Lett's Care Ltd

Hamilton's Residential Home

Inspection report

26 Island Road
Upstreet
Canterbury
Kent
CT3 4DA

Tel: 01227860128

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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 was carried out on the 15 and 16 February 2017 and was unannounced. A number of concerns raised by whistle-blowers prompted the inspection. The concerns included people were dehydrated, a lack of staff and an unsafe environment. Initially we were going to carry out a focused inspection to follow up on the concerns with a view to answering one of the key question, is it safe? But whilst at the inspection decided to carry out a full comprehensive inspection and answer all of the five key questions, as further concerns were identified.

In response to the draft report the registered manager and provider sent us comments and additional evidence. This included some medicines records that the provider told us were available on the day of the inspection. Some of these medicines records had been altered and did not match the copies of records we took during the inspection which is concerning.

Hamilton's Residential Home is registered to provide accommodation and personal care for up to 17 people. Most people were living with dementia. Some people could become anxious or distressed and displayed behaviours that could challenge. There were 15 people living at the service at the time of the inspection.

The service had a registered manager in post. A registered manager is a person who is 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.

Since our last inspection some staff, including senior staff had left the service. There had been a decline in the standards of care and a decline of the overall rating of the service. There were a large number of documents missing from the service. Evidence of audits and checks completed by the registered manager and the provider were unavailable. Relatives had been asked their views on the service but these results had not been collated or analysed. The registered manager told us that relative meeting minutes were also missing, although relatives told us that they had not attended a recent meeting. Stakeholders and staff had not been asked their views about the service.

The registered manager had not notified the Care Quality Commission of important events that happened in the service, as required by law. They told us they were, 'unaware' of this requirement, although this had been an issue brought to the registered manager's attention at a previous inspection. There had been a high level of staff turnover and a number of new staff were now working at the service. Relatives told us they were aware of some changes, and hoped they did not affect the quality of care their loved ones received. One relative said, "Overall I am happy with the care. There is a high turnover of staff at the moment. It worries me a bit that they have to get to know residents from scratch and residents have to get to know them. That could be unsettling."

People's medicines were not managed safely. There were stocks of medicines, not prescribed to anyone currently living at the service that could be given for restlessness, agitation and behaviour that could be challenging. The registered manager said when people first came to the service and were restless and agitated then the medicines may be given following consultation with a doctor. Staff did not always give people their medicines as prescribed. There were multiple instances where staff had handwritten changes on people's medicines records and there was no evidence these had been authorised by a medical professional. There were no guidelines in place for when staff should administer medicine on an as and when basis.

On two occasions staff had written they had administered people additional medicine they were not prescribed, to help them sleep as they were 'unsettled' or 'agitated.' We notified the local safeguarding team about our concerns relating to people's medicines after the inspection.

Some people became distressed and could display behaviours that challenged. When people displayed new behaviours their care plans were not always updated and incidents were not analysed to look for potential triggers or ways of reducing their reoccurrence. We identified two incidents that were potential safeguarding issues and the registered manager had not sought advice from the local safeguarding team. We informed the local authority of these incidents after the inspection.

Staff had regular supervision and had received training in topics specific to people's needs such as dementia and how to perform a 'safe hold' if people needed additional support. However, staff were not always clear about people's needs or why they needed support. Information in people's care plans was not always accurate or up to date so there was a risk people may receive inconsistent support. One person had received a skin tear when staff had physically intervened, and there was no information in their care plan about what to do if they became physically aggressive, or how to minimise the risk of this happening again.

There was a lack of guidance for staff to support people with their catheter care. Everyone was identified as requiring 'encouragement with fluids' and at 'increased risk of urinary tract infections (UTIs)' but staff were not consistently monitoring people's fluid intake. Some people did have fluid charts in place, but a daily total of what people actually drank was not calculated so staff did not know how much people had drunk daily. There was no guidance about what action staff should take if people were not drinking enough. Two people were admitted to hospital and it was recorded they were 'dehydrated' on admission.

On the second day of the inspection, people did not receive the support they needed at lunchtime. Plate guards were not on people's plates to support them to eat independently and people had to wait to have their food cut so they could eat it. One person sat in the lounge with their lunch in front of them and did not eat their meal. Staff told us, "They would have eaten if they were sitting at the table," but no one offered the person assistance to move to sit elsewhere.

People's health was monitored and when it was necessary, health care professionals were involved to make sure people were supported to remain as healthy as possible. However, when people's health needs had changed, such as their medicines stopped, this was not always recorded and care plans and risk assessment had not been reviewed and updated to reflect these changes.

The physical environment was not always safe. Staff did not take water temperatures in people's individual rooms. Water temperatures were too high and people were at risk of scalding. There was exposed electrical wiring in one bedroom and the registered manager told us they "Did not know if it was live." The registered manager locked the door after we had raised this with them and the wiring was fixed on the second day of the inspection.

There was enough staff on shift to meet people's needs. However, a volunteer who had not had all of the necessary recruitment checks was working unsupervised with people. Other staff were recruited safely.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. These safeguards protect the rights of people using services by ensuring that if there were any restrictions to their freedom and liberty, these had been agreed by the local authority as being required to protect the person from harm. DoLS applications had been made to the relevant supervisory body and renewed in line with guidance. Staff told us they understood the principles of The Mental Capacity 2005 and people were able to choose what they wore and where they spent their time in the service.

People took part in a range of activities during the inspection, including nail painting and arts and crafts. However, information about activities on offer was not displayed in a way that was meaningful to people. The registered manager and deputy manager said they would look into displaying this information pictorially.

Relatives told us that staff were kind and caring and people were relaxed in the company of staff. The registered manager told us there had been no complaints in the past year.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.You can see what action we told the provider to take at the back of the full version of the report.

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.

People's medicines were not managed safely.

The environment was not always safe. Water temperatures in people's bedrooms were too high leaving people at risk of scalding.

Risks relating to people's catheter care, fluid intake and behaviours were not assessed fully.

The registered manager had not followed safeguarding procedures and had not reported safeguarding concerns to the local authority or Care Quality Commission as required.

A volunteer was working independently with people without the necessary checks or training to ensure they were safe to do so.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People did not always receive the support they needed at meal times to eat and drink effectively.

Staff understood the principles of The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. Best interest decisions had been made when people required medical treatment

Healthcare professionals told us that staff supported people well with their healthcare needs. Records were not always updated when people's needs changed.

Staff received training in topics related to people's needs and had regular one to one meetings with their line manager. However, they did not always put this training into practice and people did not always receive the support they required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect. They did not always receive the necessary support at meal times to retain their independence.

Confidential information was not always stored securely.

Relatives told us that staff were kind and caring and people were relaxed in the company of staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff were not always clear about people's needs or why they needed support. Information in people's care plans was not always accurate or up to date so there was a risk people may receive inconsistent support.

People took part in some activities within the service. The registered manager and deputy manager agreed information about what activities were on offer could be more meaningful to people.

The registered manager told us there had been no complaints in the past year.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager had not notified the Care Quality Commission of important events that happened in the service, as required by law.

A large number of documents were missing. These included evidence of audits, relatives and staff meetings and incident forms.

Neither the registered manager nor the provider had identified the issues we found at this inspection.

There had been a high turnover of staff and relatives were concerned this may affect the quality of care provided.

Hamilton's Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 15 and 16 February 2017 and was unannounced. It was carried out by two inspectors.

Before the inspection, we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because we inspected the service sooner than we had planned. We reviewed all the information we held about the service, including information we had received from whistle-blowers. We looked at the previous inspection reports and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with the nominated individual (the provider's representative), the registered manager and the deputy manager. We spoke with five members of staff and a volunteer. We looked at nine people's care plans and the associated risk assessments and guidance. We looked at a range of other records including four staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance surveys and audits.

We spent time and spoke with most of the people living at the service. Some people were unable to tell us about their experience of care at the service so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We observed how people were supported and the activities they were engaged in.

During the inspection, we spoke with four relatives and a district nurse.

After the inspection, we spoke with the local authority safeguarding team and the commissioning manager from the local authority about our concerns.

We last inspected this service in July 2016. There were no breaches in the regulations identified at this inspection.

Inadequate

Is the service safe?

Our findings

Relatives told us they felt their loved ones were safe living at the service. One relative said, "I don't see why they would not be safe. I have never noticed any bruising." Another relative said, "You won't find a thing wrong with this place. It is perfect." However, we found that medicines were not managed safely and people were not always protected from risk of harm.

People were not always given their medicines safely. Some people were prescribed medicines to be given on a 'when required' (PRN) basis. These medicines are not needed all of the time, just now and again. These included a medicine to ease anxiety if they became distressed. Staff had hand written the MAR and changed the instructions regarding when to give this medicine to all the time. There was no evidence that this change had been on the instructions of a doctor.

On one person's MAR it stated they were to have a 3.75mg tablet to help them sleep at night. The tablet was given to the person every evening at five o'clock. On two occasions, it was recorded on the back of the MAR and signed, that the person had extra tablets as they were 'unsettled' or 'agitated.' This information was not dated. There was also an entry in the senior staff handover book, dated 2 February 2017, that stated, 'had to give [the person] a [tablet] at 21:00 due to unsettled.' Staff had administered this additional sedation without being authorised to do so by a doctor. The registered manager and deputy manager said that they consulted with people's doctors before they made changes to people's medicines but there was evidence this was not always the case.

Staff told us they were aware of people's PRN medicines, but there were no protocols in place to give guidance on when these medicines should be offered to ensure they were administered consistently and safely. The registered manager told us that they would give the PRN medicine as soon as the behaviour started.

The staff held a stock of generic medicines in the medicines cabinet. These were medicines that were not prescribed to any one person. Some of this stock contained medicines for agitation, restlessness and behaviour that could be challenging. We sought advice from a specialist pharmacy inspector who stated that, 'If the medicines were not for a named person then this was unsafe practice.' Any medicines prescribed to people no longer at the service should be returned or disposed of safely. There was a risk that people would receive medicines that were not prescribed to them and not suitable. The registered manager said when people first came to the service and were restless and agitated then the medicines may be given following consultation with a doctor.

Staff did not always give people their medicines in line with the instructions on their medicines administration records (MAR), as instructed by people's doctors. One person was prescribed 1.5mg of a medicine to be given at 3 o'clock in the afternoon. The staff were giving the person 0.5 mg in the morning and 1mg at five o'clock in the afternoon. Splitting the dose and giving it at different times to the prescription may be detrimental to the person. The MAR had been hand written by staff. The hand written record had not been signed or dated by staff and the number of tablets in stock had not been recorded. After the inspection

the provider showed us evidence that they were administering the person's medication on the instructions of the Mental Health Psychiatrist and by the GP and that the staff had been administering the medication correctly.

Medicines were stored in a locked room and were administered from a medicines trolley. The deputy manager told us that they had ordered a new medicines trolley. They said the present one was not suitable as boxes of medicines often fell out and there was a risk that medicines might not be where they should be. On the first day of the inspection there were 12 tablets missing for one person. On the second day of the inspection these had been found, as the deputy manager told us they had, 'fallen out.'

Sometimes people were prescribed tablets that had to be written by hand onto the medicines records by staff. When staff had received these tablets they had not always entered the amount of tablets that had been received, they had not signed and countersigned to make sure there was the correct amount of tablets and that they were writing in the correct person's record and that the entry was correct. There was a risk that people might not receive their tablets safely and if errors were made the staff members would not be identifiable. There was also a risk that the correct stock amount of medicines would not be accurate so the registered manager would be unaware of how much stock of what medicines was held.

Some people were given 'homely remedies' such as paracetamol and movicol. However these were not recorded on their individual medicine records and there was no way of knowing who had been given these medicines. There was a risk people could be given too much of these medicines and staff did not have a record of who had been given them or when.

Regular audits of the medicines had not been carried out to identify any errors or shortfalls and make improvements to the safe administration of people's medicines. We raised three safeguarding alerts relating to unsafe and potentially abusive medicines practice after the inspection.

People were not always receiving their medicines safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people were prescribed special drugs that needed to be counted and checked by two members of staff every time they were given to a person. All these types of medicines were given to people safely and procedures had been followed. Other people needed tablets to thin their blood. People needed regular blood checks and the dose of their tablets then changed depending on the results of the blood test. These tablets were given to people safely and correctly.

Some people were at risk of dehydration. There was a risk that people were not drinking enough to keep them healthy. Everyone was identified as requiring 'encouragement with fluids' and at 'increased risk of urinary tract infections (UTIs)' but staff were not consistently monitoring people's fluid intake. Some people did have fluid charts in place and there was guidance on how much people should be drinking daily. However, a daily total of what people actually drank was not calculated so staff did not know if people had drunk enough. There was no guidance about what action staff should take if people were not drinking enough. Staff told us conflicting information about who had fluid charts in place. Two people were admitted to hospital and when staff contacted the hospital to ask how they were they had recorded they were 'dehydrated' in the staff handover book. Although they were documented as having gastroenteritis in their daily notes staff had recorded they had 'good fluid intake' before these admissions and there were no indications in the records as to how they had become dehydrated.

There had been occasions when people displayed behaviours that may challenge. There was risk that they

may hurt themselves or other people. There were guidelines in place to explain to staff how to support people in a way that suited them best. However, staff had physically intervened in the past and caused physical harm to one person as a result. No action had been taken to prevent this happening again.

One person had an in-dwelling catheter (this is an drainage tube for urine. It is a tube that is passed into the bladder when people cannot urinate normally). The person's care plan and risk assessment gave guidance on monitoring the person's fluid intake and output, and when the catheter bag should be emptied or changed. However, there was no guidance for staff on what to look for to detect infection and what to do if the catheter became blocked. There was no information to inform staff when the catheter tube needed to be renewed by the district nurse.

Risks relating to people's care and support were not always adequately assessed or mitigated. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Changes in people's physical health had been identified and the increased risks, like the risk of skin problems had been addressed. Some people were identified as being at risk of developing sore skin. The risk had been reduced as staff were applying special creams to the areas to prevent them from becoming sore. Pressure relieving equipment like special cushions and a special mattress had been provided for people to relieve the pressure on their skin. On the day of the inspection, people were sitting on special cushions and there were special mattresses on their beds. One person needed to be moved in their bed every two hours. Staff did this and recorded that it had been done. The person had been in bed for some time and their skin was in good condition.

The registered manager had not carried out all the necessary safety checks on the environment and equipment, to make sure people lived in a safe environment and that the equipment was safe to use. In one bedroom there were electrical wires exposed and hanging from a socket. The registered manager was not sure if they were live or not. The bedroom had recently been vacated by a person and the bedroom was accessible to people. There was a risk that people could enter the room and touch the wires. The registered manager locked the door when we raised this with them.

The temperature of the water in people's bedroom sinks had not been checked to make sure the hot water was within a safe temperature. The staff had recorded the temperature in the main bathroom was 40 degrees centigrade. We asked the registered manager to check the water temperature as it felt too hot and no thermometer could be found. The registered manager sent a staff member to buy thermometers. Staff purchased a jam thermometer that could not accurately record the temperature of the water. However, the registered manager agreed that the water temperature exceeded the recommended limit of 43 degrees centigrade. There was a risk that people could scald themselves if they used the sinks in their bedrooms or the water in the bathroom. This was an increased risk for some people who were living with dementia. The registered manager contacted a local trade's person and arranged for them to reduce the hot water temperatures. One person's bedroom sink had no hot water.

The provider and registered manager had not ensured the premises were safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff carried out regular maintenance checks on systems like the electrics and gas supply. The hoists which were used to support people to mobilise had been serviced to make sure they were in good working order. Regular checks were carried out on the fire alarms and other fire equipment to make sure they were working. People had a personal emergency evacuation plan (PEEP) A PEEP sets out the specific physical and communication requirements that each person has to ensure that they can be safely evacuated from the

service in the event of an emergency.

The registered manager had a lack of awareness and insight about their responsibility to report safeguarding incidents to the local safeguarding team and to the Care Quality Commission. There were two incidents recorded which had involved people in potentially abusive situations. The registered manager and staff had dealt with the incidents but had not followed procedures by consulting with the local authority safeguarding team who would have discussed and assessed the issue. A decision would then be made on how to proceed to keep people safe in the way that suited them best. We asked the registered manager to contact the local safeguarding team to discuss these issues on several occasions and they did not. So we raised two safeguarding alerts regarding these incidents after the inspection.

Some staff had not yet undergone their safeguarding training and were therefore not fully aware of their individual responsibilities to identify and report abuse when providing care and treatment. The provider told us they were in the process of arranging training for these members of staff
Staff and the registered manager were not fully aware of their individual responsibilities to identify and report abuse when providing care and treatment. People were not fully protected from abuse and the registered manager had not followed the correct procedures to make sure people were as safe as possible. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was enough staff on shift to meet people's needs. One relative told us, "I come over nearly every day and there is always enough staff." Staff spent time talking with people and did not appear rushed. However, staff were not always effectively deployed to keep people safe. A volunteer with no training and who had not been cleared to work with vulnerable people was left to assist people with no supervision throughout the first day of the inspection.

On the morning of the first day of the inspection the registered manager told us there were, 'three care staff, the deputy manager and the activities co-ordinator on shift.' We spoke with the activities co-ordinator and they told us they were a volunteer and their Disclosure and Barring Service (DBS) criminal records check had not been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. They had not received any training on how to assist people safely. The activities co-ordinator was left on their own in the lounge with up to 15 people, at several points throughout the day. There was a risk people may not receive the support they needed as the only person available to assist was a volunteer who had received no training and was not cleared as being safe to work with vulnerable people.

A recommendation had been made at the last inspection regarding full recruitment checks being carried out. We found that other staff were now recruited safely. Written references were obtained and checks were carried out to make sure staff were of good character and were suitable to work with people.

An untrained volunteer was working in the service unaccompanied, without proper recruitment completed. This was a breach of Regulation 12 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

Relatives told us that their loved ones enjoyed the food. One relative said, "The food is brilliant, you can't fault the food." Another relative said, "The food seems fine. [My relative] can be a picky eater but they always eat dinner and breakfast."

Menus were planned in advance and if people did not like what was on offer they were given a different meal, of their choosing. The menu was written on a board in the lounge, but most people required assistance to read. The provider and registered manager both agreed that this information could be displayed in a way that was more meaningful for people and said they would look into displaying pictures of meals in the future.

On the first day of the inspection, most people sat at the dining room table for their lunch. People enjoyed their lunchtime meal and the atmosphere was relaxed, with people chatting to staff and each other. People could choose where they had their meals. Some people ate in the dining room and others chose to stay in the lounge or have their meals in their bedrooms. Staff discreetly helped people to eat and enjoy their meal. They sat beside them chatting, and encouraged them to eat. Staff made sure the mealtime was unhurried and gave people the opportunity to socialise in a relaxed comfortable atmosphere.

On the second day of the inspection there was a different atmosphere and the lunchtime meal was not as relaxed. People were supported to the dining room table just after 12 o'clock. People were waiting for nearly 20 minutes until dinner was served. People were becoming restless and were trying to get up and leave the dining room table. When meals did arrive people were not given the support they needed. Plate guards were not on people's plates to support them to eat independently and people had to wait to have their food cut so they could eat it.

Staff were unclear about people's needs and who needed support with eating and drinking. One person was served food that was all pureed together and grey in colour. Staff told us conflicting information about why the person's food was served like this and if they were at risk of choking.

People's health was monitored and when it was necessary, health care professionals were involved to make sure people were supported to remain as healthy as possible. However, when people's health needs had changed, such as when their medicines had changed, this had not always been recorded, care plans and risk assessment had not been reviewed and updated to reflect any changes. Staff were not all aware, when we asked of people's current needs, for example, staff told us conflicting information about if a person was at risk of choking.

Visiting professionals told us the staff always asked for guidance and support if they were unsure about anything .They said when they gave advice to staff it was acted on. If a person was unwell their doctor was contacted. This was documented in a senior handover book that was available for staff to read. Visiting professionals such as the district nurses went to the service on regular basis and were available for staff if they had any concerns.

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 made on their behalf must be in their best interests and as least restrictive as possible.

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

Some people were constantly supervised by staff to keep them safe. The registered manager had therefore applied to local authorities to grant DoLS authorisations. The applications had been considered, checked and granted for some people ensuring that the constant supervision was lawful. When the applications were due for renewal they were renewed in a timely manner. One person had a condition on their DoLS that their care plan needed to be updated, and this had not yet been done.

Some people's capacity assessments and records of best interest meetings were missing. There were records of best interest meetings when people had required health interventions such as flu vaccinations. These had involved people's relatives and relevant healthcare professionals. Staff told us they understood the principles of The Mental Capacity 2005 and people were able to choose what they wore and where they spent their time in the service.

There was an ongoing programme of training which included face to face training and online training. Staff completed basic training in topics such as safeguarding, mental capacity and first aid. All of this training was up to date, and staff had been booked onto refresher courses in line with the provider's policy. Staff had also completed training relating to people's specific needs, such as dementia and 'control and restraint' training. When we asked what was meant by 'control and restraint' training we were told that staff had been trained to 'safe hold' or 'break away' from people if they became physically aggressive.

Some people were assessed as requiring physical intervention when they became distressed. However, staff had intervened on one occasion and the person's care plan stated that they were never physically aggressive. The person's care plan had not been reviewed and there had been no best interest decision around this intervention. This was an unauthorised restraint.

Although staff had been trained to perform a 'safe hold' they had caused an injury, a skin tear on the person when using this intervention. The person had received medical assistance but the registered manager had not checked that staff were competent to carry out this kind of intervention following the incident. Staff and the registered manager had also failed to identify potential safeguarding issues. We observed staff moving people safely and explaining what was happening if people needed the assistance of a hoist.

Staff had performed a physical restraint on the person and caused a physical injury. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff worked through induction training which included working alongside established staff. New staff completed the Care Certificate as part of their induction, which is an identified set of standards that social care workers work through based on their competency. Most of the staff we spoke with were quite new to the service and they told us they felt supported and could ask questions when needed. Not all staff had a good understanding and awareness of people's needs., For example, they were unclear about which

people's fluid intake required monitoring. The registered manager and deputy manager organised regular supervision meetings with staff in advance. This gave staff the opportunity to talk about any training and development needs.

Requires Improvement

Is the service caring?

Our findings

Relatives told us that staff were kind and caring. One relative said, "It is brilliant here" and, "I would give it five out of five stars." People appeared relaxed in the company of staff, however, staff did not always respect people's privacy and dignity. People did not always receive the support they needed to remain independent.

On the second day of the inspection, one person was given their lunch on a small table in front of their armchair. The plate was left in front of the person by staff and they then walked away. Staff offered no assistance and the person struggled to try to eat their meal. They were unable to cut the food or eat, and in the end gave up, placing their cutlery on the table. We asked staff if the person needed assistance and they then sat with the person and supported them to eat their meal.

People's records containing confidential personal information had gone missing and were not always stored securely. We found a handover book, containing confidential information stored in a box in an unlocked room. We expect the provider to report this to the Information Commissioner and we will follow this up.

Continence pads were left exposed and untidy in people's bedrooms, this did not promote people's dignity. There was a cushion on a chair in the lounge that had urine on it and we sat on it. We asked staff why the chair cushion was soaked with urine, and they told us that a person had 'an accident' that morning. Although the person received the assistance they needed staff had not taken action to remove the cushion so that other people would not sit on it. Staff removed the cushion once we had raised this.

The provider and registered manager had not ensured that people were always treated with dignity and respect. People's confidentially was not protected. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Overall, staff were warm and affectionate towards people. They put their arms around them and held their hands to offer people comfort and support. At times, staff guided people sensitively and kindly to areas of the service they wanted to go to. People responded positively to these interactions, were smiling, and relaxed in the company of staff.

One person became distressed whilst walking up a small flight of stairs. Staff intervened and spoke to the person calmly, offering them reassurance and standing at the bottom and the top of the stairs to give them space to move at their own pace.

There was a relaxed and calm atmosphere in the lounge areas. When no activities were taking place in the lounge area there was music playing in the background. People were enjoying each other's company or just watching what was going on. Staff spoke quietly and gently with people. Staff chatted to people as they walked through the lounge area. The cleaner stopped what they were doing when someone wanted to talk to them. They bent down and spoke to the person in a friendly and sensitive way. The person wanted

another drink so they went and got them one.

People were supported to stay in touch with their friends and relatives and visitors were always welcome at the service. Relatives we spoke to said they were always kept well informed about any changes to the health and welfare of their loved one. One relative said, "The staff always contact me if anything happens, like a fall or if (my relative) has to see the doctor or go to hospital. They always contact the G.P if anything is wrong."

When we asked questions about people staff answered in a quiet voice so not everyone was able to hear.

Requires Improvement

Is the service responsive?

Our findings

Staff were not consistently responsive to people's needs. Relatives told us that people received the care they needed. One relative told us, "My (relative) is always well dressed and clean and seems to be happy." Another relative said, "When I ask staff to do anything for [my relative] it's always done. My [relative] gets everything they need."

People's needs were assessed before moving into the service, with involvement from people and their relatives. A care plan and associated risk assessments were written so staff were aware of people's needs. Care plans were signed and dated by the registered manager monthly, to say they had been reviewed. However, people's needs had changed and their care plans had not been updated accordingly. Some people were displaying new behaviours when they became distressed or anxious and their care plans made no mention of these. Other people's medicine had changed and their care plan did not reflect these changes. Care plans, used by staff, that were not up to date placed people at risk of not receiving consistent care. Clear up to date care plans were important as some people could not tell staff about their needs due to their dementia.

Staff were not sure about people's needs and told us conflicting information about people. This was a concern as staff did not have up to date care plans to refer to. One person was given a bowl of pureed food at lunchtime. The food was grey in colour with the foods all pureed together. Some staff told us this was because the person was at risk of choking as they did not like wearing their dentures when eating. The registered manager told us that the person preferred their food served this way. The registered manager told us that they had offered the person food pureed separately and they had refused to eat it. The person ate profiteroles for dessert and these were served whole. We asked staff if it was safe for the person to eat them like this, and the deputy manager told us, "They should be cut up." The person's care plan did not contain any information about how the person preferred their food served or any risks related to them eating or drinking or choking.

Another person was sitting in the lounge and did not eat the meal that had been in placed in front of them. A staff member told us, "They would have eaten it if they had been at the table." The day before the person had sat at the table and eaten all of their lunch. Staff had not supported or encouraged the person to sit at the table. We discussed this with the registered manager and the person was offered a pudding, which they ate.

Most people needed support to let the staff know what support they needed. This was due to some people's dementia or communication needs. Staff were not always clear about people's needs, or why they needed support in a certain way. For example, staff did not know who needed additional equipment to assist them to eat safely lunchtime. This information was not written in people's care plans or displayed in the kitchen, so there was a risk that people may receive inconsistent support.

There was a personal care checklist in place for each person, which staff were to complete when people had received all their personal care. Some of these had not been completed for many days. There was no way of

knowing if people had received all the care and support that they needed on a daily basis.

The provider and registered manager had not ensured that people received care treatment that met their needs or reflected their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans contained guidance about how to move people safely using specialist equipment like hoists and slings. There was guidance and information about how to keep people's skin healthy and the plans were being followed by the staff. People sat on special cushions and had special mattresses on their beds to protect their skin.

A relative told us, "Perhaps I am not here at the right time of day, but sometimes there's not much going on." There was not a formal activities timetable in place. Information about activities happening each day was written on a white board in the dining room, but most people required support to read. The registered manager and deputy manager agreed that this information could be displayed in a more meaningful way and told us they would look into displaying this information pictorially. This was an area for improvement.

A volunteer activities co-ordinator had recently been recruited and people took part in arts and craft activities and nail painting during the inspection. There was music playing and some people danced in the afternoon. People were singing along or humming and tapping their hands and feet to the music.

We were shown pictures of people participating in a movie afternoon and drinking 'larger shandies.' The deputy manager was arranging a variety of 'event days' for people including a Mad Hatters Tea Party and a blitz themed afternoon where people could try ration packs.

Relatives told us that if they had any concerns or complaints they would go to the registered manager and they felt confident that they would take action. One relative said, "There has never been anything to moan about. I have never made a complaint."

There was a written complaints procedure, although there had been no formal complaints made in the past 12 months. The registered manager told us that any complaints would be logged, investigated and responded to by the provider. The complaints procedure was not available in an accessible or easy read format that may be more suitable for people's needs. This was an area for improvement. Some relatives had left messages in the compliments book. They said, 'Warm friendly welcome every time I visit' and 'It's lovely to know my (relative) is well looked after.'

Inadequate

Is the service well-led?

Our findings

In response to the draft report the registered manager and provider sent us comments and additional evidence. This included some medicines records that the provider told us were available on the day of the inspection. Some of these medicines records had been altered and did not match the copies of records we took during the inspection which is concerning.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC check that appropriate action has been taken. The registered manager had not submitted notifications, as required by law, in a timely manner. The registered manager told us they were 'unaware' they needed to notify CQC when people sustained a serious injury or they had raised a safeguarding alert. This was an issues discussed with the registered manager at previous inspections.

The provider and registered manager had failed to notify CQC of notifiable events. This was a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

Providers are required to keep records of any accidents or incidents and look into these events in case there are any common themes, for example, time of day, place. Common themes could lead to a change in people's support to reduce the risk of reoccurrence. The registered manager told us that accidents and incidents were documented by staff when they occurred, and that staff completed additional statements when necessary to help establish a full picture of what had happened. Some accident and incident forms were stored in people's individual files. Accident forms relating to people falling or becoming distressed and displaying behaviour that could challenge were seen dated December 2016. The registered manager told us that they had, "At least one incident a week," but said that the more recent forms were 'missing.' Accidents and incidents were not collated or analysed to identify why they had occurred and if anything could be changed to prevent them from happening again. The support offered to people had not been changed to try to reduce the risk of people being injured by falling or being involved in further incidents.

Providers are required to carry out and keep records of their checks and audits of all aspects of the service to check that people are receiving safe, effective and compassionate care. The registered manager told us that audits and evidence of any checks of records, the environment and staff practice completed had also gone 'missing.' The last medicines audit was dated October 2016. This had not highlighted any of the quite serious issues we identified at the inspection. The temperature of the water in some areas was too high and placed people at risk of scalding. This had not been identified and acted on. Other audits relating to the quality of care or completed paperwork were not available.

Relatives had been sent questionnaires to ask their views on the service. Three questionnaires had been returned but these had not been analysed or collated to look for any trends or themes. The registered manager had not acted on the feedback. All three of the responses stated they felt that regular relatives meetings would be 'beneficial.' Relatives told us that they had not recently been invited to or attended a meeting to discuss the service. The registered manager told us that they had held one relatives meeting

since their previous inspection in June 2016, but this paperwork was 'missing.'

Staff, people and other stakeholders involved in the service had not been formally asked for their views. The registered manager told us that there were regular staff meetings and senior managers meeting where staff could discuss any issues and make suggestions on how the service should improve. However, we reviewed minutes of a meeting held 16 December 2016 and there was no opportunity for staff to provide their feedback.

The registered manager told us that other paperwork, including mental capacity assessments, records of best interest decisions, one person's entire care plan and a senior handover book were also missing. During the inspection we found the handover book amongst other files. There were pages missing from the senior handover book and the registered manager told us they had been torn out.

We told the registered manager to report the missing documentation to the Information Commissioners Office. This occurred three weeks after the inspection.

The provider and registered manager had failed to establish and operate systems to assess, monitor and improve the quality and safety of the services provided and failed to maintain accurate and complete records. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had been at the service for several years and was experienced in working with people living with dementia. However, there had been recent changes in staffing and a high number of new staff, including a new deputy manager. Relatives told us they were aware of some changes, and hoped they did not impact on the quality of care their loved ones received. One relative said, "Overall I am happy with the care. There is a high turnover of staff at the moment. It worries me a bit that they have to get to know residents from scratch and residents have to get to know them. That could be unsettling." Staff told us that they were aware that there were some issues and problems at the service at the present time, but they felt that it was getting better. One staff member said, "The new deputy manager is on the ball" however, we had concerns about people's safety.

We observed some kind and caring interactions throughout the inspection, however, staff were not always clear about people's needs, or why they needed support in a certain way. Some staff did not know which people's fluid intake required monitoring or if people were at risk of choking. Staff did not know who needed additional equipment to assist them to eat safely lunchtime. Staff could not rely on checking people's care plans to find this information as care plans were not up to date and most people were unable to tell staff about their needs due to their dementia. A volunteer who had no training, had not been cleared as safe to work with vulnerable people was left supporting people independently. None of the breaches of the regulations found at this inspection had been identified and addressed by the provider's governance procedures.

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 9 HSCA RA Regulations 2014 Person-centred care The provider and registered manager had not ensured that people received care treatment that met their needs or reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider and registered manager had not ensured that people were always treated with dignity and respect. People's confidentially was not protected.

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 18 Registration Regulations 2009 Notifications of other incidents The provider and registered manager had failed to notify CQC of notifiable events.

The enforcement action we took:

We cancelled the registered manager's registration for the regulated activity of accommodation for persons who require nursing or personal care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always receiving their medicines safely. Risks relating to people's care and support were not always adequately assessed or mitigated. The provider and registered manager had not ensured the premises were safe. An untrained volunteer was working in the service unaccompanied, without proper recruitment completed.

The enforcement action we took:

We cancelled the registered manager's registration for the regulated activity of accommodation for persons who require nursing or personal care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Staff were not fully aware of their individual responsibilities to identify and report abuse when providing care and treatment. People were not fully protected from abuse and the registered manager had not followed the correct procedures to make sure people were as safe as possible. Staff had performed a physical restraint on the person and caused a physical injury.

The enforcement action we took:

We cancelled the registered manager's registration for the regulated activity of accommodation for persons who require nursing or personal care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager had failed to establish and operate systems to assess, monitor and improve the quality and safety of the services provided and failed to maintain accurate and complete records.

The enforcement action we took:

We cancelled the registered manager's registration for the regulated activity of accommodation for persons who require nursing or personal care.