Clarence Lodge (Great Yarmouth) Limited

Clarence Lodge

Inspection report

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16 February 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 14 and 16 February 2018 and was unannounced. At our previous inspection of 26 and 27 October 2016, we found the service was no longer in breach of regulations, but was rated as 'Requires Improvement'.

At this inspection of 14 and 16 February 2018, we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to staffing, governance, safe care and treatment, and person centred care. We also found a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, for not informing us of a serious injury which had occurred in the service.

We took enforcement action to impose conditions on the providers
registration. This condition means the provider has to inform us of actions which have or are being taken to mitigate identified risks. We decided to impose these conditions on the providers registration because people may be exposed to the risk of harm.

Clarence Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Clarence Lodge accommodates 28 people in one adapted building. At the time of our inspection there were 24 people living in the service.

There was a registered manager in post. 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.

There were gaps in how the service assessed and monitored the quality of its provision. While there were some quality assurance mechanisms in place, these had proved ineffective at identifying areas for improvement, and not all aspects of the service were being effectively monitored. The registered manager had not notified us of a serious injury which had occurred in the service, which is required by law.

People's health, safety and well-being were at risk because the registered manager and provider had failed to identify where safety was being compromised. Infection prevention and control procedures were ineffective and we found that hygiene in the service was poor in some areas. This included in areas where food was prepared.

People did not always receive timely healthcare support. The organisation of care records meant that it was not always possible to case track people's medical history and subsequent input from health professionals.

Staffing levels were not sufficient to ensure people's safety at all times. Staff were not always able to be responsive to people's needs. Staff were not receiving regular supervision, and some staff had not received training updates.

The registered manager had applied for Deprivation of Liberty Safeguards when people who lacked capacity to consent, had their liberty restricted. However, we did not see that a capacity assessment had been carried out in advance to determine that this was required, or how any restrictions would be managed. Additionally we saw some capacity assessments that had been carried out were generic in nature and not decision specific.

People received their medicines safely, however, improvements were required in relation to recording of some documentation and the security of medicines.

Risks in relation to falls, malnutrition and pressure area care were not being adequately assessed or monitored to ensure people were cared for in a safe way. There was not always guidance in place for staff about how to manage or reduce risk.

Food and fluid charts were not always completed fully or totalled to ensure people were receiving adequate nutrition and hydration.

Care plans for people were not always reflective of people's current needs. Information held in people's care plans was not consistent across the service and there was a risk that staff did not have the most appropriate information to enable them to tailor the care they provided to people. The service needed to develop their practice in supporting people in relation to their end of life care planning.

The provision of activity was not sufficient to meet individual and specialist needs.

The provider needed to consider more fully how to maximise the suitability of the premises for the benefit of people living with dementia, and we have made a recommendation about this.

Safe recruitment procedures were in place, and staff had undergone recruitment checks before they started work to ensure they were suitable for the role. Staff knew how to recognise abuse or potential abuse and how to respond and report these concerns appropriately.

There was a complaints process in place, and people felt confident that they could raise any concerns with staff.

The dining experience was not conducive to an enjoyable mealtime and opportunity for social interactions, and we have made a recommendation about improving the dining experience for people.

We saw that staff were kind and caring when supporting people, however, we saw there were missed opportunities for staff to interact more fully with people throughout the day.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to

begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

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 associated with people's care were not always safely managed, monitored or reviewed in line with their assessed level of need.

Staffing levels were not sufficient to ensure that they were meeting people's needs at all times.

Staff knew how to recognise abuse or potential abuse and how to respond and report these concerns appropriately.

People received their medicines in a safe and timely manner, but some areas required further improvement.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Records relating to Mental Capacity Act were not always individualised and did not maximise people's ability to have control over their lives or the care they received.

People's dietary needs were not always documented fully or monitored.

Not all staff were up to date in their training. Supervision of staff was not regularly carried out.

People's health needs were not always met in a timely manner.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Due to some of the wider failings within the service people did not always benefit from a caring culture.

Staff were observed to be kind and caring in their interactions with people.

Relatives and visitors could visit at any time and there were no restrictions.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care records did not always provide staff with the information needed to provide individualised care.

Activity provision was not at a level which would meet the individual and specialist needs of all people using the service.

People and their relatives felt able to complain if they had concerns they wanted to raise.

Is the service well-led?

Inadequate

The service was not well-led.

The registered provider had not ensured that the service was operating effectively to ensure that people were receiving safe and effective care at all times.

Quality assurance systems had not identified where quality and safety had been compromised. This placed people at risk of harm.

There had been a failure to learn from previous failings and drive improvement within the service.

Clarence Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 14 and 16 February 2018 and was unannounced. The inspection team consisted of one inspector, one inspection manager, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspector returned for a second day to complete the inspection, and announced this in advance.

As part of our inspection planning we reviewed all the information we held about the service. This included previous inspection reports and any notifications sent to us by the service including safeguarding incidents or serious injuries. This helped us determine if there were any particular areas to look at during the inspection. We spoke with the local authority safeguarding team prior to the inspection.

At the time of inspection there were 24 people living at the service. To help us assess how people's care needs were being met we reviewed five people's care records and other information, including risk assessments and medicines records. We reviewed three staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service. We spoke with three people who lived at the service, four relatives, a health professional, the registered manager and provider, and four members of care staff.

Inadequate

Is the service safe?

Our findings

At our previous inspection on 26 and 27 October 2017, we rated this key question as 'Requires Improvement', and found the provider was no longer in breach of regulations.

At this 14 and 16 February 2018 inspection, we found the provider had failed to sustain improvements in relation to the cleanliness of the service, and we found that risks had not been accurately recorded or monitored, which placed people at risk of harm.

We found that one person had no care plan or risk assessments in place. They had been living in the service since December 2017, and had complex health needs. We were informed by the registered manager that their care plan had been lost. There were no risk assessments in relation to their risk of choking, nutrition, acquiring pressure ulcers, or moving and handling guidance. This meant that staff did not have up to date information or guidance on how to care for the person safely and monitor potential risks.

Where people had risk assessments in place, these were not always accurately completed. For example, one person's mobility plan stated that they could walk with a stick but declined to use it. Throughout the day we observed that this person remained in their wheelchair and required support from two staff when transferring. Their care plan also stated that they could mobilise around the service. They were assessed on 24 January 2018 as being at 'low risk' of falling. However, their falls log showed that they had sustained two falls in January 2018, and one in February 2018. Additionally, their 'falls management plan' did not include what measures were in place to reduce the risk of further falls, such as a pressure mat (which alerts staff if the person stands up) which was being used. The same person had been assessed to determine the likelihood of developing pressure ulcers. We observed that the calculation for this was not done accurately, as their skin type was recorded as 'healthy' and we saw that there was discolouration and broken spots on their skin. Additionally, we observed that the person was sat throughout the day with no pressure relieving aids, such as a pressure cushion.

Another person's care plan stated that they were diabetic, and provided information on what action to take were their blood sugars to become low causing hypoglycaemia. However, there were no details regarding what action to take if their blood sugars became high. Additionally there was no information on what the target blood sugar levels should be so staff could follow the correct guidance and act promptly.

We saw in the handover records that one person was experiencing symptoms which gave them moderate discomfort. The symptoms had been logged in the handover book from 3 February 2018, but no staff had communicated this to the GP, who was not contacted until 12 February 2018, therefore delaying the person's treatment by nine days.

Another person's care plan stated that they had a history of urinary tract infections (UTI), and records showed they had just had a course of antibiotics to treat a UTI. There was no care plan in place to describe how this should be managed, or how to reduce the risk of further UTI's.

Another care plan contained incorrect information on the persons' ability to mobilise. Their moving and handling plan was reviewed on 23 January 2018, and stated that they, "Must mobilise with a walking frame." We saw they were mobilising independently around the service. Staff confirmed that the person did not use a walking frame. Had staff attempted to provide the person with a walking frame in line with the care plan, there was a risk the person would have fallen. The care plan also said they took a particular medicine. However, the registered manager told us that this had been stopped by the prescriber. The care plan had not been updated to reflect this, and was therefore a risk it could be given in error. We found that there were infection control risks within the building due to certain areas not being cleaned properly. This included the following; in the downstairs bathroom we found gloves and apron supplies which should not be stored in a toilet area due to risk of cross contamination, an old stained urine bottle, and a commode rusted in places, which meant it could not be cleaned thoroughly. We found toilet brushes sitting in contaminated water, stains underneath hand towel and soap dispensers, and a hoist with unclean footplates. We reported our concerns to the local infection control team who visited the service.

The cleaning audits were not effective. They did not fully describe what had been cleaned, and how. For example, entries said, 'deep cleaned rooms' with a corresponding room number, and 'cleaned sink', it did not describe what had been cleaned, what products should be used, and there were no specific de-scaling records in place, which is important to reduce the risk of legionella bacteria. We found some taps in service user rooms had visible lime scale on them. A general diary was being kept of which rooms had been deep cleaned, but was not sufficiently detailed. The kitchen area was in need of a deep clean. We found staining in cupboards, the oven was visibly unclean inside and out, the deep fat fryer was covered in old oil, and the fridge seal had split on the main fridge. We reported our concerns to the local environmental health department who agreed to visit the service.

We also found that in the first floor bathroom that talcum powder, body lotion and scrub had been left unsecured, which posed a risk to people who may be living with dementia, and who may not realise that ingestion of these substances could be dangerous. Further to this, there was an unsecured store room on the first floor which people could mistakenly access, and potentially come to harm as there were trip hazards, such as a hoover, a chair and boxed items.

We concluded that risks associated with people's care and support were not safely managed, and this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Manual handling equipment, such as hoists, had been serviced, and there were systems in place to monitor the safety of water systems and the prevention of legionella bacteria, however, de-scaling records were not in place. Fortnightly fire drills were being carried out in the service, however, we saw that some staff had not received fire training since 2016. Following the inspection, the registered manager told us they had booked a training session. There were personal evacuation plans in place which described the level of assistance people would need in the event of an emergency. However, fire evacuation equipment was only available on the first floor.

Given the complex, and sometimes unpredictable needs of people, staffing levels were not always sufficient to meet both the routine and emergency work of the service. For example, following the inspection we received information that the ambulance service had concerns relating to their attendance to a person during the night; there were two members of staff on duty. Ambulance staff reported that whilst they were treating the person, staff left them, and they had to ring the person's alarm to get both members of staff back to assist in moving the person into a wheelchair. They reported that they had to wait for five minutes for them to return and the situation was 'time critical'. The ambulance staff felt that if there had been any other emergency at the service then there would have been no other member of staff on duty to assist with

it. Staff had also not considered that leaving the person may have caused them distress as they did not know the ambulance crew, and may have felt more comfortable with staff they were familiar with.

Staff we spoke with told us that staffing levels were not always sufficient to meet people's needs. They told us of two people who required additional support at times due to their unpredictable and complex needs. One staff member said, "Two [people] are quite dependent on our support now, and their needs can be unpredictable, so if they are up and about they need more time, have to watch them and make sure they are safe. Also the cooking at supper is done by [care staff], and this means staff are taken off the floor." Another said, "It is harder if [person] needs more support or if they are wandering. The late [shift] is also harder sometimes as staff go off early. In an emergency situation we would struggle."

We were informed by the registered manager that one of the care staff prepares the tea time meal, leaving only four staff to monitor and assist people, three of which require two staff to assist them with their care needs (the registered manager told us this could vary). A dependency tool was used to calculate the number of staff required for people's care needs, however, this did not take into account staff time spent preparing supper. There were also no other systems in place to assess staffing levels, such as routinely asking staff and people if the staffing levels were adequate and meeting their needs. One person told us, "At certain times I think they could do with one more [staff member], particularly in the mornings and evenings when it's very busy." A relative said, "They're always short [of staff] they do need more."

At 10.04am we observed that three people were still waiting for assistance to get up. Staff were unable to confirm whether people in bed had had their breakfast, and that domestic staff often helped out with breakfasts as care staff were very busy. One person was observed eating their breakfast at 10.00am, which was a large cooked breakfast, and lunch was due to be served at 12.30pm. Another person was seen to be having breakfast at 10.37am. This could mean that people may not be hungry enough to eat their lunchtime meal when it was served.

The above constitutes a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received their medicines as required. One person said, "All my medicine is provided on time." A relative told us, "There's never been an issue. The doctor has taken [relative] off some medicines now anyway."

We checked the systems in place for managing people's medicines. Generally medicine administration records (MAR) were completed accurately and consistently to show what medicines people had been given. However, we found some areas for improvement.

Supporting information was available for staff to refer to when handling and giving people their medicines. There was personal identification, information about known allergies and medicine sensitivities.

Medicines were stored securely in lockable facilities for the protection of people who used the service. However, during the inspection, we found a medicines fridge unlocked. There was a risk that these medicines could be accessed by people who were living with dementia, and who may not realise that consumption of the medicines could be dangerous. We alerted the registered manager who spoke to staff and ensured the fridge was locked.

Audits were in place to enable staff to monitor medicine administration and their records. However, whilst overall records showed that people were receiving their medicines as prescribed we noted some

discrepancies in records indicating occasions where people were not being given their medicines as prescribed. For example when we checked the stock levels of one person's medicines against the number recorded on the chart, the numbers did not match indicating that the medicine had not been administered as prescribed. For another two people, the medicine administration charts showed occasions when their medicines were out of stock. The registered manager told us that for one person the medicines had been discontinued and for the other the GP had not issued a repeat prescription as the person had not attended a GP review. However, this was not clear on the medicine administration charts and there were no supporting health records to confirm this.

When people were prescribed medicines on a when-required basis, there was not always sufficient written information available to show staff how and when to give them to people to ensure they were given consistently and appropriately. For example, we found that one person had been prescribed a sleeping tablet, which they could have each night if needed. We found this had been given consistently every night for the past month. There was no information on what steps had been taken before administering the medicine, and whether the person needed this. Another person was prescribed a painkiller 'as required', but had been receiving this regularly, and therefore may need this to be prescribed for regular use.

Rotation charts were in place for people who had pain relief patches applied, to ensure the site of application was varied to avoid irritation of the skin. However, we found one did not specify where on the body the patch had been applied.

We observed medicines being administered by a senior care assistant at teatime. Overall their practice was good and they followed the correct procedures. However, at one point they were distracted from administering medicines by another member of staff and there was a risk that this could lead to errors occurring.

During the inspection medicines reviews were being carried out by a pharmacist from the Clinical Commissioning Group. This meant that any issues with prescribing were being addressed as part of the review.

People told us they felt safe living in the service. One person said, "Yes I'm safe and comfortable. I know them [staff] all and their names. We do have a laugh together." Another said, "I'm happy but if I wasn't I could speak to anyone and feel listened to, I'm sure."

Staff received safeguarding of adults training, however, the training matrix showed that nine staff had not completed this training since 2016. The registered manager told us that they had booked a refresher session to ensure this was updated promptly. Staff were able to identify different types of abuse and what action they needed to take if they suspected someone was being abused. One staff member told us, "We can come across all sorts of abuse; financial, verbal, physical. Staff can be abusers as well. If I saw anything like that I'd report it. I know I can go on the CQC website and report it there. I have done so before." Another said, "I would report any concerns to [registered manager] or [provider] it would get dealt with I'm confident about that."

People were protected by procedures for the recruitment of new staff. Checks had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

The service needed to develop their practice to ensure that lessons were learned and improvements made

when things had gone wrong. For example, following our previous inspection, the provider had not ensured that improvements were sustained, and were again in breach of regulations. This did not give us confidence that the provider was learning from and developing systems and processes which supported improvement. Where accidents and incidents had been logged, details around actions taken and root causes had not been completed. There was no analysis of accidents and near misses so that they could establish how and why they had occurred to prevent recurrence.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we rated this key question as 'Good'. At this 14 and 16 February 2018 inspection we have rated this key question as 'Requires Improvement'. People's care needs were not always holistically assessed to ensure care and treatment was delivered to achieve effective outcomes.

People's health needs were not always met in a timely manner. We were unable to determine when people were seen by health professionals by looking at their care plans, and had to ask the registered manager for the information to be sourced for us following the inspection. Poor records were kept of the input people received from health professionals and there were ineffective systems in place to communicate this between care staff at shift changes. A health professional told us that communication between them and the service was not always effective, as not all information was readily available.

Nutritional and hydration needs were not always recorded accurately or consistently. One person's records showed that they had lost weight when last weighed on 16 January 2018. Food and fluid charts were being completed, however, these were not always being completed consistently and accurately. The care plan stated that the aim should be for 1.6 to 2 litres of water daily. Fluid charts show that some days the person was not reaching this target, and had as little as 300 to 600 mls of fluid. On other days no fluid intake had been recorded by staff. There was no detail about what action should be taken if the target range was not met, and it was not clear if this was being monitored. The person's 'continence' care plan last reviewed 23 January 2018, made no reference to the required fluid intake.

Food charts were also not completed consistently. One person's 'diet and nutrition' care plan stated that they must have a snack before bed. Food charts did not show that this was being offered, and were often blank in the 'supper time' section. Staff told us that often the person would decline, but there was no information about what action to take in these circumstances, and it was not possible to determine if the person had been offered a snack. Other areas of the food chart were just left blank, therefore it was not clear if the person was offered food by staff or if they declined this.

Another person's care plan said to follow a diabetic diet, but there was no detail around what this constituted, or certain foods they should avoid. The record said the person liked chocolates and sweets, but again there was no detail around how this need would be met.

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

We observed the lunchtime meal. The dining area was fairly small, and not large enough for all people to use at once, and we saw that nine people ate their lunch in the lounge. We observed that some people had to eat from their lap, as the portable table was too high for them to reach. One person's care plan said to use a clock system to show the person where the food was on the plate, however, we observed that staff just placed their food on the table and provided no support.

We asked people about the food provided in the service. One person told us, "The food's good. They [staff] come round in the morning to ask which choice you want for lunch. We've got meat and potato pie or chilli today and on Sunday we had roast chicken or beef and rhubarb pie, that was very good. Someone wanted a fry-up instead of roast so that got cooked for them." However, a relative told us, "The food is not up to standard. The food comes from cheap places. I bring in food, fish and chips sometimes. My [relative] was used to eating a lot of fresh fish, they cook fish for [relative] but it's cheap, nothing like [relative] is used to. Also the meals are often cold. I put my finger in [relative's] lunch once and the meal was cold, so were the veg, stone cold."

Our observations of lunch time were that the overall experience was not effective in ensuring people enjoyed their dining experience and that opportunities were taken to promote independence, choice and social interaction.

We recommend that the service explores current guidance from a reputable source (such as the Social Care Institute for Excellence) to ensure that mealtime experiences are an opportunity to support and promote independence, in addition to creating a positive mealtime experience, particularly for those with specialist needs including dementia.

We asked people if they thought staff were well trained. One person said, "Yes staff are trained. The staff have to put me on this thing that spins to move me around, they [staff] seem to know how to do that so that's reassuring." Another said, "Well they [staff] do seem to be efficient. Yes they're [staff] really good."

Staff received training in medicines, first aid, challenging behaviour, dementia, Mental Capacity Act 2005, infection control, safeguarding and moving and handling. However, we saw from the training matrix that eight staff had not received moving and handling training since 2016. The registered manager told us that they observed that staff were competent, however, they did not hold a qualification to assess staff competency. Following the inspection they confirmed that they and a senior member of staff had booked 'train the trainer' sessions, which will enable them to train other staff working in the service.

Supervisions and appraisals provide staff with the opportunity to discuss how they are working, receive feedback on their practice and identify any training needs. The registered manager told us that they tried to ensure staff were offered formal supervision on a regular basis, but many had fallen behind. We saw that some appraisals had been completed recently. However, staff working in the service were not supervised adequately to ensure that their competency and application of their learning was effective. Not all staff were receiving appropriate on-going or periodic supervision, or appraisal of their performance to ensure competence was maintained. Additionally the registered manager was not receiving regular supervision from the provider.

Staff had not received training in all areas relevant to their role, such as end of life care. Staff should receive appropriate support, training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

All of the above constitutes a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty.

We checked whether the service was working within the principles of the MCA, and found that this needed to be improved. For example, we found that one person had been assessed as not having capacity, but it was not clear what decision was being made in relation to the need for a capacity assessment. Additionally there were no mental capacity assessments or best interests decisions in relation to DoLS which had been applied for. This meant we could not be sure how any restrictions were being managed and met.

Where some capacity assessments had been completed, we found the wording used was generic, and not individual to the person they related to.

We saw some areas of good practice, for example, where people might decline personal care, there was a description of how best to support them so the task is made easier or more appealing to them. We also saw that where there were best interests decisions in place, they listed who was consulted as part of the decision making process, which included family members. Other areas of people's care plan described how best to communicate with people, such as being observant of facial expressions or changes in their presentation which might indicate they are distressed or in need of increased support.

Staff were able to tell us how they supported people to make decisions about their day to day lives. One staff member said, "I always ask [people] what they would like to wear, what they want to do. I don't assume. People can refuse, it's their right." Another said, "People can still make informed decisions even when they lack capacity for bigger decisions. We ask if they can understand the information, weigh it up and communicate their decision. We support people to make choices around everyday decisions." One person told us, "Staff always ask me first, certainly. The staff are careful and respectful."

The provider had not considered how to maximise the suitability of the premises for the benefit of people living with dementia. Walls were painted a similar colour with little contrast. There was limited signage available to help people to orientate themselves and did not follow best practice and up-to-date guidance to support people living with dementia. There were few clear signs, symbols or colours to help people to recognise their own bedroom. For example, some bedroom doors had names and pictures on, but not all. Some decoration in the service was tired and in need of improvement. There was a lack of sensory stimuli, for example, orientation boards and information for people in an easy to understand format. In addition, there were no memory boxes and objects of reference to help aid reminiscence or provide a stimulating environment.

We saw there was a room at the back of the building which was used as a store room with several arm chairs. One person walked into the room several times during the day, but was redirected by staff back to the main lounge. We discussed with the registered manager and provider the option of making this space a sensory area where people could spend time interacting with objects of interest, or just create a quiet space away from the from the busier areas of the service.

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

The service had worked together with other organisations. The service had been involved with a 'Hospitals admissions pilot project' to try and avoid the need for hospital admissions, and as a result the local medicines optimisation team had visited the service to review people's current medicines and ensure they were prescribed the most effective medicines. The service had also worked with a company commissioned by the local quality assurance team to support improvements, and they continue to do so.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection on 26 October 2016, we rated this key question as 'Requires improvement'. This was because staff did not always treat people in a respectful way or promote their dignity. At this 14 and 16 February 2018 inspection, we found this key question remained at 'Requires Improvement'.

Due to some of the wider failings in the service, people living at the service did not always benefit from a caring culture. The concerns we raised during our last inspection on 26 and 27 October 2016 had not been adequately addressed by the provider to ensure people were safe and the overall quality of care people received in the service was of a high standard.

We found that although people and most relatives made positive comments about staff, the staff were not supported by the provider organisation to deliver a wholly caring service. Due to the shortfalls we found at the service, the ability of staff to provide a holistic approach to people's care needs was constrained due to staff deployment, lack of supervision and ineffective governance and leadership. This meant that people were not always at the centre of the care they received.

People told us that staff were kind and caring. One person said, "My relationship with staff is great, really good. I think the staff know me. They chat to you and are friendly, it's cosy here." Another said, "The staff are caring and kind and we talk and laugh together. It feels homely here, the staff know me well." Relatives also gave their views. One told us, "I feel welcome when I come and am usually offered a tea or coffee. The staff know my [relative] and me." Another said, "We [staff] have a laugh and a joke. Yes I think the staff can read [relative] like a book."

We observed that staff were kind and caring when interacting with people, but did not always take the opportunity to interact outside of providing support with a task. For example, during lunch staff walked through the dining area, but did not engage with people. We saw several situations where staff could have interacted more readily where people were sitting alone, or looking bored. Instead we observed that staff sat writing notes in a separate room, or where they were in the same room as people, they did not take the opportunity to interact. One person was seen to have their head in their hands most of the morning, but very little interaction was given by staff who walked past. One senior staff member made an effort to encourage the person to eat some chocolate that was placed beside them, but other staff did not appear to notice their subdued manner or take the opportunity to interact with them.

Staff knew people well and how they liked their care delivered. One staff member said, "We know our residents well, we know how they like things done. I do wish the environment was nicer for them [residents] though. I sometimes feel embarrassed if I'm showing someone round." Another said, "We have some real characters here, it's good to get to know [residents] better and laugh with them."

Most of the staff we spoke with clearly knew people well but some care records did not always reflect people's life histories, past employment, family lives and relationships. This could make it difficult for new staff to get to know people and support them to initiate meaningful conversations.

Resident meetings were planned to take place in the service every month. The last one was in December 2017. People were asked for their views in relation to the decoration in the lounge and the new chairs. People were also asked if there were any other improvements they would like to see, and the feedback included asking for a television to be mounted on the wall and for the front bush to be cut down. Surveys were sent out annually to people and relatives, however we saw this had not been done since 2016.

We observed some practices' could be improved in relation to ensuring people's dignity. One person was brought into the dining area to have their lunch, but their hair was dishevelled, and they looked unkempt. Another person was seen to be dropping most of their food down their front when eating, but staff did not intervene to clean this up for them.

People felt their privacy was respected. One person said, "I'm fortunate that my health is good. The staff are very respectful, yes they are. Absolute privacy. The staff leave me in my room to read or watch TV or just have time on my own." Another said, "I could have time on my own in my room if I wanted to but I like being with people you see. The staff treat us all with respect."

Requires Improvement

Is the service responsive?

Our findings

At our 26 October 2016 inspection, we rated this key question as 'Requires Improvement', as care records were not updated when people's needs changed, and did not cover all areas of need. At this 14 and 16 February 2018 inspection, we found the same concerns and have rated this key question as 'Requires Improvement'.

People were at risk of receiving inconsistent or unsafe care and support. Whilst some people's care plans provided staff with personalised information on their preferences, we found several care plans did not contain up to date relevant information in relation to people's needs. There was often key information missing and the information around people's care was not current. This meant staff would not have essential up to date knowledge of the care people required.

The organisation of care records meant that it was not always possible to case track people's medical history and subsequent input from health professionals. For example, it was recorded in the handover notes on 11 February 2018 that one person was suffering from specific symptoms which may require GP input or admission to hospital. It was not clear from any records what action had been taken in respect of this. The information could not be found, so the registered manager had to forward us the information in relation to medical input following the inspection.

Staff were not always able to be responsive to people's needs. Staff told us that there were two people in the service who were living with dementia and whose needs could change quickly, meaning they needed more 'one to one' support from them. They told us this impacted on their time to support other people, and at times they had to wait if they needed support.

The service needed to develop their practice in supporting people in relation to their end of life care. Planning ahead for when people may no longer be able to communicate their views regarding end of life wishes is sometimes called 'advance care planning'. This involves thinking and talking about how people choose to be cared for in the final months of their life. Some care plans made reference to people's end of life wishes, however, these contained minimal information and did not follow best practice guidance. Additionally, staff had not received end of life care training which would equip them with the skills and knowledge they require.

We asked people if there was enough to do and if they ever felt bored. One person told us, "I don't really know. I usually spend time in my room reading, doing puzzles and watching some TV." Another said, "We play bingo and floor dominoes and hoopla sometimes. At our Christmas party we had Elvis come to entertain. He was very good." A relative said, "They [staff] don't do anything. There's been a board up for about a year but if you look you'll see the dates are wrong. They [staff] don't update the board because nothing goes on. They played bingo today and [relative] won a bar of chocolate."

There was a lack of stimulation for people living in the home. The registered manager informed us that they were the activity co-ordinator, and provided one hour per day, and also the care staff helped if they were

able. Given the specialist needs of some people living in the service, we did not consider this to be sufficient to meet individual needs. We also found missed opportunities for staff to interact with people. For example, at 2.00pm we saw staff writing notes in the lounge area where most people were sitting, One person was talking to themselves, some asleep, and others looked disengaged. We observed that staff members did not interact with people whilst they were present.

At other times we saw staff writing notes in the dining area, where no people were sitting. There was a game of bingo in the morning which people appeared to enjoy, but outside of this, people did not have any stimulation or activity to occupy them. One person continually walked around the service but there was not any stimulation for them, such as sensory activities or objects to interact with. Staff just directed them back to the lounge or dining area.

We observed that for the majority of the day, most people were sat for periods of time with no stimulation, and were disengaged with their surroundings. Most people spent their day in the main lounge with the television on and the volume very low. Staff were seen to be available in the lounge area, but did not take the initiative to ask people if they would like to take part in an activity other than watching the television.

All of the above constitutes a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people if they knew how to complain, and if they were comfortable in doing so. One person said, "I have no complaints, but I would talk to [registered manager] if I had." Another said, "I would complain yes. I always speak my mind." A relative told us, "Oh yes I'd raise issues. [Senior carer] or [registered manager] would be the people I'd speak to."

The provider had systems in place for managing complaints and in the main these were logged with the nature of the complaint, the source, an outcome and when they were responded to. However, we found that one complaint from a health professional had not been formally documented to show it had been responded to appropriately. The registered manager told us they had dealt with the complaint but had not written it up, but would do so.

Inadequate

Is the service well-led?

Our findings

At our inspection of 26 October 2016, we rated this key question as 'requires improvement'. This was because we had identified areas such as record keeping, activity provision and staff practice which still needed improvement. The provider's quality assurance systems had not identified these areas as a concern, and were therefore not effective.

At this inspection carried out on 14 and 16 February 2018, we found shortfalls in the service which indicated that the auditing and monitoring of the service had again failed to identify the issues we found during our inspection, and had not recognised where people were at risk of harm or where their health and wellbeing could be compromised. We found new breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which demonstrated that the audit and governance systems in place were not effective.

We have rated the service as 'inadequate' overall. This is the third consecutive inspection which has identified that the service needs to make improvements, which means we have not seen evidence of adequate leadership in place to ensure improvements are sustained. As a result we have rated this key question as 'inadequate'.

The registered manager had been in post for over five years and held a leadership qualification, They had a deputy manager to support them two days per week. The registered provider visited the service regularly. They carried out their own audit of the service on an ad hoc basis, the last one being in July 2017, which included asking people about their experience of the service, and environmental improvements needed, such as new carpets and flooring. They had not however provided sufficient oversight to identify the issues we found during the inspection. The registered manager did not receive supervision sessions from the provider to provide an opportunity to discuss their work, reflect on progress, and ensure that the service was improving. Additionally, as the registered manager was the current activity co-ordinator, this could impact on their time to complete managerial tasks in a timely manner.

The provider had not ensured that the service was operating effectively to ensure that people were receiving safe and effective care at all times.

The quality assurance mechanisms had proved ineffective at identifying areas for improvement, and not all aspects of the service were being effectively monitored. For example, there were no care plan audits which would have helped the service to identify where information was not accurate or where they needed updating. Infection control audits had failed to identify the areas we found as requiring improvement. The lack of robust monitoring or auditing processes meant that issues relating to people's care and treatment were missed and risks of potential harm were not being mitigated as far as possible.

Although the service had recorded information relating to falls in the service each month, there was no further analysis of trends to identify patterns and look at ways falls could be reduced. Data relating to falls needed to be analysed in detail to identify any trends, such as the time of day a person was most likely to

fall, and this was not being completed thoroughly. The lack of this robust analysis meant that people continued to be at risk of falls that could potentially be reduced or prevented.

All of the above constitutes a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers must notify CQC of all incidents that affect the health, safety and welfare of people who use services. The service had not informed us of a serious injury which had occurred in the service.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People told us they knew who the registered manager was. One person said, "I think [registered manager] is a nice person. I see them in the lounge and they often chat." Another said, "I like [registered manager] they show no airs and graces. You see them around the home all day. [Registered manager] came up to my room this morning actually, to sort out which newspaper I wanted." Staff also commented on the management team. One said, "In some respects I would say the service is well-led, [registered manager] is good at paperwork, but needs to be more friendly with staff sometimes. But I can speak to them, and I'll be listened to." Another said, "[Registered manager] is a good manager, they do try hard to improve things."

Both the registered manager and a senior carer were dementia care coaches. However, they had not taken the opportunity to share their knowledge in team meetings or training sessions or make changes in the service for the benefit of people living with dementia. The registered manager told us they were intending to start dementia workshops for staff to attend. They had also contacted the local quality assurance team who will support them to make improvements in the service.

Staff meetings took place in the service, the most recent one being in January 2018. However the meeting minutes were not typed up or displayed for staff who may have been unable to attend.

On day two of our inspection, the registered manager informed us that they had started to look at a more in depth cleaning rota, a falls checklist, and care plan audit. They had also contacted the 'outstanding manager's network', to share ideas and request additional audits which would help to improve the quality monitoring of the service. They had also increased the hours the cook worked to ensure the supper time was covered by them, rather than care staff.

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 service had not informed us of a serious injury which had occurred in the service. 18 (2) (1) (ii)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care plans did not include all their needs, and were not always accurately completed. The provision of activity was not meeting individual and specialist needs. 9 (1) 3 (a) (b)

The enforcement action we took:

NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health, safety and welfare were not identified and managed so as to ensure people's safety and wellbeing. 12 (1) (2) (a) (b)

The enforcement action we took:

NOP

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes did not enable the provider to identify where quality and/or safety were being compromised 17 (1) (2) (a) (b) (f)

The enforcement action we took:

NOP

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not receiving sufficient training and supervision to enable them to carry out their duties effectively. Staffing levels were not sufficient to ensure that people's needs were met at all times. 18 (1) (2) (a)

The enforcement action we took:

NOP