Crossways Residential Home Limited

Crossways Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 6 and 7 December 2016 and was unannounced. At the last inspection completed in August 2016 we rated the provider as 'inadequate' and the service was placed into special measures. We found the provider was in breach of the regulations around providing safe care, the need for consent, dignity and respect, providing person centred care, ensuring there were sufficient numbers of staff who had the required skills and effective quality assurance and management. At the inspection completed in December 2016 we found the provider had failed to make the required improvements.

Crossways Residential Home provides accommodation and personal care for up to 23 older people. At the time of the inspection there were 20 people living at the service, many of whom were living with dementia. A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not protected from potential abuse and mistreatment as concerns were not identified, reported and investigated. Plans were not put in place to protect people from further harm. Risks to people living in the service were not sufficiently recognised, assessed and mitigated. People were not supported by sufficient numbers of care staff. People were not protected from the risk of the recruitment of inappropriate staff as recruitment checks were not sufficient. People mostly received their medicines as prescribed. However, improvements were identified as being required in the safe management of people's medicines.

People were not always supported by care staff who had been given the required skills and knowledge to support them safely and effectively. People's rights were not upheld by the effective use of the Mental Capacity Act 2005. People's nutritional needs were not always met. People were not always given access to approprate support from healthcare professionals when required.

People told us care staff were caring and we saw some positive interactions between staff and people. However, staff were not given the skills to recognise when care practice was not caring or dignified. The provider and registered manager did not recognise when people were not supported in a caring way. People were not always sufficiently involved in decisions about their care.

People did not always receive care that met their individual needs and preferences. People were not enabled to be fully involved in the review of their care and care plans did not accurately reflect their needs. Activities were made available for people to participate in. However day to day leisure opportunities had not been developed to meet people's individual needs and preferences. People felt their complaints were heard by the provider.

The provider and registered manager had failed to ensure sufficient improvements were made in the service since the last inspection we completed in August 2016. The provider and registered manager had failed to

develop effective quality assurance and audit systems. As a result they continued to fail to identify areas of poor care, risks to people and where improvement was required in the service. The culture within the service was accepting of people's distressed behaviours and areas of poor practice were not recognised and challenged.

We found the provider was not meeting the regulations around safeguarding people from abuse, safe recruitment of care staff, safe care and treatment, consent to care, dignity and respect, providing person centred care, effective management of the service and submitting statutory notifications to CQC. You can see what action we told the provider to take at the back of the full version of the report.

At the last inspection completed in August 2016, we rated the provider as 'inadequate' and the service was placed into special measures. The overall rating for the service at this inspection is 'Inadequate' and the service therefore will remain 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 were not protected from potential abuse and mistreatment. Risks to people living in the service were not sufficiently recognised, assessed and mitigated. Improvements were identified as required in the safe management of people's medicines.

People were not supported by sufficient numbers of care staff. People were not protected from the risk of the recruitment of inappropriate staff as recruitment checks were not sufficient.

Is the service effective?

Inadequate

The service was not effective

People were not always supported by care staff who had been given the required skills and knowledge to support them safely and effectively. People's rights were not upheld by the effective use of the Mental Capacity Act 2005.

People's nutritional needs were not always met. People were not always given access to appropriate support from healthcare professionals when required.

Is the service caring?

Inadequate

The service was not caring

People told us care staff were caring and we saw some positive interactions between staff and people. However, staff were not given the skills to recognise when care practice was not caring or dignified. The provider and registered manager did not recognise when people were not supported in a caring way. People were not always sufficiently involved in decisions about their care.

Is the service responsive?

Inadequate

The service was not responsive

People did not always receive care that met their individual needs and preferences. People were not enabled to be fully involved in the review of their care and care plans did not accurately reflect their needs. Activities were made available for people to participate in. However day to day leisure opportunities had not been developed to meet people's individual needs and preferences. People felt their complaints were heard by the provider.

Is the service well-led?

Inadequate

The service was not well-led

The provider and registered manager had failed to ensure sufficient improvements were made in the service since the last inspection we completed in August 2016. The provider and registered manager had failed to develop effective quality assurance and audit systems. They failed to identify areas of poor care, risks to people and where improvement was required in the service.

The culture within the service was accepting of people's distressed behaviours and areas of poor practice were not recognised and challenged.

Crossways 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 6 and 7 December 2016 and was unannounced. The inspection team consisted of one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection we reviewed the information we held about the service. We looked at statutory notifications sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. We sought information and views from the local authority. We also reviewed information that had been sent to us by the public. We used this information to help us plan our inspection.

During the inspection we spoke with four people who lived at the service and two visitors who were friends or relatives. Many people living at the service were living with dementia and were not able to speak with us about their views around the care they received. To help us understand the experiences of people we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people living at the service. We also carried out observations across the service regarding the quality of care people received. We spoke with the provider, the registered manager, the deputy manager and four members of care staff. We reviewed records relating to people's medicines, people's care records and records relating to the management of the service; including recruitment records, complaints and quality assurance.

Inadequate

Is the service safe?

Our findings

At the last inspection completed in August 2016 we rated the provider as 'inadequate' for the key question of 'is the service safe?'. We also identified they were not meeting the regulations regarding the provision of safe care, safe staffing levels and safeguarding people from abuse. At this inspection we found the provider was still in breach of these regulations. We also identified more serious concerns around the provider's failure to safeguard people from potential abuse and mistreatment.

Staff we spoke with were able to explain different signs of potential abuse and how they would report these concerns. However, we found staff were not always recognising the serious nature of incidents that arose in the service. We observed one person attempting to harm people within the service on two separate occassions during the inspection. These incidents were not recognised as safeguarding incidents by the staff team. The registered manager and staff did not take appropriate action to ensure people were protected from the risk of further harm. We found that multiple additional incidents had arisen within the service prior to the inspection including people being physically assaulted. The registered manager was not aware that all of these serious incidents had taken place. The incidents had not been reported to the local safeguarding authority by the provider. The local authority have responsibility for investigating safeguarding matters and ensuring people are protected from harm. Investigations had not been completed and plans were not in place to protect people from further harm. The provider had not ensured the registered manager had effective systems in place to ensure incidents of abuse were recognised and reported. As a result they were not protecting people from harm and people had suffered continuing exposure to physical and emotional harm as a result.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment

At the last inspection we found people were not being protected by the effective management of risks to them. We found people were being moved in a way that could cause injury to them, staff did not understand how to effectively support people living with diabetes and risks associated with accidents were not effectively managed to reduce risks to people. We also found staff were not effectively managing risks around behaviours that could challenge. At this inspection we saw some improvements had been made around staff understanding of the risks associated with diabetes. However, the provider had failed to ensure sufficent improvements were made across the service.

People were being moved in a way that could cause injury to them. We saw one person being assisted to stand in a way that risked them slipping and causing injury to themselves. We also saw this person being transferred in a wheelchair without them being safely seated in the chair. We asked staff supporting this person if they understood the risks associated with transferring the person in this way. They told us they understood the person could have slipped from the chair and injured themselves. However, they had proceeded to move the person in this unsafe way as they felt there were no alternatives. Relatives told us care staff sometimes moved people in a way that might cause them injury. One relative told us, "They lift [my relative] under [their] arms one on each side, but I understand they shouldn't be doing that. Something

about health and safety". The registered manager and staff team told us they did not move people in this way. However, another relative also told us their family member was supported to move in this way. We raised concerns about this with the provider at our last inspection and were assured these practices no longer took place. We were informed additional training had been provided and monitoring was undertaken. We found staff knowledge around managing risks associated with diabetes had improved. Staff were able to identify the potential signs that someone's blood sugar may be at an unsafe level. However, two staff we spoke with were not able to describe what action they would take if they identified people's blood sugar was too high or too low. Staff did not sufficiently understand the steps they should take to manage these risks to people.

We found that many people living at the service could display behaviours that could challenge others. The provider, registered manager and staff team did not understand how to effectively manage the risks associated with these behaviours in order to keep people safe from physical or emotional harm. Most people were not able to share their views with us about the impact of the behaviour of others. One person did however tell us that another person caused them distress. They told us, "[Person's name] tries to knock the telly over". We saw multiple examples of people becoming distressed during the day due to either the environment and the actions or distress of others living in the service. We saw people shouting out using phrases such as, "Shut your mouth", "For [pitys] sake, shut up" and "Get rid of [person]. I'll bang on [person]". The registered manager and staff did not recognise the impact of people's actions or distress on others within the service. Therefore they did not take action to manage the environment and protect people's well-being. We found some behaviour that challenged were putting some people at serious risk. We found six people had been physically assaulted by one person living at the service since October. This person had also attempted to assault a further three people. The registered manager had failed to ensure these incidents were effectively monitored or managed. As a result they had not developed sufficient plans or guidance for staff to reduce the likelihood of these incidents of behaviour arising and to protect others from the risk of harm. Where healthcare professionals were involved they had not been informed of all of the incidents of attempted assault. This could result in the interventions outlined by the healthcare professional not being as effective as they otherwise could be. The provider had failed to ensure people living at the service were protected from the risk of harm.

People who were able to share their views told us they were mostly happy with the support they received with their medicines. One person did however tell us about how staff gave support with their cream and told us, "Sometimes at night [care staff] forget if they're busy". We looked at this person's medicines administration record (MAR) and found this cream should be given on an 'as required' basis. The person had not had their cream at night for several weeks. There were no guidelines in place for staff to outline how they should identify when this person needed their creams to be administered. We found where people needed creams instructions were made available to staff to outline where on the body they should be applied. However, instructions had not been made available for any 'as required' medicines to tell staff how to identify when people needed their medicines. One person had recently been prescribed an antipsychotic medicine on an 'as required' basis to assist with managing their behaviour. Guidelines had not been made available to staff as to how to identify when this medicine should be given. It is important that care staff work with the person to manage any challenges with their behaviour before these medicines are administered. We found however that the maximum dose had been administered on three out of four days since the medicines had been administered. Care staff we spoke with were not able to describe actions they took to manage behaviour without administering these medicines. The person's doctor was consulted shortly after the inspection due to an increased number of falls since the medicine was prescribed. As a result the person's medicine had been halved in dosage. We found care staff did not know how to identify other medicines that were prescribed on an 'as required' basis. This resulted in people's needs not being identified and understood. People were being given the maximum dosage of their medicines without staff

understanding if these quantities of medicine were required.

We found one person's daily care records indicated they had spat out their medicines, however, there was no record of this on their MAR. We asked the registered manager if the person had taken this medicine and they were unable to confirm if the medicine had been taken as required. We found a person who had caused physical injury to others was receiving an antipsychotic medicine. The person's medicines administration records outlined the person had taken all of their medicines as prescribed. However, the remaining stock of their medicine indicated they had not taken one of their tablets. The registered manager had not identified this error and could not confirm if the person had received their medicines as prescribed. We found additional concerns with the administration of people's medicines. Including, where the correct size of warfarin tablet was not available for one person, care staff were breaking a larger tablet in half. We saw that the tablet was not accurately split in half and therefore the person's dose may not be accurate. When people take warfarin it is very important to their health that the dose they receive is accurate and in line with the instructions of healthcare professionals. We found some of these tablets were not stored safely and were kept loose in boxes. This could have resulted in tablets going missing or becoming available to other people. The provider had not ensured safe systems were in place to manage people's medicines safely and to ensure they always received them as prescribed.

This was a continued breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

We looked at how the provider ensured staff members were recruited in a way that ensured they were suitable to work with people living at the service. We found pre-employment checks were completed prior to staff starting work; for example reference checks and checks on the staff member's potential criminal history. We did however find that background checks and references were not always satisfactory. For example, the registered manager had failed to check staff member's employment history and to ensure they had identified the reasons for any gaps in their employment history. We found references had not always been obtained from the staff members last or most recent employer. We also found that inappropriate personal references had been obtained. For example, references from staff member's friends and neighbours had been used to assess their suitability for employment. In one example we found a staff member's shopkeeper had provided a reference. The provider had not ensured effective systems were in place to ensure people were protected from harm by a staff team who were appropriate to work in their roles.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and proper persons employed

At the last inspection we found there were insufficient numbers of staff members available to support people living at the service. The day prior to this inspection the provider had increased the care staff team by one. They had also added a laundry post with the view to care staff being made available to focus on care provision. We found these changes had made some improvements to the availability of care staff during this inspection. However, we found there had not yet been sufficient change to ensure care staff were available when support was required. People who could share their views, told us they felt there were sufficient numbers of staff available. However, they told us they sometimes had to wait for support. One person told us, "The only thing I get upset about is when [care staff] say, 'I'll only be a minute'. I don't like their 'minutes'. I know they're busy". We observed people receiving insufficient support during mealtimes, we saw care staff unable to hoist people as a second staff member was not available and we identified situations where we had to locate a staff member to provide support to people due to the unavailability of care staff. For example, one person was seen to be distressed and told us their chest hurt and they needed a doctor. We

asked staff to get the person a doctor. Staff we spoke with told us they had not seen how unwell the person was as they had been too busy that morning. One staff member said, "Sometimes it's manic". We spoke with the provider about our concerns who told us they felt effective routines and deployment of staff had not been established since the increase in staffing numbers had taken place. The provider was continuing to fail to ensure people were protected by the availability of care staff when people needed support.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing

Inadequate

Is the service effective?

Our findings

At the inspection completed in May 2016 we rated the provider as 'inadequate' in the key question of 'is the service effective?'. We found the provider was not meeting the regulations around ensuring staff had suitable skills and training, obtaining consent and safeguarding people from mistreatment. At this inspection while the provider told us they had been working on staff training, we continued to find that staff skills were not sufficient to support people effectively. The provider was still in breach of the regulations around staff skills and obtaining consent.

Most people were not able to share their views about the skills of the care staff. Due to this we completed observations to see how effectively staff met people's needs. People who could share their views told us they were satisfied with the care staff. One person told us, "They seem [well trained] for me but I'm no expert". Relatives told us they felt staff were able to meet the needs of people living at the service. Staff told us training had improved since our last inspection, however. we saw there were still significant gaps in the skills of the staff and management team. We found staff did not have sufficient knowledge around how to support people with dementia effectively. The registered manager and staff did not recognise signs that indicated people were distressed and needed additional support. The training records given to us by the registered manager showed less than two thirds of the staff team had received training in dementia. This was despite the registered manager confirming to us that 18 of the 20 people living at the service had been diagnosed with some form of dementia. We found the registered manager and staff knowledge around the Mental Capacity Act (MCA) was not sufficient. We found less than half of the staff team had completed training in this area. However, we did see some care staff had started training in MCA during November 2016 and this was currently in progress. We also saw training was being provided around diabetes and behaviours that challenged although this training was yet to be reflected in staff practice. We found the registered manager's and staff knowledge around safeguarding people from potential abuse or mistreatment was not sufficient. Safeguarding incidents had not been recognised, reported and plans had not been put in place to keep people safe. As a result people had been subjected to ongoing harm. The registered manager's training records highlighted less than half of the staff team had received safeguarding training. The provider had not ensured the registered manager and the staff team had sufficient skills to recognise areas of risk within the service, keep people safe and support them effectively.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to

deprive a person of their liberty were being met.

People who had the capacity to speak with us told us care staff asked their permission to provide them with support. We did however find the registered manager and staff team did not have a sufficient understanding of the MCA. They were not always making decisions in people's best interests under the MCA when people lacked capacity to make their own decisions. The provider and registered manager told us there was nobody at the service who was currently receiving covert medicines. However, a staff member responsible for administering medicines told us one person sometimes needed their medicines to be administered covertly as they could refuse to take them. We asked the staff member what steps were taken under the MCA to ensure the medicines were administered in line with the Act and they were not able to tell us. They did not understand the requirements of the Act and there was no evidence the person's mental capacity or their best interests had been considered in their care records. Staff we spoke with had a basic understanding of the purpose of the Act but were unable to describe how they applied it in their work. Several staff members told us they would let people make 'little decisions' such as what they ate or drank but would not let them make 'big decisions' such as managing their finances or end of life decisions. This was supported by what people told us. One person said, "I don't make big decisions, maybe ones about not drinking ovaltine or something". Staff did not understand people's capacity and how to assess their abilities in making decisions. They also did not understand that under the MCA people's capacity should be considered for specific decisions. We saw one person shouting out when staff tried to move them in a hoist. After several attempts staff stopped this manouevre and told us the person had capacity to make this decision because the person knew they wanted lunch and could ask for a cup of tea. The registered manager and deputy manager however told us the person did not have capacity and they sometimes needed to be moved in their best interests to enable personal care to be completed. People's relatives told us they had not always been involved in best interests decisions where people lacked capacity. One relative told us, "I think they just do it. They've never asked our permission to do anything. They use the hoist because they know they've got to". We found further concerns about people's consent being sought, consideration of capacity and ensuring clear instructions were provided to staff. For example, one person had a 'do not resuscitate' instruction put in place by their doctor which outlined they did not have capacity to contribute to this decision. However, the registered manager had put a care plan in place in November 2016 that stated the person and their family wished staff or an ambulance crew to commence resuscitation. People's rights were not upheld by the effective use of the Mental Capacity Act 2005 and the principles of the Act were not followed.

This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent

At the last inspection we found people's liberty was being restricted as staff felt this was appropriate to protect their health and well being. However, we found the required applications to restrict people had not been submitted to the local authority. At this inspection we found DoLS applications had been submitted for all 18 people living at the home that the registered manager felt lacked capacity in some way. We found because the principles of the MCA had not been effectively applied there was a lack of understanding around the reasons applications had been submitted. For example, some simply outlined reasons such as 'personal care'. We identified situations where people may be restricted in some way but the provider and registered manager had not recognised this as a restriction. For example, the use of medicines and a person being hoisted against their will in order for personal care to be completed. The provider and registered manager have provided examples of where additional information was added to applications following the inspection.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014 Safeguarding service users from abuse or improper treatment

People gave us mixed views around the quality of food made available to them. One person told us, "I don't think it's all that good. I don't really like the sandwiches". Another person said food was, "Adequate". One person did however tell us they liked the food and told us they were able to make alternative choices if there was something on offer they did not like. People did tell us they had sufficient quantities to drink, however staff were not always proactive in offering people drinks. One person said, "I might have to ask if someone else has had a cup of tea and I haven't been offered one". We saw some improvements had been made in the care of people with dietary needs such as diabetes. Clear instructions were now available to advise care staff and kitchen staff who required an adapted diet due to their diabetes. We did however find that care and support provided to assist people in meeting their nutritional needs was insufficient. We saw people receiving inadequate support during mealtimes to eat their food. People were seen struggling to use knives and forks to pick up their food. Some were seen to be pushing food off their plate onto the table and themselves. The deputy manager observed one person pushing food off their plate and provided them with a plate guard. However, people's needs around the use of adaptive cutlery had not been assessed and implemented where required. We saw one person refusing to eat food as they felt it not warm when they touched the side of the plate. Staff did not understand how to provide support to this person and were seen to provide confusing messages to them. Their food was brought out several times, the person was then offered dessert by one member of staff and another brought their main meal back out in a bowl. We identified this person had lost over 10% of their body weight in the two months prior to the inspection. The provider and registered manager had not identified this weight loss and staff did not know the person was at risk of malnutrition. We saw another person who was not eating well during mealtimes. This person had been identified as being at risk of malnutrition by the registered manager and staff. Some staff told us this person needed support to eat by staff placing food into their hand to enable them to feed themselves. This was confirmed by the deputy manager. We saw the person received minimal support during the mealtime that was also not inline with these instructions. We also found this person had been prescribed fortisips by the dietician, however, the registered manager was not able to confirm if they had received them as prescribed. We found staff were not accurately recording people's food and fluid intake and there was no effective system in place for monitoring people's intake or weight. People were not protected from the risk of malnutrition as the provider was not ensuring the registered manager was effectively assessing and monitoring people's needs were met.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Meeting nutritional and hydration needs

People who had the capacity to share their views thought care staff would get them access to outside healthcare professionals if required to help them maintain their health. One person said, "They'd look after me. I've not been well twice". Another person said, "I think they'd get me to hospital but I don't really know". We saw from people's care records that people had regular access to outside healthcare professionals such as doctors and chiropodists. We did however identify concerns about the interventions provided by the registered manager and the staff team. For example, on the second day of the inspection we observed someone to be unwell in the lounge area. They told us their chest hurt and they needed a doctor. We asked staff to call a doctor. Staff told us they knew the person had been 'chesty' for several days but they had not noticed they were unwell that morning as they had been too busy. We saw a psychiatric nurse had been involved in the care of one person. However, as the registered manager was not aware of all relevant incidents, this information was not provided to the nurse to enable them to provide effective support. This person's behaviour continued to pose a significant risk to others living in the service. We also identified several people who had experienced significant weight loss or their body mass index was low. The provider and registered manager had not ensured additional support was provided to these people and referrals

made to nutritionists where appropriate. People's day to day health needs were not always being met.

Inadequate

Is the service caring?

Our findings

At the last inspection completed in May 2016 we rated the provider as 'requires improvement' for the key question of 'is the service caring'. The provider was not meeting the regulation around providing dignified care to people. At this inspection we found the provider was still in breach of this regulation.

Most people were not able to share their views around how staff protected their dignity. Those who could share their views told us staff protected their dignity while personal care was being delivered. One person said, "They never come in when I'm getting dressed". Relatives also told us they felt people's dignity was protected. One relative said, "They take [my relative] to a private room so there's nothing that would be embarrassing for [them]. It's never done in front of others. You are asked to leave the room". Another relative told us, "If [my relative]'s had an accident they do it discreetly. They take [my relative] to [their] bedroom. No fuss or no shouting about it".

We saw people's dignity had been upheld when completing tasks such as going to the toilet. However, we saw significant concerns in the protection of people's dignity living at the service, in particular where people were confused, disorientated or presented with behaviours that could challenge. We saw extended periods of time over several hours where people would be shouting out in distress. The provider had not ensured the registered manager and staff team had the skills to recognise the levels of distress people were demonstrating. We saw people's dignity being compromised during lunchtime due to insufficient support and adaptive equipment being made available to them. Some people were struggling to eat independently and were pushing food onto tables and themselves. The registered manager failed to recognise when people's dignity was being compromised. During one mealtime they sat talking to someone seated next to the dining area and did not recognise people needed additional support. We also saw them address someone with food down their jumper without recognising the person needed support to clean themselves. We saw the availability of staff impacted on people's dignity. For example, we saw one person in the dining area lifting up their skirt and trying to pull down their incontinence pad and underwear in view of other people. We asked a staff member to ensure this person was appropriately supported. People were not supported in a way that was dignified. Staff were not equipped with the skills and knowledge to recognise when people were not being supported in a way that protected their dignity and promoted their independence.

This was a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Dignity and respect

Most people we spoke with told us they did not always feel important. Some told us they did not feel respected. One person told us, "I don't feel important now". However, they did tell us they felt care staff were kind natured and caring. A person told us, "They're nice people here. They talk to me and treat me like a person". Another person told us, "I think [staff] are marvellous, what they have to do". People told us care staff did not always have time to speak with them. One person said, "Not like you and me are [talking]. [Staff] haven't got time. There are too many who want urgent treatment. They're very busy". This reflected what we saw. We found care staff to have good intentions and we saw some caring and positive interactions with

people. However as the provider and registered manager had not ensured the staff team had the required skills they did not always recognise when care provided was not caring. For example, when people were crying out in distress. We heard people regularly shouting out. One person shouted, "I wish I was dead". Another person told us another person caused them a lot of distress. They told us the registered manager failed to take sufficient action. They told us, "[Person's name] makes me feel upset inside They just say, '[Person's name] stop that'". We spoke to the provider and registered manager about this concern and they did not recognise the impact the person's actions was having on this person's well being. The provider and registered manager also had not recognised that the issues with the availability of staffing impacted on the quality of the care provided to people.

People who were able to share their views did tell us they were given choices around their day to day care. One person told us, "They don't mind me getting up early. This morning it was 4.30am. That was when I wanted to. Nobody forced me". Some relatives told us people were offered choices such as whether or not they wanted a cup of tea. We saw this reflected in the care we observed. We did however find that people were not always fully enabled to be involved in choices about their care, in particular where they lacked capacity to make decisions. We saw one person had confirmed with staff they wished to move from a communal area as other people were causing them distress. Staff failed to ensure this person's wishes were respected. While some relatives had told us people were involved in decisions, others told us this was not the case. One relative when asked if their family member was involved in decisions about their day to day care told us, "Not really. [My relative] objects to a lot of things, but [they] always [have]". Most people told us they were not supported to be fully involved in all day to day decisions about their care.

Inadequate

Is the service responsive?

Our findings

At the last inspection completed in August 2016 we rated the provider as 'inadequate' for the key question of 'is the service responsive?' We found the provider was not meeting the regulation around providing person centred care. At this inspection we found the provider had failed to make the required improvements and was still in breach of this regulation.

At the previous inspection we found staff were not always aware of specific care needs such as support people living with diabetes needed. We found people's personal preferences around personal care had not been sufficiently considered. Care plans did not outline people's needs. We found in the months since the last inspection the provider had updated people's diabetes care plans. However, insufficient progress had been made to ensure staff fully understood the needs of people in the service. Most care plans had not been reviewed and updated. One person told us they had been involved in and had seen their care plan. All other people we spoke with told us they had no involvement. One person told us, "I think they put it away in a drawer". People told us they were not always able to make decisions about their care. One person when asked if they could make decisions about their care and the support they received told us, "I don't think so". Another said, "Not really". We found staff did not have sufficient knowledge around how to meet people's needs in certain areas of their care. For example, when people displayed behaviours that challenged or when they needed additional support to meet their nutritional needs. We found people's needs in these areas were not outlined in their care plans. People's needs were not accurately assessed and understood. Their requirements were not accurately outlined in a care plan that provided clear guidance for staff as to the care people required to keep them safe and well.

People told us their care plans were not reviewed. Relatives told us they had been consulted about the care people received but they too had not been involved in the review of people's care plans. One relative said, "It was seen last year or the year before". We saw key workers did complete reviews of people's care plans each month. However, the provider and registered manager had not ensured these staff had the skills to identify where care plans were not accurate and did not reflect people's needs. Many care plans that did not accurately reflect people's needs were signed as being reviewed and no changes required routinely each month. People were not fully involved in the review of their care and their needs were not reviewed and assessed on a regular basis. Care plans were not updated when people's needs changed.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person centred care

People were seen to be engaged in a session involving music and singing on the first day of the inspection. People appeared to enjoy the music and were smiling and relaxed. One person told us, "I liked the singing". We also saw on the second day of the inspection, the registered manager was planning to take people out to a christmas service at a local school. One person told us they played with their ipad, enjoyed crocheting and sometimes went out with friends. We saw these positive parts of the day, however we observed that for most of the day people were sat around with little stimulation or support. One person told us they were bored and said, "I more or less just watch the television". Two people told us they liked to play the piano but could no

longer do this as there was no piano available in the home. We saw people spent most of their time sitting without interaction in either the dining area or the main lounge. People were not supported to explore appropriate leisure opportunities that would support their well-being and meet their individual preferences.

People told us they felt able to raise a complaint if required. One person told us about a complaint they'd raised about staff interactions but felt this had been dealt with appropriately. Other people told us about complaints they had raised and weren't able to tell us if these had been resolved. For example, one person told us they had complained about the heating. We saw during the inspection this had not been resolved. We looked at the records the provider and registered manager kept of the complaints people made and any investigations they had completed. We saw complaints raised had not been recorded. For example, we had been made aware of a complaint raised by a family member prior to the inspection. This was not recorded in addition to the concerns people mentioned to us during the inspection. The provider's complaints policy outlines that a full record of all complaints, including minor concerns should be kept. People's complaints were not always addressed in line with the provider's complaints policy.

Inadequate

Is the service well-led?

Our findings

At the last inspection completed in August 2016 we rated the provider as 'inadequate' for the key question of 'is the service well-led?'. We found the provider was not meeting the regulation around effectively managing the service. At this inspection we found the provider had failed to make sufficient improvements and was still in breach of this regulation.

At the last inspection we found the provider and registered manager had failed to recognise the level of risk people living at the service were exposed to. They had failed to recognise that the care being provided to people was not meeting expected standards. They had not identified the failings within the service and therefore plans were not in place to make the required improvements. We also outlined how there was a failure to recognise the culture within the service supported poor care practice and did not promote dignity and positive dementia care. The provider and registered manager both felt significant improvements had been made within the service. We saw work had been completed on the décor in some areas of the home, the provider was sourcing some dementia friendly signage and people's diabetes care plans had been updated. However, we failed to identify where other improvements had been made and in some areas found that the care provided to people had deteriorated further.

We looked at how the provider and registered manager completed quality assurance checks in order to identify issues within the service and make any required improvements. We found some new systems had been introduced however these remained ineffective. For example, a new monthly managers audit was in place to ensure all accidents and incidents were identified and investigated. The provider's action plan submitted to CQC stated that this new system had resolved all issues in this area. However, the new system had failed to identify multiple serious incidents within the service and ensure action was taken. The registered manager had not been aware of serious incidents such as assaults that had arisen. As the registered manager was not auditing or checking daily care records and other records such as behaviour charts they had failed to identify incidents that had not been formally reported to them by care staff. This meant this serious issue had not been escalated or responded to. We saw an audit was completed in medicines management each month. This had resulted in some issues being identified and action being taken. For example, one staff member had miscounted medicines and disciplinary action had been taken as a result. The medicines audit did not identify other issues we had identified such as concerns around the administration of 'as required' medicines. The registered manager showed us an audit file they told us contained new audits that had been implemented. These audits addressed areas such as the laundry, domestic and maintenance however failed to address the issues with care delivery within the service. The provider's action plan had stated that audits were in place to ensure issues with inaccurate care plans and poor record keeping were identified. We found this was not the case and issues were still not being identifed and steps taken to make improvements. The provider and registered manager had not recognised their failure to ensure effective quality assurance systems were in place to improve the quality of care provided and reduce risk to people.

The provider's action plan outlined a number of areas of concern raised at the last inspection had been addressed. During this inspection we reviewed the provider's action plan and identified neither they or the

registered manager had a sufficient understanding of the standards of care expected. They failed to identify wider issues within the service when addressing areas of concern. For example, at the last inspection we observed an example of poor moving and handling that put someone at risk of injury. The provider and registered manager addressed this concern through disciplinary processes with the staff member. However, they failed to recognise there were wider concerns about poor moving and handling in the service that we saw during the most recent inspection. We identified concerns about the recruitment checks completed for care staff. The provider and registered manager reviewed the recruitment checks for these individual staff members. However, they failed to ensure systems around recruitment checks were effective and therefore did not identify their systems were not adequate. We identified at the last inspection there were concerns about the care delivered and people's care plans reflecting their individual needs. While the provider and registered manager addressed concerns around the examples we provided, they failed to review the wider needs of the people living at the service. As a result issues around people's nutritional needs being met were not identified. The provider and registered manager were not able to effectively review and analyse the service they provided and the areas for improvement. As a result they were not identifying the failings within the service.

We found the registered manager had ensured people's weight was measured at the beginning of each month. However, they did not review the individual risk to people and where they may need more frequent measurements. They also did not ensure weights were reviewed in a timely manner therefore they had not identified people's weight loss and needs prior to CQC identifying these concerns. We also found care staff were completing food and fluid charts at the end of their shift. As these records were completed from memory and not at the time of consumption they could not be certain the records were accurate. We saw some of the entries made were not in line with what we saw. The provider and registered manager had failed to recognise this issue with the recording and monitoring of people's food and fluid. The provider's action plan outlined that staggered mealtimes were in place to ensure staff were available to provide additional support to people when needed. It also outlined that a range of adaptive cutlery was made available to people when required. During the most recent inspection we saw the provider and registered manager had not ensured that mealtimes were staggered to ensure the support could be provided. We also saw people struggling to eat without adaptive cutlery being made available to them. We saw other actions outlined in the action plan that were not in place. For example, the action plan stated that a new system of recording complaints had been implemented. We saw complaints were still not being recorded in line with the action plan or the provider's complaints policy. The plan also stated that all safeguarding incidents would be reported and we also found this was not the case. The provider and registered manager had failed to recognise their failure to implement actions outlined as completed within their own action plan.

We identified serious concerns about the skills and competency of the provider and registered manager in their ability to recognise areas of poor practice and risk to people. We saw the registered manager present during the inspection while poor practice was taking place such as insufficient support being provided during mealtimes and people struggling to eat, people being distressed by the actions of others, attempted injury by people towards others and people's dignity not being upheld. They failed to recognise or address these concerns that arose in the presence. The provider's action plan stated team leaders were now in place and were teaching staff correct procedures. However, the provider told us during the inspection that team leaders were not senior care staff and did not have additional training or skills. They told us these staff members were part of a forum to share ideas and provide feedback to the provider. We saw the minutes from a meeting held with the provider and the team leaders. This focussed on actions such as laundry and maintenance and not the provision of care or management of risk to people.

We identified issues with the heating in one area of the building. One bedroom we entered was very cold and felt as if a window had been left open. We raised this issue with the provider and registered manager.

The provider told us portable heaters had been provided and staff had been asked to check the temperature of rooms and use these heaters when required. Other people in the service told us there were issues with the heating. One person said they had had to complain about the heating. They told us, "When I'm in bed I'm fine". The provider had failed to recognise the impact of the environment on people living at the service. They had not ensured systems were in place to ensure risks to people associated with the cold environment and the quality of the provision of their care had been sufficiently managed and addressed.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

The provider had failed to ensure the registered manager had submitted all required statutory notifications. A statutory notification is required to be sent to CQC by law when a significant event such as a serious injury, allegation of abuse or death arises in the service. We found incidents such as people assaulting or attempting to assault others had not been notified to CQC.

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

People told us they were happy with the management of the service. They told us they knew who the registered manager was and that they were polite and approachable. One person told us, "The [registered manager]'s approachable. [They'll] listen if it's important". Some people did tell us they didn't always feel the registered manager listened to them. Another person said, "It depends [if the registered manager will listen to you]. [They're] certainly very busy". People told us they felt involved with some things things in the home, for example they were told some building work was going to take place. However, not everyone felt they were approached for their feedback about the service. Others told us they didn't feel as involved as they'd like to be. The provider informed us they had recently sent out surveys to obtain the feedback of people living at the service. These surveys had not been returned at the time of the inspection although the provider told us how they would use responses given to make improvements. Relatives told us they could see some improvements had been made within the service. However, the examples they gave were around the decoration and painting. They did not describe any improvements made to the care provided within the service. Care staff told us they felt supported by the management team. They told us the support and training made available to them had improved since the last inspection. People and care staff were satisfied with the management team within the service, however, improvements in involving people and seeking their feedback could be made.