be monitored to ensure that they are proving best practice and using their skills while delivering care'. Again this contrasted with our findings and we concluded that the quality monitoring systems were not working.

This is a continued breach of regulation 17: Good governance of the Health and Social Care Act 2018 (Regulated Activities)

Registered providers are required to notify the Care Quality Commission (CQC) about events which may affect people who use the service. This helps CQC to undertake its responsibilities with regard to safely of people who use service. Information received from the local safeguarding team concerning a fall and a review of a person's incident records, identified that we had not been notified when a person had been injured, and what action had been taken.

This was a Breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations.

People, relatives and visitors knew the management team and how to contact them. They told us they had a visible presence. When visitors arrived we heard staff greet and where required update relatives on a person's welfare.

Staff told us that they felt supported in their role and had regular access to discuss any concerns with the provider. The staff roster showed that the provider spent the majority of their time based at this service. We saw records to evidence that staff received supervisions and appraisals. Staff meetings were held on an on-going basis which enabled staff to share their views and be kept updated on what was happening in the service.

This inspection identified although there had been improvements, further work was needed. As part of this inspection arrangements have been made to meet with the provider. This will enable them to share with us the plans they will be putting in place to drive continuous improvements.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The Commission was not always being notified of specific incidents that had impacted on a person's safety and welfare. Regulation 18 9 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always supported in a clean and hygienic environment. Medicines policies and guidelines were not always being followed in the safe management of medicines. Regulation 12 (1) (2) (g) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not robust enough to independently identify shortfalls and take action to improve the service. Regulation 17 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Not all staff were skilled and competent to fulfil

the requirements of their role.

Regulation 18 (2) (a)