Hollydene Care Limited

Hollydene EMI Rest Home

Inspection report

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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

The inspection took place on 14 October 2016 and was unannounced. The home was previously inspected in February 2015 and the service was meeting the regulations we looked at.

Hollydene Rest Home is a residential care home providing care and support for people living with dementia. The home can accommodate up to 25 people. When we inspected the home there were 22 people using the service.

The service had a registered manager in post at the time of our inspection. 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 who used the service, and their relatives we spoke with, told us they were happy with how care and support was provided at the home. They spoke positively about the staff and the way the home was managed. However, this was not always reflected in what we saw.

We saw there were systems in place to protect people from the risk of harm. However, some staff we spoke with were not knowledgeable about safeguarding people and were not able to explain the procedures to follow should an allegation of abuse be made.

Assessments identified risks to people and management plans to reduce the risks were in place to ensure people's safety. However, these were not always followed.

During our inspection we observed people had to wait at times for assistance and staff were not always present in communal areas to ensure people's safety. Staff told us at times there was only two care staff and a team leader on duty and this was not enough staff to be able to meet people's needs.

Systems were in place to ensure people received their medications in a safe and timely way from staff who were appropriately trained. However, we identified these were not always followed and staff did not follow best practice when dispensing medicines.

We found the provider had a safe and effective system in place for employing new staff. We looked at a selection of staff files and found pre-employment checks such as, two references, and a satisfactory Disclosure and Barring Service (DBS) check, were mainly in place.

We found the service to be meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The manager had a good understanding and knowledge of this, and people who used the service had been assessed to determine if a DoLS application was required. However, some staff we spoke with did not understand what DoLS was and how it affected people they supported.

People were offered a balanced diet sufficient to maintain a balanced diet and adequate hydration. However, we observed staff did not always give appropriate support with meals to people who used the service. We found people had lost weight and their nutritional needs had not been met.
We looked at care files, although peoples choices were documented the care we saw delivered and documented did not always reflect people's care and support needs choices or preferences.

We spoke with the registered manager about staff training and found training provided was mainly completed by eLearning; however certain subjects such as manual handling were completed face to face. We looked at the training matrix, which was a record of staff training. We found that training had not always taken place. For example, only four out of eight care workers had completed moving and handling training.

The environment could be improved to make it more dementia friendly. Communal areas and corridors were not dementia friendly. Signage was small, basic and misleading and did not always enable people to orientate around the home. For example we saw a sign on a fire door saying 'garden' but the door was locked.

People we spoke with all told us staff were kind, caring and thoughtful. A relative we spoke with said, "couldn't get better care, we are happy." However, this did not always reflect what we saw. During our visit we spent time in communal areas observing people who used the service. We saw some positive interactions between people and staff, but also saw some poor and task orientated interactions between staff and the people they were supporting. Staff were not unkind in their approach but lacked understanding of looking after people who were living with dementia.

We looked at three people's care records in detail, who used the service at the time of the inspection. We found that care plans identified people's needs, setting out how to support each person so that their individual needs were met. However, these were not always reviewed when people's needs changed. We also found some old records which made it confusing to understand what was the most up to date information to be followed.

The provider had a complaints procedure and the registered manager kept a log of complaints and the outcome. We saw the registered manager had dealt with complaints in line with the company policy.

We saw audits were completed to ensure the quality of the service, however these were not always effective. There was little evidence that people who used the service and their relatives had a voice and given the opportunity to contribute ideas to the service. Accidents and incidents were logged but were not always analysed in enough detail.

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.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

The service had a policy in place to safeguard people from abuse. However, some staff did not know how to recognise record and report abuse.

People did not always receive their medicines in a safe manner.

There was not always enough staff available to meet people's needs and there were times when people had to wait for assistance.

We found the provider had a safe and effective system in place for employing new staff.

Is the service effective?

Requires Improvement

The service was not always effective.

We looked at the training matrix, which was a record of staff training. We found that training had not always taken place.

The service was meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

People were offered a balanced diet sufficient to maintain a balanced diet and adequate hydration. However, we observed staff did not always give appropriate support with meals to people who used the service.

The environment could be improved to make it more dementia friendly.

Is the service caring?

Requires Improvement

The service was not always caring.

During our visit we spent time in communal areas observing people who used the service. We saw some positive interactions between people and staff, but also saw some poor and task orientated interactions between staff and the people they were

supporting. Staff were not unkind in their approach but lacked understanding of looking after people who were living with dementia.

Staff were not always knowledgeable about people's likes and dislikes and therefore were not always able to support them in line with their individual preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We found that care plans identified people's needs, setting out how to support each person so that their individual needs were met. However, these were not always reviewed when people's needs changed.

The service dealt with complaints effectively. The registered manager kept a log of complaints and the outcome.

Is the service well-led?

Inadequate

The service was not well led.

We saw audits were completed to ensure the quality of the service, however these were not effective.

There was little evidence that people who used the service and their relatives had a voice and given the opportunity to contribute ideas to the service.

Accidents and incidents were logged but were not always analysed in enough detail.

Hollydene EMI Rest 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 4 October 2016 and was unannounced. The inspection was carried out by two adult social care inspectors.

Prior to the inspection visit we gathered information from a number of sources. We also looked at the information received about the service from notifications sent to the Care Quality Commission by the manager. We also looked at the information sent to us by the manager on the provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also spoke with the local authority and other professionals supporting people at the service, to gain further information about the service.

We spoke with four people who used the service and two relatives, and spent time observing staff supporting with people.

We spoke with three care workers, one team leader, the cook and the registered manager. We looked at documentation relating to people who used the service, staff and the management of the service. We looked at three people's care and support records, including the plans of their care. We saw the systems used to manage people's medication, including the storage and records kept. We also looked at the quality assurance systems to check if they were robust and identified areas for improvement.

Inadequate

Is the service safe?

Our findings

We looked at the systems in place for managing medicines in the home. This included the storage, handling and stock of medicines and medication administration records (MARs).

We found the temperature of the medication storage room was not monitored. It was therefore not possible to determine if medicines were kept at the required temperatures to ensure their safety. The temperature of the refrigerator was checked and recorded daily and this had maintained the required temperatures.

We found staff who administered medicines did not always record the amount of medicines received or the amount carried forward from the previous month. This made it difficult to account for medicines. For example, one person had no pain relief medication dispensed for the current month and no carried over amount was on the MAR. However, tablets were available in the service form previous months supplies but were not recorded. It was therefore difficult to audit medicines available in the service to ensure people received their medication as prescribed. We also found eye drops opened and undated, this meant it was not possible to determine if they had been opened longer that the recommended 28 days. After which they should be destroyed.

We found people were prescribed medication to be taken as and when required known as PRN (as required) medicine. For example, pain relief and to alleviate agitation. We found people did not always have PRN protocols in place or if they were in place they did not give adequate detail to enable staff to determine when the medication was required. PRN protocols would detail when to give PRN medication and explain how people presented when they were in pain or agitated. Staff told us people who were prescribed these medications were not always able to tell them when they were in pain or distressed due to their medical conditions. This meant that people who used the service could be in pain or distressed and not have medication administered as staff did not know what signs to determine when it was required.

The medication was administered by staff who had received training to administer medication. However, we observed staff administering medication and they did not always follow best practice. We saw the medication trolley was left opened and unattended. Medicines were left on top of the trolley when it was unattended and staff placed medication in their hands, when they should have been dispensed straight into a medicine pot. We also observed staff did not wash their hands between dispensing medicines to people and they had assisted people by putting medicines into their mouth. This posed a risk of cross infection and put people at risk.

We also checked controlled drug (CD) records, we found these were not always recorded accurately. We found one person took a controlled tablet at night. There was no carried over amount on the MAR and we found 13 in stock recorded in the CD record. However, when we checked the cupboard there were a further 56 in the home that were not recorded either in the CD record or on the MAR. This did not follow robust procedures for the handling and management of CD's.

We looked at care plans and found people's needs had been assessed when they came to live at Hollydene .

Plans of care had been developed and risk assessments were in place. However, we identified risk assessments aware not regularly reviewed to ensure risks were managed. This put people at risk of receiving unsafe care. For example, people who were at risk of weight loss were not reviewed, one person had lost weight and this was not reflected in the risk assessment. This meant the risk was not managed to ensure people received adequate nutrition. The tool the provider was using identified an amount of weight loss to increase the risk factor not a percentage of total weight. Therefore someone who was of low weight could lose up to 3.5kgs in a month and not be classed as at higher risk yet this could be 6% of their body weight, which is significant and should identify an increased risk.

Moving and handling risk assessments did not detail the sling to be used and we observed staff using hoist slings inappropriately, for example toileting slings were used when transferring people to other seating. This put people at risk of falling as the toilet sling is much smaller and we saw people being taken across a considerable distance for transfer form a wheelchair to an armchair. We also found one person's bedroom opened out onto a step then a small landing area then the main flight of stairs. If the person tripped on the step as they left their bedroom there was a risk they could fall down the flight of stairs. The persons moving and handling risk assessment just said they were independent but did not refer to the step. This did not ensure the risks were identified, minimised or reviewed.

This was a breach of Regulation 12 (1) (a) (f) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us there was not always enough staff on duty to meet people's needs. On the day of our visit there was an apprentice on duty, staff told us as they were an apprentice they were not included in the numbers so when they were not on duty there was only two care staff and one team leader on duty. They told us when this happened they struggled to meet people's needs in a timely way. Our observations identified people's needs were not always met in a timely way and staff were not always present in communal areas to ensure peoples safety. For example, when no staff were in the dining room one person who required thickened fluids went to during another person cup of tea that was not thickened, a staff member walked in at that moment and stopped this happening, this could have put the person at risk if they had been able to drink the tea.

We saw care staff also had to do the laundry; this was accessed outside the building so when staff were in the laundry they could not be called to give assistance if required. Staff told us there was only two night staff on duty and when they started a night shift at 8pm most people were still up and required assistance to go to bed. At least four people required the support of two care staff so why they were being supported other people were left unobserved in the communal areas. This put people at risk.

We saw dependency assessment in plans of care that identified people's dependency needs. However, we did not see how care hours were determined from this assessment.

The home employed eight care workers, one domestic, one laundry assistant, two cooks and a maintenance person. We spoke with the registered manager about the lack of staff and were told that they had tried to recruit but that recruitment was difficult. Agency staff had been used to cover shifts when the providers own staff were unable to.

On the day of our inspection there was no domestic on duty which meant that care workers were expected to complete essential cleaning as well as their own tasks. This meant that less time could be spent with people who used the service. We found from talking to staff that the cook had left and the care staff were also going to be asked to cover catering shifts.

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

Most of the staff we spoke with were knowledgeable on safeguarding and whistle blowing policies and procedures. Whistleblowing is one way in which a staff member can report suspected wrong doing at work, by telling someone they trust about their concerns. Most staff told us they would not hesitate to report any safeguarding concerns. They told us if they felt the manager wasn't responding appropriately they would report to the regional manager or the local authority. However, some staff we spoke with did not know what this was and were not sure of policies or procedures. We looked at the training records and found that only three staff had received training in this area.

During our inspection we carried out a tour of the building and identified some concerns regarding infection prevention and control. We found correct procedures were not followed and areas of the service were not maintained to be able to be kept clean. The laundry was very unorganised, cluttered and dirty. We found wooden shelves that were encrusted in dirt, the wall covering behind the sink was splattered with dirt, the concrete plinth below the washing machine had paint peeling and was encrusted in dirt and debris, many items were stored on the floor so unable to be cleaned properly, the radiator had a build-up of dust and had not been cleaned. Food was also stored in this area along with paint and other maintenance equipment.

We also found linen cupboards had linen stored on the floor; therefore the floor area was not easily accessed to clean. We raised this with the registered manager who began to address the issue. We noticed that linen on people's beds was old and stained and quilts were ripped and exposing the inner filling material. We informed the registered manager and the clinical lead for the service and they purchased new bedding, which arrived during our inspection.

Most of the bins around the home in toilets and bathrooms did not have lids in place. We found dirty washing stored in baskets in a shower cubicle also without lids, inappropriately stored.

We saw commode seats throughout the home were dirty. Care staff we spoke with told us they emptied the commode in the toilet and washed them in a wash hand basin, which was situated in the domestic cupboard. They said this was not ideal as they were unable to wash them properly, but there was no sluice facility.

We also identified that care staff used the same sling for numerous people when hoisting. This put people at risk of cross infection. Said told us there was one sling for the stand aid and one for the hoist and two different people used each piece of equipment. They also said there were only the two slings in the home so when they were in the wash there was nothing to use. This meant if the sling became soiled during the day people could not be moved until it had been washed and dried.

We observed staff wearing opened back shoes which could cause a trip hazard. Some staff were also wearing jewellery below the elbow, including bracelets and stone rings, which meant they could not wash their hands thoroughly.

We spoke with the registered manager about the cleanliness of the service and looked at the staff rota for domestic staff. The home currently employed one domestic staff and a person who did the laundry. On the days when there were no domestic in the home, care staff were expected to do essential cleaning of bathrooms and toilets and the laundry, as there was no additional care staff on duty to complete these duties they were not always carried out as staff told us they prioritised people who used the service over cleaning.

This was a breach of Regulation 12 (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the provider had a safe and effective system in place for employing new staff. We looked at a selection of staff files and found pre-employment checks such as, two references, and a satisfactory Disclosure and Barring Service (DBS) check, were mainly in place. The DBS checks help employers make safer recruitment decisions in preventing unsuitable people from working with vulnerable people. This helped to reduce the risk of the registered provider employing a person who may be a risk to vulnerable people. However, we looked at one file which only contained one reference, which was not from their most recent employee. We spoke with the registered manager about this, who felt this may be at the company head office.

Staff we spoke with explained their recruitment process. They said they could not start work until they had received references and a satisfactory DBS check.

Requires Improvement

Is the service effective?

Our findings

We observed breakfast in the dining room. The dining room was very cramped and people could not move around the room when everyone was in using frames or wheelchairs as there was not enough room. People had a choice of what they wanted to eat and many were enjoying the food. However, no menu was displayed on the tables. There was a chalk board on the wall but this detailed Friday 30 September meal and had not been updated for three days. We observed staff standing over people giving assistance as there were no chairs to sit on and no room to bring a chair into the room. Staff were not responsive to people's needs. For example we saw one person took another person's half eaten toast and ate it saying it was very nice, staff did not observe this or offer the person their own toast. Another person was falling asleep putting their head on the table and not eating. Staff did not intervene to provide support to this person.

During the meal staff were not always available in the room to offer assistance. When people started leaving the room there was not enough staff to enable a staff member to be present in the dining room, this put people at risk as many were still eating. For example one person's care plan stated they required 'stage 1' diet due to swallowing difficulties and was to be observed at all times when eating, we saw this person was not observed when they were eating their breakfast and was left with other food on the table that they could reach which if eaten put them at risk of choking.

We looked at food and fluid monitoring, we found charts were not completed accurately, were not reviewed or monitored. This meant they were ineffective. Staff were recording ate half or a quarter but were not detailing how much was served so impossible to tell the amount that was eaten. Fluid charts we checked showed people had not been offered a drink, on some occasions for over 15 hours. From 17.15hrs on one day through to 8.30 am the following day. We identified during our inspection that people had lost weight, therefore this did not evidence people were receiving adequate nutrition and hydration.

Care plans we looked at detailed people's needs and how they were met. We saw evidence of involvement form health care professions when required. For example we saw referrals to speech and language therapists when people presented with swallowing difficulties. However, some staff we spoke with were not knowledgeable on people's needs in regard to diet. Staff were not always aware of special diets, people's cultural needs and if they were at risk of choking. Staff had guidelines and assessments form dieticians and speech and language therapists to follow but we found old information in care plans that made it confusing what the person needs were. We spoke with the cook who was very knowledgeable on people's dietary needs and they did assist with serving meals. The cook we spoke with was part time and they told us the permanent full time cook had left so care staff would have to cover some meal preparation.

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

A high proportion of the staff team were new, bank staff or agency staff. They were not all clear about their roles and responsibilities to ensure people's human rights were protected. They did not know people well and were not always aware of their communications needs or how best to enable them to make decisions

for themselves. They did not have the knowledgeable regarding the process that needed to be followed when people were unable to make certain decisions. Some staff did not understand the need to make decisions that were in people's best interests to ensure the decision made was the least restrictive.

We also identified the provider was looking to install CCTV in the home, which was to increase the safety of the building. However, they were considering putting this in communal lounges to observe people who used the service, this could be an invasion of their privacy and was not the least restrictive way to ensure their safety. It is best practice to use CCTV on external doors for security. However, consent would need to be sought in line with the Mental Capacity Act if CCTV was to be considered for use in communal areas.

We spoke with the registered manager about staff training and found training provided was mainly completed by eLearning; however certain subjects such as manual handling were completed face to face. We looked at the training matrix, which was a record of staff training. We found that training had not always taken place. For example, only four out of eight care workers had completed moving and handling training. We also found that three care workers who had not completed the training had been employed within the last six months and on occasions had worked together. This potentially put people at risk. We spoke with the registered manager who told us these staff had previously worked in care and had been trained in moving and handling in their previous post. However, evidence of this, or of any competency checks, could not be found.

The manager told us to enable staff to understand their role in supporting people staff had received specific training in topics such as equality and diversity and dignity in care. However, we did not see this in practice We also saw from the training matrix that these topics were not included. We found that only four of the eight care workers had received training in dementia care.

We saw from the training record that only two staff (both cooks) had received first aid training and no staff had received training in Control of Substances Hazardous to health (COSHH). This could potentially put people at risk. We also saw that only four care workers and two cooks had completed infection control training completed. From the training record we saw that only four care staff had completed medication training.

The record did not identify that domestic staff had completed this. Infection control training could have potentially highlighted some of the concerns raised on our inspection.

This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staff files and found that staff supervision had not always taken place in line with what we were told was the providers policy by the registered manager. Staff supervision was a one to one meeting with the person's line manager. The registered manager told us there was a policy in place in relation to staff support, but this could not be located. The registered manager and the clinical lead told us that staff were supervised every three to six months. Two of the four staff files we looked at contained one supervision session for 2015. One of the four files contained a supervision session for 2015 and an annual appraisal for 2016. The registered manager showed us a plan they had in place for addressing the gaps in staff support.

Staff told us they received supervision and support. They said it had been difficult time as many staff were new in post or bank staff but felt they worked well as a team and supported each other.

We found the service to be meeting the requirements of the Mental Capacity Act 2005 and Deprivation of

Liberty Safeguards (DoLS). The manager had a good understanding and knowledge of this, and people who used the service had been assessed to determine if a DoLS application was required. We looked at care files of people who had an authorised DoLS. We saw this was not always detailed in a care plan. For example, staff thought people had an authorised DoLS in place but it was an urgent authorisation and had expired, the standard authorisation had been applied for but had not been reviewed by the Local authority. Staff we spoke with were not all aware of DoLS and how this affected the people they supported.

The design and layout of the main entrance area was not dementia friendly. General floor covering on the corridors showed very little regard for the needs of people living with dementia. People living with dementia may mistake patterns as litter and may attempt to pick up what they are seeing. This may result in the person falling. There was no evidence to show that the service had explored the relevant guidance on how to make environments used by people with dementia more 'dementia friendly.' Communal areas and corridors were not dementia friendly. Signage was small, basic and misleading and did not always enable people to orientate around the home. For example we saw a sign on a fire door saying 'garden' but the door was locked.

During our observations at meal times we saw no consideration had been given to the people who lived with dementia. All crockery was traditional white rather than coloured, there was no picture menus for people to be able to make a choice and the menu written on the board was out of date. Best practice guidance the 'EHE Environmental Assessment Tool' from Kings fund 2014, suggests that if food and drinks should be presented on coloured plates it is appears more appealing to people living with dementia.

We also found the decoration was all similar colours, dementia guidance suggests that having different colours on walls and doors makes it easier for people living with dementia to locate things.

Some hard flooring in communal area was shiny. People living with dementia may interpret shiny floors as being wet or slippery. Rooms were not personalised for people to be able to identify it as their room, no use of 'Memory boards' which would help people who were living with dementia locate their bedrooms. The Kings fund guidance also details the use of memory boards as good practice for people living with dementia.

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

Requires Improvement

Is the service caring?

Our findings

People we spoke with all told us staff were kind, caring and thoughtful. A relative we spoke with said, "Couldn't get better care, we are happy."

However, this did not always reflect what we saw. During our visit we spent time in communal areas observing people who used the service. We saw some positive interactions between people and staff, but also saw some poor and task orientated interactions between staff and the people they were supporting. Staff were not unkind in their approach but lacked understanding of looking after people who were living with dementia.

We saw staff carrying out support for people without asking them first or explaining what they were going to do. For example, leaning over people to cut up their food with no explanation, hoisting people form wheelchair to armchair without any explanation or reassurance.

People's needs and preferences were recorded in their care records. Staff were however, not always able to describe the ways in which people preferred to be supported, but were aware of information in the care plan, which included information about people's likes, dislikes, and life history.

Staff understood the need to respect people's confidentiality and not to discuss issues in public, or disclose information to people who did not need to know. Any information that needed to be passed on about people was discussed at staff handovers, which were conducted in private.

The manager told us there had been champions identified for dignity but this appeared to be in name only and also some had left. They said the staff required more training and support to be able to promote dignity in the home.

During our tour of the home we saw people's bedrooms were quite sparse and not always personalised. The registered manager told us that people were welcome to bring in personal items to make their room more homely.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On bedroom walls we saw 'speech bubbles' which contained things about that person, for example what they were interested in, family members, and preferences. This was information for staff as the people were unable to identify with the written comments due to living with dementia. The registered manager told us that this helped staff to support people and to hold a meaningful conversation with them.

Requires Improvement

Is the service responsive?

Our findings

We looked at three people's care records in detail, who used the service at the time of the inspection. We found that care plans identified people's needs, setting out how to support each person so that their individual needs were met. However, these were not always reviewed when people's needs changed. We also found some old records which made it confusing to understand what was the most up to date information to be followed.

We found plans were not regularly assessed changes recorded or reviewed to show peoples changing needs and some information was old and did not reflect people's current needs. This put people at risks of receiving inappropriate care that was not responsive to their needs. For example one person's care need for nutrition said they were low risk, it showed they were of normal weight and had not last weight. Yet from February 2016 to September 2016 they had lost 9.6kgs. The plan also stated they ate a full diet and the food and fluid chart for 3 October stated they had eaten all their breakfast. However, we observed this and they did not eat their breakfast it was thrown away by staff uneaten and no alternative offered. Therefor their changing needs had not been responded to by staff to ensure these were met.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found peoples choices and preferences were documented in plans of care but were not always followed. For example one person stated they liked to have a bath or shower twice a week, yet the records we looked at did not detail that this had occurred. In fact only one entry of having a bath in the last month was recorded. We observed this person hair was greasy and lank and did not seem to have been washed recently. We also observed many people's hair was unkempt, when we asked staff they told us the hairdresser had not been for a while. We also saw people had dirty nails many were black under the nails and had not been cleaned.

There was not a dedicated activity co-ordinator and we did not see any activities on going at the time of our visit. Staff told us they were meant to provide activities but most times struggled to do this due to other tasks. Although we did see an activity plan and some entertainers came into the service. We also saw the apprentice painting some people's nails during our visit. However, some people who were unable to join in group activities received very little social stimulation.

The service did not provide items recommended for people living with dementia, such as rummage boxes or tactile pictures. This meant that people did not receive much social stimulation and there was not a lot to occupy people.

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

The provider had a complaints procedure which outlined how to make a complaint. We spoke with the

registered manager who showed us a log of complaints and the investigation and outcome. This had been completed in line with the provider's policy for dealing with complaints raise with the provider.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection the service had a registered manager who had been the manager since March 2016, and registered with the Care Quality Commission since July 2016. There was no deputy manager the registered manager was supported by senior care workers. Although we identified some of these were also new in post so learning their roles and responsibilities. The registered manager had been supported by periodic visits by the clinical lead. This made up the management team. Staff we spoke with told us the registered was supportive. One member of staff we spoke with said, "Things are very hard at the moment as we have a high turnover of staff, there is no deputy manager and the manager is trying to do everything, which isn't possible."

We saw several audits were completed on a regular basis with the intention of ensuring that a quality service was being provided to people who used the service. However, some of the issues we identified had not been highlighted as part of these audits and had therefore not been addressed. For example, the infection control audit completed in September 2016 stated that pedal bins were in all key areas apart from one bathroom. Our observations found that most areas did not have these in place. We also saw a care plan audit which did not identify the issues around reviews not taking place and therefore information being out of date and not in line with people's current needs.

We also found that where audits had identified issues, these had not always been actioned. For example, the medication audit, completed at the beginning of September 2016, had highlighted that some medicines had no carried over stock recorded on the MAR sheet. This was identified on inspection as still being an area of concern.

The operations manager had completed an operational service review in September 2016. This was to monitor the performance of the home and the registered manager. This review highlighted that no social trips were planned, supervisions and training needed completing. No other areas were identified and there was no action plan in place to address these issues.

We looked at the accident and incident log and found that there was a list of accidents which had occurred on a monthly basis. However, we spoke with the registered manager about completing an accident analysis so that contributing factors could be identified and risks of reoccurring accidents prevented. There was an analysis section on each accident form for the registered manager to complete. We found that this had not been completed in enough detail. For example, one accident we looked had had not been investigated by the registered manager to determine how the accident had happened. Therefore it was difficult to determine that the actions put in place were appropriate.This meant any triggers or themes may not been identified to reduce the risk to people who used the service.

The service arranged relatives meetings and the last one took place in May 2016. A further meeting was planned to take place in November 2016. The service sent out a quality survey to people living at the service and their relatives and to professional visitors to the home. This was last completed in April 2016 but there was no evidence of any being returned. We spoke with the registered manager about this who said that

some had been received however, these could not be located. We found that no action plan or outcome had been communicated to people.

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

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 did not always ensure that the care and welfare of people was appropriate and met their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect There was a lack of understanding about dementia care. Staff were task focused and their was a lack of communication between staff and people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not always ensure that they were meeting people's nutritional needs.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not always completed and people were not always safe. The provider did not ensure that infection prevention and control measures were in place and correctly followed. The provider did not always ensure that people received their medicines in a safe way.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always ensure that governance was robust. Audits that took place did not always identify the areas to improve the service.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff available to meet people's needs. Staff were not always supported and did not always receive training to support their role.

The enforcement action we took:

Warning notice