Mr & Mrs R Cowen

# Stonehaven

## Inspection report

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## Ratings

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

## Overall summary

This inspection took place on 28 November and 1 December 2014 and was unannounced. The service provides accommodation and personal care for up to 27 people, including people living with dementia. It also provides short-term respite care for people. There were 22 people living at the service when we visited.

The home had a registered manager in place. 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.

People's safety was being compromised in some areas. There was not enough staff to meet people's needs. People frequently had to wait for staff to support them, for example to transfer them from wheelchairs into lounge chairs. When people tried to move without support, it put them at risk of falling. For periods of up to 20 minutes, people were left unsupervised in the lounge with no means of calling for assistance.

# Summary of findings

All required medicines were in stock and people received most medicines as prescribed. However, there was a lack of information for staff about when 'as required' medicines, such as laxatives and sedatives, should be given. Consequently, people may not have received these medicines when needed. The fridge used for storing medicines that had to be kept cool was not working and the arrangements for the disposal of unused medicines were not robust.

Risks relating to the use of bedrails, the management of pressure injuries and supporting people to move safely were not always managed in a way that ensured people's welfare and safety.

There were mixed views from people about the food and drink provided and some people told us there was little choice. The lunchtime menu did not offer a choice of meals. An alternative was available but this was usually a plain omelette. The amount people ate and drank was not monitored effectively, which meant people were not protected from the risk of losing weight or becoming dehydrated.

Most people using the service were living with dementia. Any restrictions placed on people were properly authorised and appropriate safeguards were in place. However, people's ability to make decisions was not assessed. There were no records to show why certain decisions, such as the use of bedrails, had been made on behalf of people. This meant people's rights were not protected.

The provider's induction and training programme followed national standards and staff had completed most essential training. However, they had not received training in how to support people who displayed behaviours that challenged and were not knowledgeable or skilled in this area.

People told us they were cared for by kind and compassionate staff, although two relatives said staff could be "short" or "off hand" with people. We observed occasions where staff interacted well with people, but also some instances where staff showed a lack of consideration and understanding of people living with dementia.

Care was not always personalised to meet people's individual needs. For example, staff organised a range of activities for people, but these were not tailored to meet people's interests. Care plans did not contain enough information about people's continence needs and pain assessments were not conducted to make sure people received pain relief when needed.

People told us staff were good and worked hard; however, two relatives and a visiting doctor were critical of how the service was organised. Staff were focussed on tasks rather than people's needs and staff shortages meant they were frequently called away before completing the task they had started.

The systems used to monitor and assess the quality of service were not effective. Audits had not identified the concerns we found, such as lack of information in care plans or the inadequate monitoring of what people ate and drank.

The provider had appropriate policies in place to protect people from abuse and people told us they felt safe. Staff had received training in safeguarding adults and knew how to identify, prevent and report abuse. Recruitment processes were safe and the provider carried out pre-employment checks to make sure staff were of good character.

People's preferences, likes and dislikes were recorded in care plans, and staff were aware which people liked to sit together; they supported them to do this and used their preferred names. Staff took practical steps to ensure people's privacy was not compromised and kept confidential information securely.

People's care was reviewed regularly and they or their relatives were involved in the reviews. The provider conducted surveys to seek feedback from people, families and visitors through the use of questionnaires. Recent questionnaires provided positive feedback and the provider had made improvements as a result of the feedback. Staff told us they enjoyed working at the service and felt supported by the registered manager.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

# 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. There were not enough staff to meet people's needs and people frequently had to wait to receive support.

The arrangements for managing medicines were not always safe as the medicines fridge was not working. Disposal arrangements were not robust and there was insufficient guidance for staff about when to administer 'as required' medicines.

Risks relating to the use of bed rails and the management of pressure injuries were not always managed safely. Most people were moved safely when supported to transfer from chairs to wheelchairs. There were policies in place to protect people from abuse.

Environmental risks were managed effectively and recruitment processes were safe.

**Is the service effective?**

**Inadequate**

The service was not effective. People were not protected from the risk of malnutrition and dehydration as the amount they ate and drank was not monitored effectively.

Staff did not follow the principles of the Mental Capacity Act when assessing people's ability to make decisions or taking decisions on behalf of people. The service was meeting the requirements of Deprivation of Liberty Safeguards.

Staff were appropriately supported and trained for their roles. However, they had not received training in supporting people who displayed behaviour that challenged.

People had appropriate access to healthcare.

**Is the service caring?**

**Requires Improvement**

The service was not always caring.

Staff did not always treat people with consideration or respect. At times they showed a lack of understanding for the needs of people living with dementia and did not always attend to people promptly. However, at other times they showed compassion and comforted people when they were upset.

People and their relatives were involved in discussing and planning their care and treatment. People's privacy was protected appropriately.

# Summary of findings

**Is the service responsive?**

Requires Improvement

The service was not responsive to people's needs. Activities had not been tailored to meet people's individual interests. Continence was not managed in a personalised way. An assessment tool was not used identify when people needed pain relief.

Care plans did not contain information about how staff should support people who displayed behaviours that challenged. Reviews of people's care were conducted regularly and family members were involved where necessary.

The provider had a complaints policy in place and we viewed examples of complaints that had been responded to promptly and in accordance with the policy.

**Is the service well-led?**

Requires Improvement

The service was not well-led. Staff were focused on tasks rather than the individual needs of people. Audits of care plans and medicines had identified some, but not all of the concerns we found. Systems to monitor the quality of other aspects of the service were not effective.

The provider sought feedback from people and their family members and had made changes as a result. Families and friends told us they were encouraged to visit and become involved with the home.

Staff told us they enjoyed working at the home and felt they were supported by the registered manager.

# Stonehaven

**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 28 November and 1 December 2014 and was unannounced. The inspection team consisted of an inspector, a specialist advisor in the care of older people and an expert by experience in dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service including notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 11 people using the service and seven family members. We also spoke with the registered manager, the deputy care manager, seven care staff, the cook and the cleaner. We also spoke with a doctor and four community nurses. We looked at care plans and associated records for 10 people, staff duty records, three recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records. We observed care and support being delivered in communal areas. 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 last inspected the home in November 2013 and found no concerns.

Inadequate

# Is the service safe?

## Our findings

People and their relatives told us there were not enough staff to meet people's needs. One person said there were "not really enough staff, it's a matter of waiting [for support]". Other people made the following comments: "If you need the toilet, you sometimes have to wait 20 minutes"; "every time she says she'll be two minutes, she means 20"; "The staff do seem very busy lately; you can't blame them but I feel for them as they are so busy". A relative said, "The staff are usually tearing around and you see them fleetingly".

We observed that staff were reactive rather than proactive in their response to people's needs and frequently heard staff using expressions such as: "You'll have to wait"; "I'm just helping someone in the bathroom"; and "I'm busy at the minute". People sometimes had to wait in wheelchairs until there were enough staff to support them to transfer into armchairs. On one occasion, after waiting for staff for 10 minutes, a person transferred themselves into a lounge chair and then placed both of their legs on top of the wheelchair. When a staff member arrived they told the person "this was so dangerous, you must not move yourself, you could fall". The person replied "You should try sitting in that wheelchair, I got fed up with waiting, dear". Another person was left in their wheelchair by a member of staff who said, "I'll be back in a minute". They did not return for 30 minutes, during which time the person tried repeatedly to move on their own.

We observed periods of up to 20 minutes when no staff member entered the lounge and saw people attempting to get out of their chairs and calling out for assistance. There were 10 people in the lounge at this time, many of whom were at high risk of falling and had no access to individual call bells. This put people's safety at risk. Community nurses told us there were not always enough staff to accompany them when they visited to treat people.

Staff felt there were enough of them to meet people's needs on each shift. The registered manager told us they were currently advertising for additional staff to fill vacancies and were recruiting a person to provide additional support to people in the evenings. They said this would ensure there was always a staff member available in the lounge, which was not always possible with current staffing levels.

The registered manager did not use a staff planning tool which took into account the amount of help each person needed. This meant the provider was unable to show that staffing levels were based on people's needs.

The above issues were a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The fridge used to store medicines that needed to be kept at cooler temperatures, such as liquid antibiotics, was not working. Although there were no people using such medicines at the time of our inspection, the service would not have been able to store these safely if they had been prescribed to people at short notice.

People who needed their medicines at set times, such as before food, received them. However, they were not always recorded correctly on the Medicines Administration Records (MAR). For example, a person who needed to take their medicine before breakfast was given it by the night staff, before 8:00 am, but the MAR chart showed it had been given at 9:00 am when night staff were no longer on duty.

The arrangements for the disposal of medicines were not appropriate. Where people had refused to take tablets that had been dispensed from their packaging, they were recorded in the disposal register and placed in a jar with other medicines that had been found. These were mixed together, so it was not possible for the provider to confirm that all tablets recorded in the register were present in the jar. The jar was not tamper-proof so medicines could potentially be removed from it without the provider's knowledge. We discussed this with the registered manager who told us they would introduce a system to label and store such tablets individually, so they could be properly accounted for.

There was insufficient information available to ensure staff gave 'as required' medicines in a consistent way. The MAR charts for people who needed laxatives stated they should be "offered at every medicine round" and did not make any reference to the bowel action chart which would show whether or not a laxative was needed. The care records for people prescribed medicines to relieve their anxiety contained no advice for staff about when and at what dose

# Is the service safe?

it was appropriate to give them and staff were not clear about this. People may not have received medicines when needed or may have been given more medicine than they required.

The above issues were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Appropriate arrangements were in place for obtaining medicines. All required medicines were in stock and there was an effective system of daily checks to make sure people had received each of their medicines. Apart from medicines that needed to be refrigerated, all other medicines, including those controlled by law (CDs), were stored safely.

Risks of people being harmed by the use of bed rails were not always managed effectively. The care records for a person who used bed rails showed they had a history of climbing over them and had recently become entangled in them. The registered manager told us the risk assessment had been completed by the community nursing team, who had provided the bed. However, this was not available and there was no evidence to show that the person's history and recent behaviour had been communicated to the community nursing team. Staff were aware of the risks, had continued to use the bed rails and had not questioned their safety. This put the person at risk of harm.

Care records showed plans were in place to assess and monitor the condition of people's skin. However, staff responses to two people who had shown indications of occasional, low-level pressure injuries were not adequate to ensure the injuries did not develop further. People who showed signs of skin injury may not have received care and support that met their needs. In more serious cases, people had been referred to the community nursing team for treatment and appropriate equipment was being used, such as pressure relieving cushions and mattresses. However, we noted that one pressure relieving mattress was set up for a person weighing 80 kgs, when the person using it only weighed 55 kgs. The mattress was therefore too firm for them and may not have worked effectively, putting them at risk of further injury.

We observed eight people being transferred between chairs and wheelchairs. These were conducted safely, appropriate equipment was used and staff supported the person well. However, during another transfer, we saw a staff member take hold of the waist band at the back of the person's trousers to move them into the wheelchair. Their care plan specified the need for a handling belt, but this was not used and they were not transferred safely.

The above issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks were managed safely. A person who staff had identified was at risk of choking had been placed on a soft diet and been referred to a specialist for assessment. They were given soft or pureed food at mealtimes and staff attended to them quickly when they started to cough while eating. A fire risk assessment had been completed and staff knew what action to take in the event of a fire, having taken part in fire drills. Risks relating to the environment and people's bedrooms had been identified and were being managed appropriately. A 'business continuity plan' was in place which included individual evacuation plans to identify the support people would need if they had to be evacuated, and arrangements for calling in additional staff and finding alternative accommodation.

The service had appropriate policies in place to protect people from abuse and people told us they felt safe. Staff had received training in safeguarding adults and knew how to identify, prevent and report abuse. They were able to explain the role of external statutory organisations and how they could contact them. A safeguarding investigation in relation to an allegation of abuse had been fully completed and an appropriate investigation had been conducted. However, in another case, relating to an allegation that a person's purse had gone missing, a record of the investigation had not been completed. The provider had notified the local authority safeguarding team of the outcome of the investigation, but had not completed the investigation report as requested. The registered manager described the action they had taken to investigate the allegation, but the lack of records meant they could not confirm the investigation had been robust and thorough.

Recruitment records showed the process used was safe. The provider carried out the relevant checks to make sure staff were of good character with the relevant skills and experience needed to support people appropriately.

Inadequate

# Is the service safe?

Recently recruited staff confirmed these procedures were followed. The registered manager was also aware of the recruitment requirements for volunteers, and had conducted appropriate checks for a person who wished to act as a volunteer at the service.

Inadequate

# Is the service effective?

## Our findings

We received mixed views from people about the food and drink they received. One person said, "We get good food and care here". However, others told us there was little choice. For example, a person said, "The meals are beautiful. The only thing I worry about is there's no choice and if you don't like the main meal the only alternative is an omelette and I'm sick to death of them. Just a plain omelette, not even a mushroom one". We confirmed that one main meal was offered at lunchtime and two choices were offered for the evening meal. The cook told us the usual alternative offered to the main meal at lunchtime was an omelette.

People's nutritional intake was not monitored effectively. We identified three people had experienced significant weight loss in the three months before our inspection. We found their care plans had been reviewed, but the only action recorded to address their weight loss was an instruction for people to be weighed weekly instead of monthly. We saw this was not happening, nor was their body mass index (BMI) being monitored. BMI is a measure that can be used to see if people are a healthy weight for their height. Charts to record people's food and fluid intakes were not being used, although a food chart was put in place for one person during the second day of our inspection. Staff told us they were able to provide fortified meals and drinks for people, but there were no records to show people had received them. This meant people were at risk of continuing to lose weight.

People were not protected from the risks of dehydration and not all people were encouraged to drink well. Drinks were not readily available to people, apart from those offered on drinks rounds in the morning, the afternoon and the evening. Most people were only offered, and drank, one small cup of drink at each drinks round. At lunchtime, water was the only option available to people. When we asked staff about this, they could not explain why other drinks were not offered at lunchtime and said, "it's always been that way since I've been here". One person, whose meals were served in their room, did not eat any breakfast or any lunch on the second day of our inspection. We saw a glass of water was left next to their untouched meal. A staff member told us the person "won't drink water" and said this was probably why it had not been drunk. The person's care plan stated they needed to be "prompted" to eat and drink. However, records did not show whether the person had been prompted.

A doctor told us they had visited a person the week before our inspection and advised staff to keep the person hydrated. However, we found no evidence to show that suitable arrangements had been put in place to ensure the person remained hydrated. On the second day of our inspection, we saw the person was given a jug of fruit squash and encouraged to drink frequently, but the amount they drank was not recorded and there was no advice to staff about how much the person needed to drink to remain hydrated. A community nurse also expressed concerns about people's levels of hydration at the service.

The above issues were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some of the people using the service had cognitive impairment to some degree. Staff had received training in the Mental Capacity Act, 2005 (MCA), but did not always follow its principles. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant. One person's care records showed a person had been appointed to make decisions on their behalf. The registered manager told us this related to decisions about the person's finances, care and welfare, but the legal authority confirming this was not available and there were no records to show which decisions the appointed person had made.

The care records for another person showed bed rails were used to protect them from falling out of bed. A brief assessment of the person's capacity stated they were "unable to make rational decisions". However, this assessment was not detailed, did not relate to individual decisions and did not comply with the requirements of the MCA. Staff were also using continence products for people and were managing medicines on behalf of people whose mental capacity had not been fully assessed. It was not clear who had made these decisions, who had been

# Is the service effective?

consulted and why the decisions were in the person's best interests. Staff were not aware of which decisions people needed help to make and which decisions should be made in their best interests. This compromised people's rights.

The above issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had appropriate policies in place in relation to Deprivation of Liberty Safeguards (DoLS). DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. A DoLS authorisation was in place for one person. All but one staff member knew about this and the support the person needed as a consequence.

People had appropriate access to doctors, who visited regularly. Care records showed involvement by community specialists such as chiropodists, opticians, psychiatric nurses and psychiatrists. Staff were aware of one person who needed to attend a hospital appointment. The person was woken early and supported appropriately to attend their appointment.

The home's induction and training programme followed national standards. Training records showed staff were up to date with the provider's essential training requirements. Staff praised the extent and quality of training available, describing it as "very good". However, staff had not received training in how to support people who displayed behaviours that challenged and we found they were not knowledgeable or skilled in this area.

Most staff told us they felt appropriately supported and received one to one sessions of supervision and appraisal. Records confirmed this and showed these opportunities were used to discuss staff development and training needs. Most staff members had obtained vocational qualifications in care or were working towards these.

Requires Improvement

# Is the service caring?

## Our findings

People told us they were cared for by kind and compassionate staff. One person said, "The staff are wonderful, they'll do anything for you". Another person described staff as "very good". The relative of a person told us "The staff are wonderful and kind, they work really hard to make sure Mum is OK and she is happy here, I am grateful for that." Another relative said "I sleep at night knowing [the person] is well cared for. The staff are excellent, he's very happy here". However, two other relatives told us staff could sometimes be "short" or "off hand" with people.

The provider had appropriate policies in place that required staff to treat people with dignity, respect and sensitivity. However, we observed some instances where staff were not warm and compassionate in their approach to people. One member of staff spoke abruptly to a person and told them to "calm down". They added, "you must stop shouting, you are upsetting other residents". This had the opposite effect and the person became more agitated and distressed. On another occasion, when a person became agitated at lunchtime, a staff member told them they were going to "take you into the lounge to calm down". The person was taken through to the lounge in their wheelchair and left facing away from other people. In these cases, staff showed a lack of understanding for the needs of people living with dementia, who, as a result, were not always treated with dignity and respect.

People's preferred times for getting up and going to bed were included in their care plans. Staff told us they were led by people's wishes and tried to meet them whenever possible. However, people told us their preferences were not always met. For example, one person told us they liked to get up early, but were sometimes not supported to get up until 10:00 am. Another person told us they were woken and taken to the lounge at 7:00 am, but preferred to get up later. Records showed that a person who preferred to get up at 07:00 am was supported to get up at 05:30 am on two days in the week of our inspection.

People frequently had to wait for staff to support them. For example, one person told us they got up at 6:00 am each morning and had to wait until 9:00 am for their breakfast. At 7:00 am on the second day of our inspection, a staff member brought them a cup of tea and the person asked if they could have a biscuit. The staff member told them "That's going too far; we're busy getting people up". The person did not receive a biscuit or anything else to eat until 9:10 am.

We observed another person sat in their wheelchair in the lounge looking very uncomfortable; they were leant forward and to one side. As they started to fall asleep, their head fell further forward and was unsupported. On several occasions, they awoke and tried to re-position themselves but did not have the strength to do so. Over the course of an hour, staff occasionally entered the lounge to bring in another person using a wheelchair. During this time, no staff member identified that the person was uncomfortable or attended to them. At one point, four people were in one corner of the lounge, each in a wheelchair. They were left at random angles to each other, facing in different directions. Staff did not ask people how and where they wished to be positioned and no attempt was made to place them in positions where they could see and communicate with one another. One person repeatedly put their hand up to try and attract the attention of staff, but was ignored each time.

The above issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On other occasions staff interacted well with people. For example, when a person became upset by inspectors being in the home, and refused to take their medicines, staff persevered and gently encouraged the person to take them, knowing that they would help reduce the person's level of anxiety. When another person appeared to be in pain, a staff member gently massaged the person's hands and forehead. They got a cold flannel and held it against the person's face as a compress. Whilst doing this, they spoke in soothing terms to the person and we saw they visibly relaxed. When people were transferred using the hoist, staff explained what they were going to do before they did it, made sure the person was happy to be transferred and reassured them throughout the process. When staff gave people their medicines, they explained what they were and what they were for. This helped people understand why they were taking them.

Comments in care plans and reviews of people's care showed they, and their relatives, were involved in

Requires Improvement

# Is the service caring?

discussing and planning their care and treatment. People's preferences, likes and dislikes were recorded in care plans, and support was provided in accordance with people's wishes. For example, at lunchtime, staff were aware which people liked to sit together and supported them to do this and staff called people by their preferred names. Records showed people or their family members had been involved in discussions about resuscitation. People were also able to specify whether they preferred a male or a female staff member to support them with certain aspects of their care and we saw these preferences were respected.

The provider had appropriate policies in place to protect people's privacy. Staff were able to tell us the practical steps they took to ensure people's privacy was not compromised. These included knocking and waiting for a response before entering people's rooms and ensuring doors were closed when providing personal care. We saw staff followed these steps at all times. All bedrooms had locks and people were able to request a key and use the locks if they wished to; staff had access to a master key to use in an emergency. Confidential records were held securely and only staff who needed to view them were able to.

Requires Improvement

# Is the service responsive?

## Our findings

We received mixed views from people about the care they received. One person said, "I've got a warm bed and warm room with a roof over my head. I get all the help I need". However, the relative of a person was critical of the care delivered and said they sometimes had to show staff how to care for the person effectively. One person told us that there was "not enough to do, particularly in the mornings". The relative of a person said, "the staff do their best but there is not much for people to do apart from sit and watch TV and have meals."

A range of activities was provided, including trips to local attractions, shops and theatres, together with quizzes, games and music in the lounge. Information in people's care plans included their interests and hobbies and the activities coordinator maintained a file to note which people were present for which activity. However, daily activities were at a set time and there was no clear link between people's interests and the activities they were offered. We observed a staff member attempting to run a 'Music and Movement' session with people in the lounge, but they chose to play loud pop music, which was not popular. The session came to an end due to a lack of participation.

Guidance issued by the National Institute for Health and Clinical Excellence (NICE), and the Alzheimer's Society identifies the benefits of providing meaningful activities for people living with dementia. These include improving behaviour that challenges; encouraging closeness with people around them; and improving feelings of comfort and security. The service was not following this guidance as meaningful activities were not tailored or designed to meet the individual needs and interests of people.

Care plans lacked information about how people's continence was managed. Care records showed three people were incontinent at times during the day, but their care plans contained no information about how staff should support them to manage this. They did not always specify which products should be used, how often they should be changed or what each person's usual bowel and bladder routines were. Records were not always kept to show when people had been supported with their continence. A community nurse had found four [unsuitable] continence pads were being used for one person who had not been assessed for their use. Consequently, people did not receive personalised continence care that met their needs.

The provider did not maintain pain assessments or pain care plans for people, although seven of the care plans we viewed had recorded incidents of people suffering from pain. Most people had been prescribed 'as required' paracetamol for pain management, but their care plans did not provide guidance to staff about when pain relief might be required. Guidance issued by the National Institute for Health and Clinical Excellence (NICE) states that people with advanced dementia are unable to identify or express pain except through behaviour such as agitation, loss of appetite and withdrawal. The lack of assessments meant people's pain may not have been managed effectively.

Care plans for people living with dementia were not personalised to the needs of varying types of dementia. For example, one person had a type of dementia that affected their movement and memory over the course of the day and also had a sensory impairment. However, their care plan did not take account of this or provide guidance to staff about how to support the person effectively with their varying needs.

People who displayed behaviour that challenged staff were not always supported effectively. The care records for one person showed on several days during the week before our inspection they had been "hitting and swearing", "rude and racist towards staff", and were "agitated". A doctor had been called, who had increased the person's medicines, but we found there was no care plan in place to advise how to support the person when they displayed such behaviour. The care records for two other people who displayed behaviours that challenged staff similarly did not provide guidance to staff about how to support them appropriately at these times. Staff did not use monitoring charts to record details of triggers, what they did and whether their intervention was effective. These would have helped staff develop suitable care plans to enable them to provide appropriate care and support.

The above issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

# Is the service responsive?

Staff responded appropriately to other aspects of people's care. For example, they identified that one person was distressed and had a dry tongue. They spent time with them on a one to one basis until they became calm and they encouraged the person to drink. They also assessed that another person was likely to become distressed by a trip to hospital, so gave the person a mild sedative in advance to help control their anxiety. We saw this person was calm and relaxed when they left for the hospital.

Reviews of care were conducted regularly by key workers. A key worker is a member of staff who is responsible for working with certain people, taking responsibility for planning that person's care and liaising with family members. People and their relatives were consulted as part of the review process and records of the consultations were recorded on 'family review sheets'.

The provider had a complaints policy in place and we viewed examples of complaints that had been responded to promptly and in accordance with the policy. The relatives of one person told us a care review had been held in response to concerns they had raised. They said all concerns were satisfactorily resolved apart from their concern about the lack of activities. Following a complaint by the relatives of another person, we saw staff had agreed to change the time the person was woken and had altered the timing of the person's medicines, which had been effective.

Requires Improvement

# Is the service well-led?

## Our findings

People told us the staff were good and they got on well with them. One person commented that "staff work really hard." However, two relatives told us staff were "defensive" when they raised concerns". Another relative told us, "They're not organised and basic things just don't get done". A visiting doctor told us staff were "disorganised but very well meaning".

A management structure was in place consisting of an experienced manager and 'deputy head of care'. Care staff were clear about who was in charge and were given areas of responsibility and tasks to perform at the beginning of each shift. However, the shortage of staff meant they were frequently unable to complete one task before being called away to help someone whose needs were more urgent. Staff were focused on tasks rather than the individual needs of people.

A recent audit of infection control procedures concluded that the systems were working effectively and no action was required. The systems used to monitor and assess the quality of other aspects of the service were not always effective. For example, each care plan was audited each month and actions identified to address any shortcomings. Records showed these actions were monitored to ensure they were completed. Whilst most actions were completed promptly, we noted some were carried over from month to month, such as the requirement for staff to fully complete the bowel movement charts. The audits had not identified the concerns we found during our inspection, such as the lack of information about pain relief, continence and behaviour that challenged, so did not protect people from the risks of unsafe or inappropriate care.

The system used to monitor the management of medicines relied on staff conducting daily checks. We found these were effective. Where stock levels of medicines did not match the records, investigations were conducted and the issue resolved promptly. An audit had identified the need to replace the medicines fridge, but the provider had not specified a date by which this would be installed. The audit had not identified other concerns, including the lack of care plans for "as required" medicines and the inappropriate arrangements for disposing of medicines. The registered manager told us they were half-way through the process of completing a quality self-assessment manual to audit all areas of the service. The process had not identified concerns we found relating to people's nutrition and hydration, dignity and respect, the application of the Mental Capacity Act or the inadequate staffing levels.

The above issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider conducted a rolling programme of surveys to seek feedback from people, families and visitors through the use of questionnaires. Recent questionnaires provided positive feedback. The provider had made some improvements to the service as a result of feedback, for example by placing a copy of the complaints policy on display and by improving the laundry arrangements. A business development plan was in place to make improvements to the environment, including the installation of more en-suite facilities in people's bedrooms.

Staff told us they enjoyed working at the service and felt they were supported by the registered manager. One member of staff said, "I have great confidence in [the registered manager]; she is an excellent manager". The service had an appropriate whistle blowing policy in place, which encouraged staff to raise concerns. A staff member told us of a time when the registered manager resolved a concern they had raised. They said "It was sorted and I was supported". Staff meetings were held monthly. Minutes showed they were well attended, with representatives from each shift, including nights. The meetings included a training element as well as opportunities for staff to make suggestions for improvements. The registered manager provided examples of improvements that had come from staff members, such as an initiative to provide additional staff in the evenings.

The service had local links with a range of faith organisations, voluntary groups and the local primary school. Families and friends told us they were encouraged to visit and become involved with the service. The registered manager told us about a newsletter they had recently produced for people and their families to keep them informed about the service.

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 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 2008 (Regulated Activities) Regulations 2010 Management of medicines<br><br>**The registered person had not made appropriate arrangements to protect service users against the risks associated with the unsafe use and management of medicines.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services<br><br>**The registered person had not made suitable arrangements to ensure service users were treated with consideration and respect.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment<br><br>**The registered person had not made suitable arrangements for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing<br><br>**The registered person had not taken suitable steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.** |

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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services<br><br>**The registered person had not taken proper steps to ensure service users were protected against the risks of receiving care and treatment that is inappropriate or unsafe by means of the planning and delivery of care to meet service users' individual needs.** |

**The enforcement action we took:**
We issued a warning notice and required the provider to become compliant with the regulation by 28 February 2015.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers<br><br>**The registered person had not protected service users against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to regularly assess and monitor the quality of services provided.** |

**The enforcement action we took:**
We issued a warning notice and required the provider to become compliant with the regulation by 28 February 2015.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs<br><br>**The registered person had not ensured that service users were protected from the risks of inadequate nutrition and dehydration.** |

**The enforcement action we took:**
We issued a warning notice and required the provider to become compliant with the regulation by 28 February 2015.