Mont Calm Residential Care Home Limited

Mont Calm Sandgate Road

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This was the first inspection of this service since it registered under Mont Calm Residential Care Home Limited on 28 September 2015. The inspection was undertaken on 9 and 11 December 2015, and was an unannounced inspection.

The service is registered to provide accommodation and personal care to 20 older people who may have dementia. The premises are a detached house situated on one of the main roads going in to Folkestone. The service has 18 bedrooms all of which have a wash hand basin and two have ensuite facilities. Bedrooms are spread over three floors and the first and second floors can be accessed by the use of a passenger lift. People had access to two assisted bathrooms and a dining room, lounge and conservatory. There is a street parking available nearby. Sixteen people were living at the service at the time of the inspection.

The registered manager had resigned prior to our inspection. However at the time of writing this report the Commission had not received an application to cancel their registration. A registered manager is a person who has registered with the Care Quality Commission to

Summary of findings

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 time of the inspection the day to day running of the service was being undertaken by an acting manager. The service lacked leadership and staff were unclear about their roles and responsibilities particularly in relation to safeguarding, the Mental Capacity Act 2005 and notifying outside agencies about events.

People received their medicines when they should. However we found shortfalls relating to medicine management. Some risks associated with people's care and support had been assessed, but some risks still required assessing and more detailed guidance was needed to ensure people remained healthy and safe. There was no analysis or learning from accidents and incidents leaving a risk of further occurrences.

People benefited from living in a satisfactory environment although not all areas were cleaned to an adequate standard and some practices did not promote good hygiene. Some equipment had not received regular checks or servicing to ensure it was safe. The service needed to take advice from the fire safety officer and to check smoking legislation in relation to the building.

People did not have their needs met by sufficient numbers of staff. Staff rotas were not based on people's needs or the environment in which people lived. Training records were not available to evidence that staff had appropriate training and knowledge to meet people's needs. Staff had not had support and opportunities for one to one meetings with a manager, to enable them to carry out their duties effectively.

People were not always supported to maintain good health as referrals to health professionals were not made or were not made in a timely way.

Two people did not have a care plan and those in place were not personalised sufficiently to enable staff to deliver personalised care to meet people's needs and in line with their wishes and preferences. They did not always detail people's skills in relation to tasks and what support they required from staff, in order that their independence was maintained.

There were some institutionalised practices and people's privacy and dignity was not fully respected. However staff were kind in their approach to people.

Menus did not reflect people's likes and dislikes. We were unable to ascertain whether people had a varied diet, but there were examples of this not being the case. People had limited opportunities for interaction and activities.

People or visitors did not have access to an up to date complaints procedure. There were no effective systems for monitoring the quality of care provided or assessing and mitigating risks within the service. Records were not accurate or available during the inspection. Policies and procedures required review to ensure staff had clear guidance.

People were protected by safe recruitment procedures. The provider had already made some changes to staffs practices, which resulted in people receiving a choice about the time they wished to get up. Staff felt the provider was supportive and were confident that they would change things for the better. A staff meeting had identified that some shortfalls had already been identified prior to the inspection.

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

Summary of findings

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.

Summary of findings

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's health and welfare had not all been assessed and where assessments were in place more detailed guidance was required to keep people safe.

People received their medicines when they should, but improvements were required in some records and guidance to ensure risks in relation to medicine management were mitigated.

People's needs were not met by sufficient numbers of staff on duty.

Accidents and incidents were not properly recorded or responded to, to reduce the risk of further occurrences. A lack of checks and servicing on some equipment meant the provider could not be sure it was safe. Some areas of the service were not adequately cleaned.

Is the service effective?

Inadequate

The service was not effective.

The principles of the Mental Capacity Act 2005 were not upheld in relation to people's rights and restricted liberty.

People health needs were not always met as appropriate referrals to health professionals for assessment or interventions were not made.

Menus did not reflect people's likes and dislikes and people's food at times lacked variety.

Staff did not receive appropriate training, support and supervision in order to meet people's needs effectively.

Is the service caring?

Inadequate

The service was not always caring.

People did not receive personalised care and support; they were subject to institutionalised practices which did not enhance their privacy or dignity.

Some practices had been changed recently, which meant people had a choice in the time they got up, but in other areas choices were no offered or were limited.

People felt staff were kind and caring and staff demonstrated kindness.

Is the service responsive?

Requires improvement

The service was not responsive.

Summary of findings

Not every person had a care plan and those in place did not reflect personalised care in line with people's wishes and preferences.

People had limited opportunities for activities and engagement. Some people spent long periods of time asleep.

People did not have access to an up to date complaint procedure.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager had resigned. The acting manager of the service lacked knowledge, skills and experience.

Events had not been appropriately reported to outside agencies including the Commission.

Staff did not have access to a set of policies and procedures which were complete, clear and reflected current legislation.

Mont Calm Sandgate Road

Detailed findings

Background to this inspection

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

This inspection took place on 9 and 11 December 2015 and was unannounced. The inspection was carried out by two inspectors.

This inspection was brought forward and undertaken as a result of concerns received by the Commission. Therefore the provider was not asked to complete 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. Prior to the inspection we reviewed information we held about the service. This was limited as the service had only been registered since 28 September 2015, but included notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with one person who was able to tell us about their experience of living at the service, two relatives, the provider, the acting manager and seven members of staff and an agency staff member undertaking a shift at the service.

Most people were not able to tell us about living at Mont Calm Sandgate Road. 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 also carried out general observations of staff carrying out their duties, communicating and interacting with people to help us understand their experiences. We reviewed people's records and a variety of documents. These included seven people's care plans, risk assessments, medicine administration records, accident and incident records, daily reports made by staff, policies and procedures, staff meeting minutes, the staff rota's and quality assurance surveys.

We contacted two social care professionals before and after the inspection that had had recent contact with the service and received their feedback.

Inadequate

Is the service safe?

Our findings

One person told us they felt safe living at the service and relatives felt their family members were safe the service.

People were at risk of harm because medicines were not managed effectively. Where people were prescribed medicines on a 'when required' basis, for example, to manage constipation, pain or skin conditions, there was in most cases individual guidance for staff on the circumstances in which these medicines were to be used safely and when they should seek professional advice on their continued use. However not all medicines prescribed this way had guidance in place. For example, there was no guidance in place for four people prescribed QV cream or two people prescribed codeine phosphate. This could result in people not receiving these medicines consistently or safely.

The bulk of medicines were stored securely and at the right temperature to ensure the quality of medicine people received. Two topical medicines were stored in a toilet used by people, but there were no risk assessments in place to ensure this was safe for anyone who might use the toilet.

Medicines that were no longer required were stored in the medicines trolley or a locked filing cupboard. These medicines had not been entered into the returns book whilst they remained in the service. This meant there was not a clear audit trail of medicines within the service and there was a risk of misuse.

There were clear medicine administration procedures in place. During the inspection administration followed safe practice. However there had been several occasions when a person had refused to take medicines. The policy stated that when this happened staff should monitor and 'refer all cases of non-compliance back to the original prescriber, to the service users GP and/or nurse'. One staff member told us they had reported some refusals to the mental health team who said they would discuss this with the doctor at a meeting planned for the future. This meant no immediate decision was made despite the person's medicines recently being changed due to results of blood tests and there was a risk that their health could deteriorate as a consequence. Medication Administration Records (MAR) charts showed people received their medicines when they should or appropriate codes were used. However some handwritten entries on the MAR charts had not been signed, dated and witnessed, which is good practice as recommended by the Royal Pharmaceutical Society and in line with staffs training.

People were at risk of harm because risk assessments were inadequate and did not keep people safe. People had the same risk assessments in place for bathing, going out of the building, using the garden, using the nurse call system and falls, which left a risk that any information relating to an individual and a particular risk was not properly assessed, to ensure the right action was taken to reduce that risk for each person. People's mobility had been assessed, but the moving and handling assessments only contained the number of staff required for a task and any equipment that might be used and did not detail how the person should be moved safely. Records showed that when people had a fall, their falls risk assessment was not reviewed, to ensure it was still relevant or further steps could not be taken to keep the person safe. Some risks associated with people's care and support had not been assessed. For example, people who were at risk of urine infections had no assessments in place and charts used to calculate the level of risk had not always been fully completed. This left a risk that people may suffering more frequent infections because proper steps were not in place to keep people healthy. Three people had diabetes, but there were no assessments in place should they become unwell due to their diabetes or guidance about what action staff should take. This meant there was a risk that timely action may not be taken by staff to help ensure people remained in good health. Where steps were in place to reduce further risks there was no evidence that these were carried out by staff. For example, one person was to be checked half hourly to keep them safe, but there was no evidence to show these checks were actually happening. Toiletries were stored in bathrooms and toilets, but there were no risk assessments in place to ensure this was safe.

One person displayed behaviour that challenged others and staff, but no formal risk assessment was available to staff, to help ensure they managed this behaviour safely and consistently. Some information had been written in a shared communication book, but this did not detail clearly how staff should managed this behaviour in order to keep themselves and people safe. This was despite staff having to use restraint twice recently, by holding the person by the arm and around the wrists to stop them lashing out, for which they had not been trained, to ensure the restraint

they used was safe, the least restrictive and for the least time possible, in order to keep people safe. The steps that were detailed to keep people safe were either not in place or were not consistently adopted by staff. For example, the individual was to be supervised in communal areas at all times, but we observed this was not happening during the inspection and staffing levels were too low to ensure this could be adopted by staff.

Daily reports showed there had been a number of falls and incidents of challenging behaviour. However these were not always detailed on an accident or incident form, so in many instances we were unable to ascertain what had actually happened. The accident policy in place did not make it clear that all accidents and incidents should have been recorded in detail. It was also not clear if a person had a fall, whether or when a health professional would be called to check the person for any injuries. This meant there were inconsistences in recording and reporting, which left people's well-being at risk. This had not been addressed as there was a lack of accident and incident analysis by management.

The building provided a satisfactory environment, but it would benefit from redecoration and refurbishment. There were many areas of scuffed paintwork. Although a fire alarm test was carried out during the inspection, records available during the inspection showed there were shortfalls in checks for ensuring equipment was safe. For example, there was a lack of records regarding the testing of emergency lighting and fire extinguishers and for carrying out fire drills. Records could not be found for the servicing of fire equipment or the nurse call system. A tour of the premises identified that a bolt had been fitted to a fire exit and the garden, which was one assembly point had a gate fitted with a padlock and key. This meant if staff forgot to take the keys people would not be able to get out of the garden and away from the building. The acting manager agreed to discuss this with the fire safety officer. Discussions with staff identified during the inspection that there was only one sized hoist sling. Staff told us that one person's mobility had deteriorated and they were sometimes unable to stand, but staff were unable to use the hoist as the sling was not suitable. This left people at risk and meant the provider was unable to assure themselves that the equipment was maintained or safe.

One person was a smoker and staff regularly used the conservatory during the inspection as a place where they took this person to smoke. However there was no risk assessment in place despite the person grabbing or snapping the cigarette in half on two occasions and once when it was alight. The acting manager was unaware of legal restrictions relating to smoking in care homes, but agreed to speak with the fire safety officer about this. This meant people could be at risk because proper procedures had not been followed.

The provider had failed to mitigate risks in relation to proper and safe management of medicines, the premises and the health and safety of people. This is a breach of Regulation 12(2)(a)(b)(d)(e)(g) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from abuse or avoidable harm. There was no safeguarding policy for staff to refer to, staff had not received up to date training in abuse, and incidents in which people experienced harm had not always been reported. Staff had recently been reminded of their responsibilities of reporting any suspicions of abuse under safeguarding by the provider. The provider had also reiterated that staff should feel safe in whistleblowing about any poor practice. This had resulted in staff coming forward to discuss their concerns both within the service and also reporting to outside organisations. We were unable to ascertain whether staff were trained in safeguarding vulnerable people as no training records were available. There was no evidence of a safeguarding policy during the inspection, although one was developed following the inspection and sent to the Commission. However although some incidents had been reported by management appropriately one incident had not. This meant people were at risk because management did not act in a timely way to involve professionals under safeguarding procedures.

The provider had failed to protect people from abuse by establishing systems and processes that operated effectively. This is a breach of Regulation 13 (2)(3) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not sufficient numbers of qualified, skilled and experienced staff to respond to and meet people's needs. Staffing rotas were not based on people's needs and the environment. At the time of the inspection there were 16 people living at the service. Staff told us there were three care staff on duty during the day 8am to 2pm and 2pm to 8pm and two staff on duty at night 8pm to 8am. In addition

Is the service safe?

there was an activities person and handyman who worked five days a week and a cook seven days a week. There had been two domestic staff rostered each day, but due to resignations there had been no domestic staff in the nine days prior to the inspection and none were rostered for that week. Staff told us that care staff would be expected to keep toilets and other areas clean. Staff felt there were not enough staff on duty to meet people's needs. Observations showed that during the inspection most people were asleep in the lounge or wandered around looking for someone to engage with. On day one of the inspection there was one member of staff present in the lounge area from 8am to 10am who was only involved in medicine administration although there were at least eight people present during this time. Staff told us that one person could require two or three people to assist them due to deterioration in their mobility, which would leave no one available to assist other people at that time. Another person demonstrated behaviour that challenged others and required staff to regularly intervene. On day two of the inspection the senior on duty was required to reorder the medicines, which they told us would take them away from caring duties for at least one to two hours if they were not interrupted. A person during the inspection unlocked the safety gate three times at the bottom of the stairs and went up the stairs and on two occasions staff had to be called by the inspectors to ensure the person's safety. There were no call bells situated in the communal areas of the service should people need to summon staff. We asked management what the on-call arrangements were for out of office hours should staff need support in an emergency and were told there were none in place.

The provider had failed to provide sufficient numbers of suitably qualified, competent, skills and experienced staff to meet people's needs. This is a breach of Regulation 18(1) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of the inspection most areas were cleaned to an adequate standard. However we found some areas that were not, such cobwebs hanging from ceilings, a dirty toilet seat and pipework in toilets. Staff told us a cupboard had recently been knocked out in the laundry and this had resulted in every surface in the laundry being covered in dust including excess bedding, which was stored on open shelves. None of the surfaces in the laundry were easily cleanable. We checked on the second day of day of the inspection and the laundry remained in the same state. There were other practices which were not hygienic, such as dirty clothes on a toilet floor next to a basket of clean laundry, equipment, such as toilet seats stored on toilet or bathroom floors. Each person had a named pot for their medicines, which were used each time medicines were administered, but these were not washed. There had been allocated cleaning staff. However staff told us and rotas showed that these staff had resigned or been transferred to cover care duties or activities and had not been replaced. We asked to see cleaning schedules to check how frequently areas were cleaned and although staff told us these were in place they could not be found during the inspection.

The Commission had received concerns that the clinical waste container located outside had been overflowing and not emptied. We found that the container had since been emptied and a contract was in place to ensure this happened regularly. However the clinical waste bin should have been locked to ensure people could not access this type of waste, but was not.

The provider had failed to provide equipment that is clean and secure and maintain standards of hygiene. This is a breach of Regulation 15(1)(a)(b)(2) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected by robust recruitment procedures. The new provider had not recruited any new staff so we looked at recruitment files of staff previously recruited. Recruitment records included the required pre-employment checks to make sure staff were suitable and of good character.

Inadequate

Is the service effective?

Our findings

One person told us they were happy with the care and support they received. Relatives confirmed that they also were satisfied with the care and support their family members received. One relative said, "It is a nice place".

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes are called Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Management had submitted a DoLS application for one person who had moved in during October 2015. However during discussions it was apparent that the acting manager was not aware of their responsibilities regarding DoLS and management had not submitted an application when it was clear that another person who moved in during October was deprived of their liberty. The person's capacity had been assessed in relation to receiving care and support and showed they did not have capacity. This person displayed behaviour that challenged and regularly asked to get out or go home during the inspection, daily reports showed staff had used restraint on at least two occasions during incidents of challenging behaviour, something for which they were not trained to do and implemented further restrictions of a pressure sensor mat outside their bedroom door and a bolt on a door, which we highlighted during the inspection as a fire exit. Other restrictions were in place, such as bolts on bedroom doors and other locked or coded gates and doors, there were no evident risk assessments to ensure these restrictions were the least restrictive required and remained under review. People did have capacity assessments in place for less complex decision making although this was not decision specific as it should be, confirming staff did not understand the principles of the legislation. One care plan had contradictory information regarding the legal arrangements of a person's finances. In one part the care plan stated that a solicitor had an enduring power of attorney and in another part it stated a relative handled the finances.

The provider had failed to act in accordance with the law, make decisions based on the principles of best interest and obtain consent appropriately. This is a breach of Regulation 11(1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staff had not received appropriate training and did not have the knowledge and skills which were necessary for them to carry out their roles and responsibilities. The provider had not recruited any new staff and the staff working within the service had transferred from the previous provider although new staff were actively being recruited. We spoke to the acting manager about induction training and the new Care Certificate, but they were not aware of this. The Care Certificate was introduced in April 2015 by Skills for Care. These are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life. The acting manager was not aware at the time of the inspection what training staff had undertaken or was due for refresher as no records were available apart from some certificates on individual staff files. The acting manager told us that staff had previously received mandatory training and this had been refreshed each year, but could not evidence this. A training matrix was sent to the Commission following the inspection, but this was not up to date and showed some staff were overdue for refresher training. The acting manager told us staff had received training in dementia, but none of the staff were trained to manage challenging behaviour or undertake restraint safely.

Most staff had not received supervision and therefore had not had an opportunity to discuss their development or support needs. The acting manager told that since the service was registered three staff including them self had received a one to one meeting to discuss any concerns. They said that the plan was for an independent advisor the provider was using to meet with each member of staff and then handover the supervision of staff to the acting manager. However there was no formal plan in place to show when these meetings would take place. Some staff had recently changed roles and it was evident during the inspection that staff lacked direction. For example, one member of staff sat on the stairs and was heard to say "I don't know what to do now". Another member of staff spent periods of time where they were not actually engaged with people or a task. Staff were using the communication book to ask for advice and guidance on matters relating to meeting people's needs. The acting

manager told us they had made changes to the practices of staff, such as people having a choice about when and where they had their breakfast, but we observed this not to be the case.

The provider had failed to ensure staff received appropriate support, training and supervision. This is a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People's health care needs were not met. When people were unwell, had a specific health need or an accident, advice and treatment from health care professionals was not always sought in a timely manner. There was an additional risk that people's health would deteriorate further before they were seen by health professionals and appropriate action could be taken. Staff told us about a person whose mobility had deteriorated and this had resulted in two or three staff being required to assist them with their personal care. Staff said they could not use the hoist as the sling was not a suitable size. We saw this had been discussed at the recent staff meeting and staff told us the provider had brought in a different hoist to try, which had not been suitable, but this was without consultation with a health professional for proper assessment, advice and guidance. At the time of the inspection this person had still not been referred appropriately to a health professional to access an assessment and suitable equipment. The acting manager told us they were looking to move one person from one bedroom to another, later it emerged this was because they had fallen although they had not referred this person for proper assessment before making this decision. Care plans identified that people were incontinent, but there was no clear guidance about how frequently people should be assisted or reminded to go to the toilet. Staff told us one person had been referred to the nurse for incontinence pads. However when staff described the concerns the issue was positioning when going to the toilet rather than incontinence. Records showed that staff had identified on 22 November 2015 that a person had 'bruising to the top of their right thigh', which they felt might be due to a 'previous fall', swelling to their right thigh, again 'possibly from a previous fall' and a lump to the right lower leg 'feels like fluid inside', but there was no records of staff requesting health intervention in a timely way and this person did not see a health professional until 27 November 2015.

The provider had failed to properly assess risks to people's health and put in place safe procedures to ensure their health and welfare. This is a breach of Regulation 12(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We were unable to assess whether people had adequate food and drink due to a lack of records. There was a rotating four week menu displayed within the kitchen although staff told us this was often deviated from as people did not like things on the menu or it was a case of what was in the cupboard. During the inspection we saw that accompaniments, such as stuffing and yorkshire puddings were not served with the meal, which was roast chicken. Staff told us they had not been served because people did not like these or meatballs, which were also on the menu and this was based on the fact that previously they had been left on plates. The desert was changed from the menu on both days of the inspection. The deviation from the menu meant that people did not always receive a varied diet. Staff should have recorded the teatime meals, but these were not always recorded. During the week commencing 27 October 2015 records showed that people had baked beans three times for tea that week and in one case on two consecutive days. Records showed people had not been weighed since September 2015. The acting manager told us no one was at risk of poor nutrition, but one person's care plan stated they were at risk of becoming underweight. This person had lost considerable weight during 2015, although they had not been weighed since September 2015 and they had not been referred to a health professional. The only guidance in place was for staff to offer 'anything' to encourage them to eat. Staff told us no one was on any special diets, such as a fortified diet to increase weight.

The provider had failed to ensure that care and support was meeting people's nutritional needs and had regard to their well-being. This is a breach of Regulation 9(3)(b)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

During the inspection staff noticed one person was not well and they told us this person "went downhill quickly when they were unwell". A doctor was called directly and visited that day. In another instance staff recognised that a person's dressing required changed and the nurse was called. One person had been seen by their doctor during November 2015 and had been referred to the person to the

Inadequate

Is the service effective?

speech and language team. Care plans contained information about people's health needs, such as information about different types of dementia, to inform staff.

Staff were heard offering some choices during the inspection, such as a choice of breakfast cereals and on the second day of the inspection people were offered a choice of squash with their lunch. Staff told us two people did not like the main meal, which was fish on the second day of the inspection so had soup instead. Two people were assisted by staff to eat their meal.

Care plans contained information about how to communicate with people, such as 'Staff to speak slowly and clearly when engaging in conversation'. This was reflected in staffs practice during the inspection. Staff were patient and acted on what people said although at times people did have to wait. For example, when someone wanted their shoes from their bedroom.

Inadequate

Is the service caring?

Our findings

One person told us that staff listened to them and acted on what they said. They told us they liked the staff who were very kind and caring. One person said during the inspection, "They are lovely staff aren't they". Relatives thought the staff were kind and caring and kept them up to date. One relative said, "The staff are brilliant, can't fault them at all" and "They make us welcome". .

Care and support was not always personalised and staff demonstrated behaviours at times, which reflected institutionalised practices. Each morning the staff member administering medicines collected a number of glasses and a jug of water. The glasses were all lined out on a desk and a pot with each person's name on was also lined out ready for their medicine. We spoke to staff about why they had the named pots and they said it was so people's medicines did not contaminate another person's medicines by using the same pot. We asked if the pots were washed and they told us they were not and that the medicine administration had always been done this way. Where people were prescribed creams these were applied during the medicine administration round and not when people were assisted with their personal care. This resulted in people having creams applied whilst they were at the breakfast table, which did not afford their privacy or dignity.

In the morning as people were assisted to come downstairs for the day they were seated in the lounge. Observations confirmed that when people came downstairs they were not offered a drink or any breakfast. On both mornings of the inspection when it was 'breakfast time' every person seated in the lounge was asked to go to the dining room for breakfast. This also happened at lunchtime. When we discussed this with the acting manager they told us they had already addressed this with staff and thought it had stopped. During the inspection one person asked an inspector "Shall I go down there (the lounge) and a staff member told them "You can go to the dining room for breakfast". There was no choice offered about where they wanted to sit or whether they wanted breakfast.

At mid-morning and mid-afternoon a tray of mugs of drinks were brought out from the kitchen and given to each person sitting in the lounge. People were not asked what drink they would like. At lunchtime on the first day of the inspection each person had the same cold drink with their lunch. Although on the second day people were given a choice.

Two people were observed to be asleep for at least 40 minutes at the breakfast table, their breakfast was taken away during this time, but they remained asleep in the dining chair at 11.30am. Staff were not around for most of this time, but when they were they did not offer to assist people to sit in more comfortable chairs and we did not see or hear staff offer any fresh breakfast or an alternative.

During lunchtime on the first day of the inspection a member of staff sat and assisted a person to eat their meal. However every person the member of staff spoke with they addressed as "My darling", "My lovely" or "Sweetheart" although these can be terms of endearment it can also be a habit staff adopt regardless of people's preferences. We checked care plans to see if this is how people wanted to be addressed and found preferred names were not recorded.

People's toiletries and two dirty hairbrushes were stored in toilets and bathrooms, but these were not named. Staff told us they did belong to individuals, but staff could not be certain that a toiletry or hairbrush belonging to one person was not used for another person as the hairbrushes were the same type and there were containers of the same product. We also noted that there were many notices of instruction to staff in toilets, bathrooms and people's bedrooms, most of which were removed when highlighted by the inspectors as this did not enhance people's dignity.

People did not receive personalised care and support that reflected their wishes and preferences. The service had a bathing rota for people which rotated every two weeks. Care plans did not reflect people's choices in relation to bathing, but had the same statement in each about offering a regular bath. According to records one person had a bath on 22 October 2015 and then did not have a bath or 'strip wash' until 22 November and there was no records of any refusals. Since the 23 November 2015 only three baths/strip washes or refusals had been recorded.

Staff used a 'communication book', but we found that personal and confidential information about people was recorded here, which was contrary to data protection legislation and did not uphold people's dignity. For example, '… pants so soiled had to throw away' and '... is

Inadequate

Is the service caring?

looking very unkempt and we have not had any laundry recently'. There were notices around the service, which listed each person by name and again this did not enhance people's right to privacy, although those seen during the inspection were removed by staff.

The failure to provide people with appropriate person-centred care to meet their needs and reflect their preferences is a breach of Regulation 9 (1)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The Commission had received concerns that people were being left in bed for long periods of time when they had been incontinent. We found that this was not the case and that the provider had recently changed the practice that night staff must get everyone up before day staff came on duty regardless of people's choice. At the start of the inspection eight people were up when we arrived at 7.30am, others had woken up and then been assisted with personal hygiene and chosen to go back to bed and a number had not yet woken up, which was confirmed by discussions with staff and records. Staff talked about how some people living with dementia had been up during the night and were encouraged back to bed. Staff told us they welcomed the changed as it moved practices away from institutionalisation practices where people did not have a choice. One staff member said, "A couple of months ago all the service users would have been up by now. Things are changing for the better".

Some staff had worked at the service for some considerable time and had built up relationships with people and knew about their recent histories. However as care plans did not contain this detail new staff and agency staff would not know this information, which would help them understand people and their needs and also use the information to engage with people.

Once people came downstairs unless they were able to use the lift unsupported they would require assistance from staff to access their room. Downstairs people were able to walk freely between the hallway, lounge and dining room. There was a conservatory which may be used in better weather, but at the time of the inspection this was not a pleasant place to sit due to it being used for quite a bit of storage.

We observed some kind interactions between people and staff. For example, the staff member undertaking medicine administration showed an enormous amount of patience, explaining and directing a person quietly to take each tablet and then have a drink. Another member of staff sat with a person and they went through a folder of photographs talking about each one. A member of staff showed patience when a person wanted to go upstairs to get their shoes and another quickly went a got a jumper when someone said they were chilly. Staff were kind, gentle and reassuring with a person who required assistance to walk to the dining room.

One agency member of staff told us people's wishes were not respected here, but it is changing. They gave the example of people being got up ready for the 8am day shift regardless of their choice of what time they wanted to get up.

The acting manager told us no one had needed to use an advocate, but should they need this service they would ensure contact details and information were available.

Requires improvement

Is the service responsive?

Our findings

One person told us they were happy with the care and support they received and felt it met their needs. Relatives were also happy with the care and support their family members received, although one felt their family member was "Bored, just sits down all day". One relative talked about a Halloween party that had taken place.

People did not have a personalised care plan in order that they could receive care and support in line with their wishes and preferences. Two people had moved in since the service had registered. There was no evidence that the service had undertaken a pre-admission assessment on either person, so they could judge they were able to meet the person's needs. In one instance management had obtained information from the local authority before the person moved in. However although this had identified that the person had displayed some challenging behaviour no guidance was in place to help staff manage this safely. Neither person who had moved in had a care plan in place reflecting how they wanted to be supported, in order that staff could meet their needs or other information about how to manage risks, to keep them safe despite them living at the service since October 2015.

Care plans were in place for the other people living at the service. Care plans contained information about people's personal hygiene, getting up and going to bed, continence/ toileting management, mobility, activities, communication, medication, medical history, mental capacity and dietary needs. However care plans lacked detailed information about people's preferences and wishes in relation to how they wanted to receive their care and support, to ensure their support was delivered consistently and in a way they wanted. For example, people's preference around bathing were not recorded only 'offer regularly' and if people required assistance to go to the toilet there was no detail about the frequency or the continence products they may use. Statements in different people's care plans were often the same. For example, 'to be offered a bath regularly but this is their choice'. If people became anxious there was no guidance about how staff should manage this. This meant staff may deliver care and support in an inconsistent way and not in line with people's wishes and preferences.

The Commission had received concerns about the times people were got up from bed, but care plans did not detail what people's wishes were in relation to this. This left a risk that some people could being got up or were disturbed in the mornings outside of their preferred routine.

In some care plans there were details to enable staff to maintain people's independence, such as giving the person a flannel with soap on and with verbal prompts they would wash themselves. However this was not consistent in each care plan although staff told us some people would be able to do "Some parts themselves".

Care plans had previously been reviewed monthly. However since August or September 2015 despite care plans stating they should be reviewed monthly they were not, which meant care plans may not be up to date if people's needs had changed or their health had deteriorated since that time.

The provider had failed to ensure that care plans reflected people's assessed needs, preferences and remained up to date. The above is a breach of Regulation 9(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The service had a complaints procedure on display, although this required updating as the contact details for the provider were out of date, which meant people and visitors did not have the correct contact details of the provider should they have wished to complain. Relatives felt they were able to approach staff or the provider with any concerns they may have. There had been no formal complaint since the service had registered.

The provider had failed to establish an effective complaints procedure. The above is a breach of Regulation 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People had limited opportunities for activities. A member of staff had recently been appointed to the activities role. On the first morning of the inspection at least four people spent most of their time asleep in the lounge, for others the televisions were on and there was little or no interactions with staff unless they were being asked to go to the dining room or given a drink. During the afternoon an outside entertainer came in with music and did exercises. People became animated and quite obviously enjoyed this session very much. During the second day of the inspection again people spent long periods asleep, but there were one or

Requires improvement

Is the service responsive?

two appropriate one to one activities carried out which engaged people and were enjoyed. Two televisions were on in adjoining open plan rooms, during most of the inspection and on one day these were on different channels, although no one was actually watching any of these. One person had a newspaper, but there were no other items in evidence to distract, amuse or stimulate people living with dementia. Daily reports showed that some activities had recently taken place including a church service, pet therapy, music and feathers or balloon games; keep fit and listening to music or singing. We saw that one person was given a hand massage and had their nails painted. Some people were supported on a one to one basis to write Christmas card and letters or supported to open and read cards they had received.

We observed one lovely moment when a member of staff was in the lounge and was approached by a person who started to dance with them, another person started to clap and other people engaged with what was going on and smiled, but thought wasn't given to turning the televisions off and playing music to continue this.

People's bedroom doors had their names and a picture on them and there was some signage for toilets, but no colour coding on doors or walls to assist people living with dementia to with find their way around.

People had some opportunities to provide feedback about the service provided. There was a suggestions box in the hallway where people could leave suggestions. The acting manager told us the provider hoped to hold relatives meetings to meet them and discuss future plans. Relatives told us they had met the provider and had discussions about their family member and the provider's plans for the future.

Inadequate

Is the service well-led?

Our findings

The registered manager resigned on 25 November 2015 and the deputy manager had resigned on 20 November 2015, both left with immediate effect. An acting manager took up post on 30 November 2015, which meant on the first day of the inspection they had been in post 10 days. The acting manager had previously been employed in another role at the service. The acting manager worked Monday to Friday 9am to 3pm. They were supported by an acting head of care that also took up post on the same day and had also previously worked in another role at the service. The acting head of care worked full time although all their hours were on shift and they did not have any additional hours for management tasks.

The acting manager had worked within the service for two years, but we found at the time of the inspection they lacked knowledge of systems and processes and management experience of social care and this was evident in their ability to the address concerns and shortfalls with the speed and effectiveness which was required when a service had so many identified shortfalls. For example, we spoke to the acting manager about them having to track through numerous daily reports to find out information about when people had seen a doctor or nurse. They told us they had also found this extremely time consuming and although agreed a simple solution would be for staff to record directly onto a health professional log this had not been put in place and time was still being consumed by checking through daily reports when information was required.

During the inspection the acting manager was unable to confirm what the minimum staffing for the service was including ancillary staff and what vacancies the service had. There was no overview of what training staff had completed and when. There was no plan in place to ensure staff received regular support and supervision. The acting manager did not have appropriate knowledge in relation to the requirements of safeguarding or the law on the Mental Capacity Act 2005.

One person was supported to smoke within the premises. There are legal restrictions in place for smoking in care homes, but the acting manager and senior staff were unaware of these. This meant people could be at risk as proper procedures were not in place.

There were no effective systems to assess, monitor and mitigate the risks relating to people's health, safety and welfare. Accidents, incidents and falls were not properly recorded, investigated or analysed for trends and patterns. When accidents and incidents had occurred management had not taken appropriate action, such as referrals to health professionals, submission of a DoLS application or carried out a review of staffing levels. There was no analysis of accidents and incidents to look at patterns and trends to help reduce future risks to people's health and welfare and to ensure that accidents and incidents were monitored appropriately in the future. Any learning from incidents and accidents was not embedded into practice and did not link to risk assessment and care plan reviews.

The provider had put in place any effective systems in place to audit the quality of service provided to people. No formal audits had been carried out that had resulted in an action plan with timescales to address shortfalls. The management team told us they were "firefighting" concerns day to day. This meant people could not expect the service to improve in the near future.

The acting manager was unable to produce some records required during the inspection; other records were not easily accessible or were incomplete. Although 'agency' appeared frequently on the staffing rota, there was no evidence or name of the agency worker who had worked that shift as they did not sign in into the building and there was no copies of their timesheets until the agency invoiced the service. Staff employed by the service also kept their own timesheets and did not sign in or out of the building. This meant if there was a fire or emergency there would be no accurate record of who was present in the building. If staff did not arrive on time for their shift the rota was not changed so there was no accurate account of the rota worked. A care plan contained contradictory information about who funded the person's care and who had legal responsibility for a person's finances. Cleaning schedules and evidence of checks and servicing of some equipment could not be found during the inspection. The provider had failed to ensure that records were accurate and complete.

Staff were reminded about the policies and procedures at a recent staff meeting, these were available to staff and were developed by the previous provider although they did not always reflect current legislation. There was no safeguarding policy available, although one was developed following the inspection. Other procedures did not give

Inadequate

Is the service well-led?

clear guidance about what staff should do in situations, such as when an accident or fall occurred. This meant there was inconsistency in staff's practices when these events happened and appropriate action was not always taken or taken in a timely way to keep people safe and well.

The provider had failed to have systems and processes established and operated to ensure compliance with requirements. The above is a breach of Regulation 17 (1)(2)(a)(b)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

An incident that occurred on 1 December 2015 was not reported appropriately to the safeguarding team or the Commission. All care providers must notify us about certain changes, events and incidents affecting their service or the people who use it. These are referred to as statutory notifications. This includes any allegation of abuse, any serious injury to a person and when the registered manager will be absent from the service for a period of 28 days or more.

The provider had failed to notify the Commission of events which they had a statutory obligation to do so. This is a breach of Regulation 18(2)(a)(b)(e) of the Care Quality Commission (Registration) Regulations 2009.

Disciplinary action had however been taken when staff performance or behaviour failed to meet the required standards. The provider had also held a staff meeting on 24 November 2015 where the expected procedures and practices were discussed with staff and each staff member had received a copy of the minutes. The meeting had already identified some of the shortfalls found during the inspection. In addition the provider was using the services of an independent health and social care advisor, who had already had a meeting with the acting manager and acting head of care to discuss the shortfalls they had identified and set some timescales for actions to start to address these. An action plan to address shortfalls was also received by the Commission following the inspection. This showed the provider was acting to protect the quality and safety of care provided. In discussions with the provider they expressed their determination and willingness to work with outside agencies to improve the standards of care and support provided.

Staff told us they felt the provider was more "Approachable and was addressing problems and things are resolved". They had confidence that things were and would continue to change for the better.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider had failed to protect people from abuse by establishing systems and processes that operated effectively.** Regulation 13 (2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The provider had failed to provide equipment that is clean and maintain standards of hygiene.** Regulation 15(1)(a)(b)(2)

Regulated activity	Regulation
	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The provider had failed to establish an effective complaints procedure.** Regulation 16(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The provider had failed to notify the Commission of events which they had a statutory obligation to do so.** Regulation 18(2)(a)(b)(e)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had failed to mitigate risks in relation to proper and safe management of medicines, the premises and the health and safety of people. The provider had failed to properly assess risks to people's health and put in place safe procedures to ensure their health and welfare. Regulation 12(2)(a)(b)(d)(e)(g)

The enforcement action we took:
A warning notice was issued to the provider that they take action to ensure that people received care and treatment in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had failed to provide sufficient numbers of suitably qualified, competent, skills and experienced staff to meet people's needs. The provider had failed to ensure staff received appropriate support, training and supervision. Regulation 18(1) (2)(a)

The enforcement action we took:
A warning notice was issued to the provider requiring them to take action to ensure that people had their needs met by sufficient numbers of suitably supported, competent, skilled and experienced staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider had failed to act in accordance with the law, make decisions based on the principles of best interest and obtain consent appropriately. Regulation 11(1)(3)

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
A warning notice was issued to the provider requiring them to act in accordance with the law, make decisions based on the principles of best interests and obtain consent appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider had failed to ensure that care and support was meeting people's nutritional needs and have regard for their well-being. The provider had to provide people with appropriate person-centred care to meet their needs and reflect their preferences The provider had failed to ensure that care plans reflected people's assessed needs, preferences and remained up to date. Regulation 9(1)(a)(b)(c)(3)(a)(b)(i)

The enforcement action we took:
A warning notice was issued to the provider requiring them to ensure that care and support met people's nutritional needs and had regard for their well-being. They were required to provide people with appropriate person-centred care that met their needs and reflected their preferences . They were required to ensure that care plans reflected people's assessed needs, preferences and remained up to date.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had failed to have systems and processes established and operated to ensure compliance with requirements. Regulation 17 (1)(2)(a)(b)(c)(d)

The enforcement action we took:
A warning notice was issued to the provider requiring them to have systems and processes established and operated to ensure compliance with requirements.