Dr Sunita Nagpal and Partners

# Salisbury Residential Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| Is the service safe? | Requires Improvement |
| 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 16 and 17 August 2017, and was unannounced.

Salisbury residential home provides accommodation and personal care to a maximum of 31 people. This includes older people, some who may be living with dementia. At the time of our inspection there were 26 people using the service.

We previously carried out a comprehensive inspection of this service on 6 June 2016 where we found that the service was not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was in breach of regulation 18 of the Care Quality Commission (Registration) Regulation 2009, as they had failed to notify us of an incident resulting in serious harm to a person. Regulation 11, because formal mental capacity assessment and best interests decisions were not always carried out, and Regulation 9 because the service had not ensured that people received responsive care that met their needs. We also identified a breach of regulation 17, because the service had failed to implement effective systems to monitor and improve the quality of the service. We issued a warning notice in relation to Regulation 17. In November 2016 we returned to check if the service had met the requirements of the warning notice, and we found that improvements had been made and they were no longer in breach of Regulation 17.

At this inspection in August 2017, we found a continued breach of Regulation 9, and a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We took enforcement action to impose conditions on the providers registration. We asked the provider to identify the root causes of the shortfalls in the oversight and governance of the service and what action is being taken to mitigate these from reoccurring. This must include and consider risks associated with nutrition and any associated weight loss, falls, and pressure area care. This condition continues on a monthly basis, whereby the provider informs us of actions which have or are being taken to mitigate identified risks. We decided to impose these conditions on the providers registration because people may be exposed to the risk of harm.

The registered manager had left the service in June 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was a manager in post who was still in their induction period, and they were planning to register with the CQC.

People's health, safety and well-being were at risk because the registered provider had failed to identify where safety was being compromised. Quality assurance and auditing mechanisms did not identify concerns we found during this inspection and had not been effective at driving and sustaining

improvements. This constituted a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks associated with people's care and support were not always safely managed, monitored or reviewed in line with their assessed level of need. This constituted a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst the registered provider had taken steps to improve the provision of activity, this was still not meeting the individual and specialist needs of people. Care plans were not always accurate or sufficiently detailed to reflect people's needs and provide adequate guidance for staff. People's nutritional and hydration needs were not accurately documented or monitored to ensure their intake was sufficient. We could not be assured that relevant referrals to other professionals had been made promptly, or were being followed, as documentation was not available to demonstrate this. We also found that one person had not been referred for specialist input regarding their falls. This constituted a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received their oral medicines safely and in a timely manner. However, topical application, such as creams were not being documented as having been applied. This meant we could not be certain that people were receiving their topical medicines as prescribed.

Staffing levels were adequate and had been regularly reviewed to ensure they were meeting the needs of people living in the service. Staff were trained in subjects relevant to the people they were caring for.

The registered provider and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Systems were in place to check if people were at risk of being deprived of their liberty. Systems were in operation to obtain consent from people and to comply with the MCA.

Procedures were in place which safeguarded the people who used the service from the potential risk of abuse. Staff understood the various types of abuse and knew who to report any concerns to.

People told us they had good relationships with staff who protected their privacy and dignity. We observed pleasant and patient interactions throughout our inspection. However, we received mixed feedback about the staff, with some people saying the staff approach could vary. Staff had a good knowledge about the people they supported.

Safe recruitment procedures were in place, and staff had undergone recruitment checks before they started work to ensure they were suitable for the role.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

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

Accurate records were not being kept of topical medicines administered by staff. This meant we could not be sure people were always given their prescribed medicines.

People were cared for by adequate levels of skilled staff. Due to the complex and unpredictable needs of people living in the service, staffing levels required continual review to ensure they were meeting the need of people at all times.

Staff were knowledgeable in how to recognise and report abuse.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

People were supported to access a range of health care professionals. However, recommendations made by other professionals were not always available on peoples care records.

Staff were trained in subjects relevant to the people they were caring for.

People were asked for their consent before any care, treatment or support was provided. Staff were knowledgeable about their responsibilities in line with the principles of the MCA.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

People told us that the majority of staff were kind and caring, but some people told us that the staff approach could vary.

Care plans were not always signed by people to show they had been involved in creating them and their views were known.

Staff knew people who used the service well and had good knowledge of their needs, likes and dislikes.

The atmosphere in the service was relaxed and people were listened to.

People's dignity and privacy was respected and maintained.

## Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

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

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

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

## Is the service well-led?

**Inadequate**

The service was not well-led.

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

Communication between staff and management was not effective, and as a result roles and responsibilities were not clear.

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

# Salisbury 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.

The inspection took place on 16 and 17 August 2017, was unannounced and undertaken by two inspectors 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.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service: what the service does well and improvements they plan to make. We also reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also spoke with the local quality assurance and safeguarding teams.

During the inspection we spoke with six people living at the service, three relatives, a social care professional and six members of care and catering staff. We also spoke with the registered provider who was present on both days of the inspection.

To help us assess how people's care needs were being met we reviewed seven people's care records and other information, including risk assessments and medicines records. We also observed the interactions between staff and people. We reviewed three staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

Requires Improvement

# Is the service safe?

## Our findings

At our previous comprehensive inspection on 6 June 2016, we found that risk assessments did not always contain specific risks which might affect people. However, information relating to risk was available to staff for guidance in the main care plan.

At this inspection we found that some risks were not adequately assessed, monitored or reviewed to ensure any concerns were quickly identified. For example, we found that one person was at risk of malnutrition and was losing weight. There was no information in their care plan referring to their weight loss and how staff should support the person to eat more and boost their calorie intake. The care plan for another person who was at risk of malnutrition and of low weight specified that they liked to eat at night. We checked their food chart and for nine consecutive nights no food intake had been documented. However, staff told us the person had been eating food at night. The same person was having their food fortified with cream and butter to increase their calorie intake, however, when we checked their food diary, staff were not documenting whether the food was fortified or not. This meant staff did not have a clear picture of what the person had eaten to ensure that this risk was sufficiently monitored and managed. Some people who had been assessed as high risk required their weight to be monitored on a weekly or fortnightly basis. However, we found this was not happening which meant the risks to these people was not being adequately managed.

At our previous comprehensive inspection in June 2016, we found that staff monitored people's food and fluid intake via a chart in their care plans. However, some gaps were found in the recording of people's intake. At this inspection we found that this had not improved. Fluid intake had not always been totalled to establish the total fluid intake for each day and to monitor that the intake was adequate for their needs. Food charts were not consistently completed where people were at risk of weight loss. This is important to as it helps staff to monitor if peoples food and fluid intake is adequate to support their needs. For example, one staff member had recorded that a person had 'toast' for breakfast. Another staff member told us that sometimes they ate four slices of toast, and on other days, just one slice. Therefore the detail around how much people had eaten was not recorded accurately.

For people at risk of developing pressure ulcers, waterlow screening tools (which estimate the likelihood of developing a pressure ulcer) were used to assess the level of risk. The team leader told us that the majority of waterlow assessments had not been reviewed since May 2017, as the staff member responsible for this task had left the service. One person had been assessed as being at 'very high risk'. Their care plan said to, 'observe changes in skin' but there was no information about how this should be done or where it should be recorded. We looked at the person's daily records, but staff had just repeatedly documented 'cream applied'. There had been no information documented regarding their skin integrity and if any changes were observed. Another person was assessed as being 'at risk' of developing a pressure ulcer, however, there was no associated risk assessment in their care plan which made reference to this so staff knew how to reduce the risk.

Some people were living with dementia and experienced episodes where they became agitated and

disorientated. We observed one person repeatedly trying to leave the building which posed a risk to their safety. We found there was no risk assessment associated with the person attempting to leave the building, which would provide guidance to staff on how best to support the person in these situations and to keep the person safe. Some staff told us of particular triggers, and the time of day when they became agitated. However, this was not recorded in the person's care plan to ensure they received the most effective support at the right time. We brought this to the attention of the team leader, and a risk assessment was promptly put in place. Another person was experiencing behaviours which challenged staff and other people living in the service. We saw there was a behaviour chart in place, but no associated risk assessment to guide staff in how to reduce the risk.

We found that some people had thickened fluids prescribed, which indicated they were at risk of choking. Care plans provided guidance on how to prepare the fluids, however, there were no risk assessments in relation to choking. This information is needed to provide guidance to staff on how to minimise the risks associated with choking, such as positioning safely when they were eating or drinking. Some people were having their food pureed, due to difficulties with swallowing. These types of foods will usually be prescribed following assessment by a speech and language therapist (SALT), and will specify how the pureed food should be served, for example, a thin or thick consistency. We spoke to the cook about the preparation of these foods. They told us that there were several people in the service having 'liquidised' foods. We asked how each person's food should be prepared, and they told us they had no other guidance other than to 'liquidise' the food. This meant that there was a risk that people could receive the incorrect consistency of food, which might cause them to choke. The team leader assured us that people had been assessed by SALT but were unable to source their recommendations for us to review. They assured us they would review each person's requirements promptly, and refer back to the SALT team where needed.

People had risk assessments in place to help staff support people with their mobility. Risk assessments detailed the numbers of staff required and the equipment used, such as hoists and stand aids, and people's care records confirmed they were supported in the correct way. However, one person's care plan contained conflicting information. The moving and handling plan stated that the person 'no longer walks any distance'. However, the care plan said the person was 'unable to walk more than a few steps'. This meant the person was at risk of not being supported in a safe and consistent manner.

Some medicines and other products had not been stored securely. For example, we found a powder which is used to thicken drinks in one person's bedroom. Ingestion of this substance can cause fatal choking. Topical applications, such as creams, were stored in a bathroom cupboard downstairs. We found this did not have a lock on it. A staff member told us that the key had broken last week, but nobody had secured the door in the interim whilst the lock was fixed. Therefore vulnerable people were not protected against access to these medicines to prevent them from accidental harm.

We found some hot water pipes were exposed in some bathroom areas, and when the hot tap was in use, these pipes became extremely hot, posing a risk of scalding should a person come into contact with them. The provider assured us they would address this issue promptly.

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

Our previous comprehensive inspection on 6 June 2016, identified some concerns with the management of medicines in relation to topical applications, such as creams, as there were gaps in the records of their administration. At this inspection we found that this had not improved. We looked at five topical application

charts and found several gaps on each. This meant that we could not be assured that people received these medicines as prescribed, and we brought this to the attention of the provider.

Where people were receiving medicines covertly (crushed and given to them in food or drink without their consent) we saw that documentation was in place and involved relevant people, such as a GP, pharmacist and family members. However, for one record we saw that this had not been reviewed for nine months. The continued need for covert administration must be regularly reviewed within specified timescales. We found this was not documented.

Records showed that people received their oral medication as prescribed, and staff had consistently signed to show they had been given. Information on people's MAR (medicine administration records) charts described people's preferences for how they preferred to take their medicines, for example, on a spoon with water. Allergies and sensitivities were clearly documented, to enable medicines to be given safely. Controlled drugs were stored securely and stock checks were correct. Staff had received training in medicines, and had their competency checked at regular intervals.

Risks to people injuring themselves or others were reduced because equipment, such as hoists had been serviced and checked so they were fit for purpose and safe to use. There were systems in place to monitor and reduce the risks to people in relation to the water system and legionella bacteria.

At our last inspection 6 June 2016, we received mixed feedback regarding the staffing levels in the service, and we made a recommendation for the service to use an assessment tool to ensure staffing levels were adequate. The provider showed us that they had implemented a tool, and we saw that they had reviewed this regularly. Additional staffing had been implemented in the morning as a result. We saw that staff were visible around the service, and that the deployment of staff was effective. Staff told us that staffing levels were adequate. One staff member said, "Staffing is fine, we all work well as a team, we allocate tasks. We are monitoring people and we are always around." Another said, "Staffing has improved, there is enough of us, we can answer call bells quickly and support people well." We observed that at times, if people became agitated that staff had to remain with people constantly to ensure their safety. This temporarily impacted on staffing availability, and we asked the provider to consider this going forward.

Staff received training in safeguarding adults and were able to name types of abuse they may come across. One staff member told us, "If I notice anything of concern, emotional abuse, verbal abuse or abruptness, I will report to a senior member of staff. We have policies and procedures which we follow. The contact number for the safeguarding team is on the wall." Another said, "I have reported concerns before to 'head of shift'. If I reported something and they didn't take action, I would call [safeguarding team] myself."

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

Requires Improvement

# Is the service effective?

## Our findings

Records showed that people had access to healthcare services and received on-going healthcare support. This included physiotherapists, dentists, occupational therapists, and health professionals. However, we could not always be sure that relevant referrals had been made, or were being followed, as documentation was not available to demonstrate this. For example, speech and language therapy referrals could not be sourced. The team leader assured us that people had been assessed by relevant professionals but were unable to source their recommendations for us to review. In one case we found that a person had been experiencing falls. Whilst the service had implemented control measures to minimise injury, they had failed to refer the person for specialist input in a timely manner. This meant that there was a risk that people may not receive the care they require in a timely manner which could be detrimental to their health and wellbeing.

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

We advised the team leader and registered provider to review each person and ensure relevant referrals had been made. Following the inspection they made contact with us to confirm people were reviewed and referrals made as required.

At our last comprehensive inspection in June 2016, we found a continuing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because mental capacity assessments and 'best interests' decisions were not always carried out. At this inspection we found that processes had improved and the provider was no longer in breach of this regulation.

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

We found that mental capacity assessments and best interest decisions had been made for people unable to consent to areas of their care. This included medicines administration, personal care, and equipment which could be deemed as restrictive, for example, bed rails. This demonstrated that the service had considered people's ability to consent, and took appropriate measures to ensure that the care delivered was in people's best interests. Where people had legal representatives in place, these were documented, and included what legal authority the representative held. Best interests meetings had been held where appropriate, and included relevant professionals and representatives.

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

The service had made appropriate applications under DoLS to ensure people's human rights were protected. We also saw during the inspection an urgent DoLS had been made in relation to one person who repeatedly attempted to leave the building, putting their safety at risk. On the second day of our inspection, we saw a social care professional visiting to assess and authorise the DoLS. They told us the documentation the service had compiled in relation to the person and why a DoLS was required was, "Very good and very detailed".

Staff had a good understanding of the MCA and DoLS procedures. One staff member said, "Peoples capacity can fluctuate. We [staff] would assess, review, and always assume capacity." Another said, "Deprivation of Liberty is closely linked to MCA. So for the person who keeps trying to leave the building, we [staff] need to keep bringing them back, and we have to have a DoLS to legally do that." We observed staff asking people for their consent prior to assisting them. For example, during lunch we observed staff asking people if they wanted assistance to eat. We saw one person had managed to slide their chair away from the table. The staff member spoke kindly to them explaining the chair had moved and asking if they wanted to move back. The staff member said, "Right, I'm going to push you back in now, is that alright?"

We observed the lunchtime meal. The dining room overlooked the beach and was decorated in a nautical theme. There were five tables which had table cloths, place mats and condiments. There was a serving hatch into the kitchen which had a blackboard listing what the meal options were. There were jugs with different squashes ready to offer people, food portions looked generous and were served hot. One person made a point of going to the hatch and thanking the kitchen staff. They said, "lovely meal, really delicious today." Another said, "The food is good here, it's hot and there's plenty of it. Pudding was lovely." There was cooperation and teamwork between the staff during the lunch time service. When people had finished their puddings they were asked if they'd like a little more. Two people wanted some more, and we saw staff take the bowls back and serve the extra portions.

The provider had systems in place to ensure that staff received training, achieved qualifications in care and were supported to improve their practice. Staff told us that they felt that they were trained and supported to meet the needs of people who used the service. Training included, safeguarding, moving and handling, dementia, MCA/DoLS, falls prevention, and medication. One person said, "The staff are well trained, I know that because they know what they're doing." A relative said, "I think they know what they're doing with [relative]."

The registered provider told us that staff new to the service received an induction and period where they could shadow staff. Staff received an induction booklet which experienced staff signed off as the staff member was observed to be competent in various care tasks. However, we received mixed feedback regarding staff's experience of their induction. One staff member said, "I had no guidelines given to me, I was allocated a team leader initially, but they didn't really show me anything." Another said, "I wasn't shown how to do things properly. I was experienced in care, but the induction wasn't great." A third said, "It was ok, I picked things up quickly." The registered provider was aware of this as it had been discussed during supervision. They said they had planned to meet with two staff regarding this at the end of August 2017, to discuss their experiences and review the induction process.

Records showed that staff were provided with one to one supervision meetings. Supervision provides staff with a forum to discuss the way they worked, identify training needs, and receive feedback on their practice. The registered manager told us that they were aware that some staff were overdue supervision due to the recent changes in management. Supervision records showed that staff were provided with the opportunity to discuss the way that they were working, their training needs and achievements.

Requires Improvement

# Is the service caring?

## Our findings

At our previous inspection in June 2016, we found some practices which were not always respectful to people living in the service. This included the lack of staff available in one of the lounges, which resulted in people having to call out for help if they, for example, needed to use the toilet. We also saw that information relating to people's care was unsecured and kept in the lounge. At this inspection we found improvements had been made.

Staffing levels had been reviewed and increased. We observed staff to be present regularly throughout the day, available to people situated in the lounge areas. We also saw that confidential information in relation to people's care, including their care plans, were now stored securely in a locked room.

We received mixed feedback from people about the staff approach. One person said, "They [staff] are hard working. Some days they are friendly, sometimes they have bad days, anyone can have one of those." Another said, "They are kind, most of them are very good." A staff member told us that sometimes a particular staff member could be abrupt in their manner with people and that this had been reported to the new manager. The registered provider was aware of this allegation, and said they would investigate this further.

Care plans provided person centred information in relation to how people liked to have their care delivered. This included their preference for the gender of staff. Communication methods were well described, which provided guidance for staff on the most effective techniques, for example, using closed questions, making eye contact, and particular signs of distress to look out for. A relative said, "Communication is very difficult for [person] but the staff are encouraging them to talk more, they're [staff] very patient and give [person] time. They encourage [person] to tell them what they want." However, we did not always see that people had signed their care plans which would demonstrate that they had been fully involved in creating them and that their views about their care were known.

We observed that positive and caring relationships had been developed between staff and people. Many of the staff had worked in the service for a long period of time and therefore knew people well. We saw people readily ask for assistance from staff who reassured them. One person was becoming distressed in the lounge, and we saw two staff sitting with them holding their hand and reassuring them. We saw another person trying to leave the building which would pose a risk to their safety. Two staff were present and dealt with the situation well, reassuring the person, and ensuring they gave the person physical space so they didn't increase their agitation. One staff member said, "We know [person] well, we give [person] space and try to distract them as much as we can to keep them safe."

We were told that there were two people living in the service whose first language was not English. The registered provider told us that there were staff working in the service who could speak their language, and they always tried to ensure there was a staff member on shift able to communicate with them. We observed staff supporting a person, communicating with them in their language. This meant that the person was aware of what staff were going to do, and were able to provide reassurance to them. One staff member said,

"I speak [language] so I am allocated to provide their care. It's good for the [person], they know what's going on."

Privacy and dignity was respected, and we saw that staff attending to people's personal care ensured that doors and curtains were closed. Where people were sharing a room, there was a screen dividing the room which ensured privacy when needed. We also saw staff speaking discreetly with people when they needed assistance to use the toilet so others close by could not hear. A relative said, "I think they treat [relative] with respect. [Relative] is always smartly dressed and they keep [relative's] room lovely."

Relatives were able to visit as they chose, and there were no restrictions. People told us their friends and relatives often visited.

Requires Improvement

# Is the service responsive?

## Our findings

At our previous comprehensive inspection in June 2016, we found the registered provider was in breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) 2014. This was because the service had not always ensured that people received responsive care that met their needs. This included people having to wait for staff to assist them. Examples included people having to wait half an hour or more to be supported by a staff member. The provision of activity was also not meeting people's individual needs.

At this inspection we found whilst some improvements had been made the provider remained in breach of this regulation.

Staff were now more visible in all areas of the service, and responded to people's requests for assistance in a timely manner. However, we still observed that staff were not always able to be fully responsive to people's needs. For example, on the morning of our inspection we saw one person ask to go out shopping to a nearby shop to purchase some clothes. The person told us they preferred to go out with a staff member to make sure they were safe. The staff member agreed and said they would organise this later on in the day. In the afternoon we asked the person if they were still going out, and they told us that staff did not now have the time to do this. Although the person was accepting of this, we observed them to be disappointed that the plans had changed.

At our previous inspection in June 2016, care staff were responsible for delivering activity to people as there was not a dedicated activity co-ordinator. Staff reported that it was difficult to deliver care tasks in addition to their caring duties. As a result staff were unable to engage in long periods of meaningful interaction, or meet people's individual or specialist needs. At this inspection we found that the registered provider had subsequently employed an activity co-ordinator, but unfortunately they had been unable to continue in post. The registered provider had taken steps to try and cover the post, and a staff member had been dividing their time between caring and delivering activities. The plan was for them to become the full time activity co-ordinator. They told us, "I wanted to do activities because I think it's important. I like to do one to one things, so for example we might sit and talk about the past, or I might take someone into the garden for a walk and to look at the lavender." The registered provider had also made contact with a recruitment centre to arrange some cover for a temporary period of time but this was still not in place.

The majority of people spent their time in the main lounge with the television on. We noticed in one lounge that there were two radio stations playing simultaneously which we found quite distracting and confusing. Additionally, the radio was playing modern pop music, which some people living in the service may not particularly enjoy or be able to connect with. We observed during the morning staff interacting with four people, which involved throwing a beach ball back and forth to each other. The majority of people in the lounge were unable to join in with this activity. We saw that when people did engage with staff they responded in a positive way, smiling and talking.

In the afternoon an outside entertainer visited the service to sing well known songs. 13 people were seated in the lounge area for this event, and we observed people to be enjoying this level of entertainment. People

were joining in, smiling and playing musical instruments. We were informed that the entertainer visited the home every two weeks.

Although the provider had taken steps to improve the provision of activity, this was still not meeting people's individual or specialist needs. We were also concerned that people who did not wish to leave their rooms, or who were cared for in bed, were not receiving 'one to one' activity time with staff at present. Improvements were required to prevent social isolation. This is particularly important where people are developing, or living with dementia. There was also a lack of sensory stimuli, for example, orientation boards and information for people in an easy to understand format. In addition, there were no memory boxes or objects of reference to help aid reminiscence or provide a stimulating environment. One person said, "I do get bored sometimes. There aren't many activities at the moment, we used to be able to go out for a ride on the train [road train] or go to the café but we haven't recently, I think it's because there aren't enough staff." Another said, "I feel they could use the café and the beach more than they do. Last year they did." A staff member said, "We need more activity for people. We [staff] haven't had the time to take people out to the beach café, like we used to."

People's care records included care plans which guided staff in the care that people required and preferred to meet their needs. This included, personal care, nutrition and hydration, social and cultural, mental health, skin integrity and behaviours. We found the level of detail in some care plans reflected people's preferences well. However, some care plans did not contain important information. For example, one person's care plan said they experienced particular behaviours which staff and others might find challenging and when this occurred staff should 'distract with activities'. However there was no information on what activities staff should offer which would be most effective in distracting the person. Another person had displayed behaviours which put others at risk. There was no guidance to alert staff to potential triggers for behaviours that challenged staff, or advice as to what suitable de-escalation techniques might be. This meant the person, staff and other people who used the service may have been at risk.

There was a complaints procedure in the service which people and others could use to raise concerns. We saw that issues which had been raised were logged and actions taken clearly recorded. One relative said, "I know who to complain to, and I have before." People told us that they would raise any concerns with the manager or a senior carer.

Inadequate

# Is the service well-led?

## Our findings

At our last comprehensive inspection in June 2016, we found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as we found that systems which monitored the quality and safety of the service were not effective. We subsequently served the registered provider with a warning notice informing them that they had to comply with this regulation within a set timescale. In November 2016 we returned to check that improvements had been made. We found that although some improvements were still required, the service was no longer in breach of this regulation.

At this inspection carried out on 16 and 17 August 2017, we found shortfalls in the service which indicated that the auditing and monitoring of the service had again failed to identify the issues we found during our inspection, and had not recognised where people were at risk of harm or where their health and wellbeing could be compromised. We found repeated breaches and new breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which demonstrated that the audit and governance systems in place were not effective.

We have rated the service as 'requires improvement' overall. This is the third consecutive comprehensive inspection which has resulted in this overall rating for the service, which means we have not seen evidence of adequate leadership in place to ensure improvements are sustained. As a result we have rated this key question as 'inadequate'.

The registered provider informed us that in June 2017, the registered manager had resigned from the service. In May 2017, the care co-ordinator (who assisted the registered manager) had also resigned. The care co-ordinator was responsible for reviewing risk assessments, and as a result care records had not been routinely reviewed since May 2017. This meant that the service had failed to ensure accurate and complete records of people's care. A new manager was in place, but had only recently started working in the service. Given that these key staff members had left the service, allocation of tasks should have been delegated to other staff in the interim to ensure they were carried out. This had not been done, and as a result staff were not clear on their roles and responsibilities. A staff member told us, "I assumed other staff were reviewing the risk assessments."

During our last inspection in June 2016, we found that medicines for external applications, such as creams, had not been consistently signed by staff to show they had been given as intended by the person who prescribed them. At this inspection we found that this had not improved, and gaps were found in several records we reviewed. The registered provider told us that medicines were audited, but not the records relating to external applications. Given this was identified as an issue at the last inspection, the registered provider should have ensured this was improved by implementing an audit which monitored this.

During our return inspection in November 2016, we made a recommendation that the provider further develops its quality monitoring system in order to fully identify and effectively rectify any issues identified. During this inspection we saw that the provider had implemented new audits. In January 2017, the provider had organised for a care manager (from another location) to visit the service and carry out a quality

assurance visit. The registered provider told us that this was to have a 'fresh pair of eyes' on documentation and current processes in place. The audit covered areas in line with Care Quality Commission key lines of enquiry to identify areas for improvement. As a result of the information, the provider set up another monthly audit which listed the identified areas for improvement. This included checks on risk assessments. The audit for July 2017 had not identified any issues with risk assessments. The monthly care plan audit carried out in July 2017 also did not identify any issues. This meant they had been ineffective at identifying issues which we found.

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

The registered provider had arranged meetings with staff to discuss updating the care plans in April 2017, and had also met with the night staff in relation to improved recording of documentation. Staff spoke positively of the registered provider who regularly visited the service. One staff member said, "They [registered provider] have been nothing but supportive and encouraging." Staff also felt that due to the management changes this has made staff feel unsettled. One staff member said, "Since [registered manager] and [care co-ordinator] have left we [staff] have been clawing our way back up. Staff morale has been low, but we will work together and support the new manager." Another said, "Leadership is slowly improving, but we are starting from scratch again."

Staff meetings were held in the service so that information was shared and known across the staff team. Minutes form the staff meeting in July 2017 showed that relevant items were discussed such as the results of the quality assurance inspection and areas for improvement such as documentation and a communication book for staff. It also discussed implementing 'Resident of the Day' which is a system to review all areas of people's care. The registered provider also discussed how they were using the CCTV (in communal areas of the home) to review falls which had occurred. This had been effective in identifying how staff were deployed at the time of the fall, and the way in which the person fell.

'Resident', relative and professional surveys had been issued in November 2016 to gain feedback on the service provided. These showed mainly positive responses, but where people had made negative comments, these were followed up with the person and meetings were held.

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<br><br>People's care plans did not consistently reflect their current needs. Staff did not have accurate and up to date information on people's needs to refer to.<br><br>The provision of activity was not meeting people's individual and specialist needs.<br><br>9 (1) 3 (a) (b) |

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<br><br>Risks to people's health, safety and welfare were not managed, monitored or reviewed so as to ensure people's safety and wellbeing.<br><br>12 (1) (2) (a) (b) |

**The enforcement action we took:**

Impose a condition

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Quality assurance systems had failed to identify where improvement was needed.<br><br>17 (1) (2) (a) (b) (c) |

**The enforcement action we took:**

Impose a condition