ARMSCARE Limited

Docking House

Inspection report

Station Road
Docking
Kings Lynn
Norfolk
PE31 8LS

Tel: 01485518243
Website: www.armscare.co.uk

Date of inspection visit:
20 November 2017
22 November 2017

Date of publication:
09 February 2018

Ratings

Overall rating for this service	Requires Improvement

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

This inspection took place on 20 and 22 November 2017 and was unannounced.

Docking House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Docking House accommodates 39 people in one adapted building, some of whom may be living with dementia. On the day of our visit, there were 38 people living at the home.

The home had a registered manager. 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.

At our last inspection in November 2016, we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in respect of sufficient staffing, safeguarding service users from abuse and improper treatment, meeting nutritional and hydration needs and good governance. We rated the key questions of safe, effective, responsive and well-led as 'Requires Improvement'.

We asked the provider to complete an action plan to show what they would do and by when to meet these legal requirements. They told us these would be fully met by 16 November 2016. As they told us they would be meeting these requirements at the time of this inspection, we checked to see if improvements had been made. At this inspection, we found that the required improvements had not been made and that the provider continued to be in breach of these five legal requirements.

We also found the provider to be in breach of Regulations 11, 12 and 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014. These relate to the need for consent, safe care and treatment fit and proper persons being employed. You can see what action we told the provider to take at the back of the full version of this report.

Risks to people's health were not always identified. Where they were identified, the service had not always taken appropriate actions to minimise the risks to people's welfare. In some cases, potential risks to people had been wrongly and inaccurately assessed.

The numbers of staff on duty and their deployment was not effective in ensuring people's needs were met in a timely way. People often waited for their care and did not receive enough interaction and stimulation.

Staff training and checks of their competency, to ensure that they could meet the needs of people living at the home, had not been fully completed. Not all staff had supervision and development to support them in their role. New staff were allowed to work without supervision before being deemed competent to do so.

There were significant gaps in staff completing or refreshing mandatory and essential training. Some staff did not have the skills, abilities and confidence to support people living with advanced dementia.

Maintenance of the premises had been routinely undertaken and records about it were complete. Fire safety tests had been carried out and fire equipment safety-checked.

There was limited understanding and application of the Mental Capacity Act 2005 other than at a basic level. Staff did not always seek peoples consent before providing them with support. Staff did not always respect and maintain people's dignity.

People's care plans did not contain accurate, up to date or clear information for staff to help ensure that they provided a high standard of care and support to people. People's preferences had not always been identified so that staff could provide care in the way people wanted.

Complaints to the service had been managed in line with the provider's stated procedure.

People were supported to maintain their relationships with people who mattered to them. Relatives and visitors were welcomed at the service at any reasonable time.

The provider's auditing system was not robust and had not identified the concerns we found during this inspection. The provider had not made improvements since the November 2016 inspection.

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.

Some risks to people's safety had not been adequately assessed or managed.

Some staff had not received appropriate training or supervision prior to them working unsupervised.

Is the service effective?

Requires Improvement

The service was not effective.

There was limited understanding or practical application of the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards when significant decisions needed to be made.

Where people were at risk of not eating or drinking enough, adequate monitoring and record keeping was not in place.

Staff training did not ensure staff had the knowledge and skills they needed to support people effectively. Staff did not receive supervision or checks of their competency to support people.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some staff were kind and caring but this was not consistently applied. Staff knowledge of people was variable and interaction with people was mainly task focussed.

Some people's dignity was compromised and they were not always treated with respect.

People's independence was not always appropriately maintained.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans did not contain clear instructions for staff to follow which meant that people might not have received appropriate care.

People did not always receive adequate levels of stimulation.

Complaints were managed within the providers own procedure.

People received appropriate support at the end of their life.

Is the service well-led?

Inadequate

The service was not well-led.

Actions identified by the previous inspection, and deemed as completed by the provider to improve the quality of the service, had not been sufficient.

The provider had failed to ensure that existing governance systems were effective at monitoring the quality of care provided or to mitigate risks to people's safety.

There was an open culture in the service but improvements are required to the leadership of the home to ensure high quality care and support is delivered.

Docking House

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 visit was unannounced and was carried out on 20 and 22 November 2017. Two inspectors and an expert by experience visited on the first day of our inspection, one inspector returned for a second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of 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 home, what the home does well and improvements they plan to make. We checked the information we held about the home. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us.

On the days we visited the home, we spoke with seven people living at the home, three members of care staff, a senior member of care staff, the cook, the provider's operations manager, and the provider's managing director. We also spoke with relatives of five people living at the home. We looked at records relating to six peoples' care, which included daily records, risk assessments, medicine administration records, guidance from health professionals and mental capacity assessments. We also looked at staff training and recruitment records, as well as quality assurance audits that were completed by the registered manager and the provider. We also carried out observations of how people were cared for and supported.

Requires Improvement

Is the service safe?

Our findings

We inspected the home in November 2016 and rated Safe as Requires Improvement. At this inspection, the safety of the service people received still needed to improve and therefore, we have continued to rate Safe as Requires Improvement.

At our previous inspection, we found the provider had not ensured that the safeguarding of people who lived at the service was appropriately managed. Staff had not all undertaken training in safeguarding people from the risk of abuse. Their understanding of recognising and responding to potential incidents of abuse between service users was poor. This had resulted in a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. At this inspection, we found that sufficient improvements had not been made, and that the provider continued to be in breach of this regulation.

Staff we spoke with had limited understanding of safeguarding matters. They were able to describe to us some of the different types of abuse people living at the home were at risk of experiencing. However, staff could not tell us whom they would report this too, outside of the service, if they were concerned actions were not being taken. Knowing who to report any concerns to externally is an important corner stone of safeguarding practice. Staff were clear however that they would report any concerns they had to the registered manager or senior member of staff on duty.

Some staff we spoke with told us that they saw incidents of physical and verbal abuse between people living at the home. A staff member told us of an incident that occurred shortly before our inspection where they saw a person hitting another. They told us they had reported this to the senior member of staff on duty but no record of this incident was made. We spoke to the senior care staff on duty, who confirmed that this person could on occasions hit other people living at the service. We reviewed the person's care plan, which stated they could be 'aggressive' and would 'hit or push'. However, there was no further detail about how this may take place, or information for staff to use to support the person and keep others safe when this occurred.

We observed that staff did not always have the abilities and confidence to intervene when potential safeguarding incidents occurred. For example, one person who became distressed and frequently called out or screamed, was often the target of verbal abuse from other people living at the home. On several occasions, we saw that staff walked by or did not intervene as this intensified. On one occasion, we saw a member of staff laugh at people swearing at each other, and did not intervene but walked away. These incidents were not recorded in the services records. We also saw that they were not reported as a concern as is required to the local authority safeguarding team, and statutory notifications to the CQC had not been submitted. This meant that people were not always protected from the risk of abuse. People with impaired understanding or capacity, who were at risk of being a perpetrator of abuse, did not receive the support they needed to reduce the risk of this.

We asked to look at the services training matrix so we could see documented evidence that staff had completed training in safeguarding people from abuse. The operations manager told us that not all staff

were up to date with their safeguarding training. The records we reviewed showed that only 21 of the homes 25 care staff named on the duty rota were included on the training matrix. Of these 21 staff, four had not completed any training in the safeguarding of vulnerable adults, and two staff, including the homes registered manager, were substantially overdue in renewing their training. We asked the provider's managing director if they knew why staff had not updated their training in this area. They told us that it was difficult to motivate staff to complete the training, as staff were expected to do this unpaid and in their own time. They went on to say they had identified this as an issue, and had recently implemented a bonus scheme to encourage staff to complete their training.

We concluded that not all staff had received sufficient training and guidance to ensure that they had the knowledge, skills and abilities to keep people safe from the risk of abuse. The management of safeguarding in the home had not improved since our last inspection, and the recording and reporting of incidents was still not always completed.

This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations

At our previous inspection, we found the provider had not ensured that there was enough staff on duty to keep people safe at all times, and meet their needs in a timely way. This had resulted in a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. At this inspection, we found that sufficient improvements had not been made, and that the provider continued to be in breach of this regulation.

Since our last inspection, the provider had increased the number of staff on duty by one staff member on each shift during daytime and evening hours. However, people's relatives and staff told us that despite this, there were still not enough staff deployed at certain key times of the day. For example, staff said that people often had to wait to get up in the mornings, and that they did not have time to spend with people and engage with activities. One relative told us, "Staff don't have time to sit and talk with people, or play games with them." They also told us that they saw people who required assistance to have continence pads changed, often have to wait for long periods before staff were available to do this. The provider's operations manager told us that staffing levels were calculated by the directors of the provider, and that a recognised calculation tool was not used. They were unable to provide any evidence of needs assessments being completed to ensure that number of staff scheduled to work was suitable.

During our observations of communal areas, we saw that staff were unable to attend to people in distress, or who were calling out for assistance. Staff were very busy, and attended to people's needs as quickly as they could, but often had to leave communal areas unsupervised for long periods of time. We observed that in one sitting area, staff did not check on people for 40 minutes. People sitting in the area had not been supported with their drinks that had been provided, and they had gone cold or in some cases been spilt as the person could no longer hold the drink. Some people had fallen asleep and were sliding out of their armchair, and appeared uncomfortable, staff did not have the time to stop and assistant them to move to a comfortable position. People had been given biscuits that were placed next to them, however, they were out of reach for some people, and staff did not have time to stop and help people to eat them.

During our observations of the lunchtime meal, we saw that there were not enough staff to support people in a timely way. People experienced delays in receiving their support. We saw people wait at their table for periods of up to 30 minutes before a meal was brought to them. Some people who required assistance to eat then experienced further delays of up to 20 minutes before this help arrived. Staff were not deployed effectively at mealtimes, and did not know who they were needing to support, this meant that the ensuing

confusion caused further delays or people not getting any support at all. We observed one person got up from the table and walked around the dining room and other areas of the home. Staff had not noticed this and the person did not receive a meal. We observed one person who needed help to eat their meal, did not receive this despite them asking for assistance because there were no staff available to do so. We saw that their plate was cleared away, with most of the food remaining on it.

The provider had recently recruited a number of staff, however, we saw that these staff were working a high number of hours at the service, but had not completed all of their mandatory and essential training. Some staff were not experienced in providing care and support to people living with advanced dementia, and did not have the training and development provided to meet these needs. We saw that staff often appeared nervous or hesitant to support people who were distressed or confused.

We tracked the working patterns of two members of staff employed within the last four months at the home. We saw that for the month of October, one staff member worked an average of 56 hours per week, and the other staff member 59 hours per week. According to the providers training records, neither staff member had undertaken training in supporting people living with dementia and behavioural support needs. The records also showed that one of these staff members had not completed induction training although had worked at the home since August 2017.

We reviewed the records for staff working at night. We saw that one member of staff who had commenced employment in the last month, was included in the deployment of the four staff scheduled to work at night time. However, they had not yet undertaken any training since commencing employment. We spoke to the provider's operations manager and the senior member of staff on duty covering for the registered manager's absence about this. They confirmed that the staff member was included in the deployment, and was not shadowing an experienced member of staff. They also confirmed that no checks had been undertaken of their competency or supervisions completed, to ensure that the staff member was competent to provide people with care and support.

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

Recruitment processes were not robustly applied to contribute to protecting people from the employment of staff who were not suitable to work in care. We found that the employment histories of staff, gaps in employment and reasons for leaving previous employment had not been explored with three new staff when they applied to work in the home. References had not been sought from suitable people. This information is required by law. We saw that for one staff member, there was no history of employment between 2010 and 2015, this had not been explored with them. We saw that one member of staff had started employment at the home before references had been received from their previous employer who had dismissed them. Although this was known to the provider, suitable checks had not been completed to explore the reasons for this before commencing employment.

This is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each prospective employee did have a Disclosure and Barring Service (DBS) check; the DBS helps employers make safer recruitment decisions.

Information contained in risk assessments for people's health and safety was not clear or regularly reviewed. We found that several care plans did not have identified actions for staff to take to reduce any potential

impact. We saw that staff practice was not consistent and did not reduce risks to people whilst receiving care and support.

For example, we saw that one person had been assessed in a tissue viability care plan as being at risk of developing pressure ulcers, and should use a pressure-relieving cushion to sit on. It did not state when or how often staff should ensure it was provided for use. We spoke to one member of staff about this, who told us that the person was not at risk of developing a pressure ulcer, and did not need to use it. We also observed staff re position this person in the chair, and when doing so, removed the pressure cushion from underneath them and not replace it. This meant staff knowledge and practice was inconsistent and put the person at risk of developing pressure ulcers

We spoke to a person who was using a variable air flow cushion, to reduce the risk of them developing a pressure area. This is an electronically controlled device, with fixed settings according to the persons assessed need. Whilst we were talking with them, the device stopped working and an alarm sounded. We saw that staff did not respond to this alarm, so our inspector asked staff to intervene. The member of staff we asked told us they did not know what to do with the device, and walked away. We then asked another member of staff, who intervened and the device began to work again. We observed the device alarm sound again on three occasions throughout the day, and on each occasion, staff did not respond to this. This meant that the person would be at risk of developing a pressure area, as the equipment provided to reduce this was not working correctly, and staff did not intervene to address this.

We reviewed a completed Waterlow assessment for another person, which identified them as being at very high risk of developing a pressure area. A Waterlow assessment is a recognised tool used to estimate the risk for the development of a pressure area or sore. However, although the person had been assessed as being at very high risk, the care plan did not identify any actions that staff should take to mitigate this. The assessment had not been reviewed for five months, although people assessed at being at this level of risk should have this checked at least monthly. Staff we spoke to about this were not aware the person was at risk, or how to reduce this risk.

We observed that staff did not always follow safe practice when providing people with support with their mobility or to move position. For example, we saw two staff help one person to their feet by pulling on their arms which put them at risk of injury. On another occasion, we saw staff support a person to move back in their chair by pulling them up underneath their arms. This also put the person at risk of injury. Staff did not give people the opportunity, or encourage them to move themselves first, before intervening.

Staff did not intervene in a timely way when people became angry, or began to challenge others with their behaviour. For example, one person became very angry towards another person in a communal area. They were pointing some cutlery at the other person, making threatening gestures and being verbally abusive towards them. Staff were hesitant to intervene, and when asked to do so by our inspector, became flustered and nervous. They were not able to engage with the person, or use any techniques to diffuse the incident. Our inspector asked a senior care staff member to attend, who was then able to de-escalate, distract and calm the person down.

On another occasion, we saw a person walking around the main dining room during lunch, carrying another person's walking frame above their head. Staff did not intervene to attend to this, which put the person and others in the room at risk of harm. We observed that one member of staff ducked to walk underneath the persons arms as they held the frame above them, to get past them, and out of the room.

We reviewed the service training records, and saw that of the 21 staff entered on to their training matrix, six

had not undertaken any training in supporting people living with dementia and challenging behaviour. We also noted that another two members of staff were over due in refreshing their training in this topic.

We concluded that staff did not receive the training, support and guidance required to support people living with dementia and other complex support needs safely. Systems for managing and minimising risks and the monitoring of this did not properly contribute to people receiving safe care and treatment.

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

People that we spoke with all told us that they felt safe living at the home. One person told us, "I feel safe with all the staff." Another told us, "….I always feel safe with the staff." Relatives we spoke to confirmed this and told us they had no concerns about their family member's safety.

We saw that risks associated with the premises were appropriately managed. There were personal emergency evacuation plans in place for each person living in the service to make sure they were assisted safely whenever there was a need to evacuate the premises. Records of fire safety checks, water temperatures, refrigerator and food temperature checks had been completed. This helped ensure that the service was a safe place to live, visit and work in. Equipment used to support people with the care they needed, were serviced and check in line with the appropriate regulations. When accidents took place, we saw that these were recorded, reviewed, and any leaning from these shared with staff to reduce the risk of this reoccurring.

We looked at how information in medication administration records and care notes for people living in the service supported the safe handling of their medicines. Medicines prescribed were stored safely for the protection of people who used the service and at correct temperatures. Supporting information was available to assist staff when giving medicines to individual people. There was personal identification information on each person's record to help ensure medicines were administered to the right person and information about how they preferred to take their medicines.

When people were prescribed medicines on an 'as and when required' (PRN) basis, staff had written information about when to give these medicines consistently and appropriately. Records showed that people living at the service were receiving their medicines as prescribed. Frequent internal audits were in place to enable staff to check records and monitor and account for medicines.

Medicines were stored securely in a locked cupboard and there were appropriate processes in place to ensure medicines were ordered, administered, stored and disposed of safely. Staff authorised to handle and administer people their medicines had received training and had been assessed as competent to undertake medicine-related tasks.

We looked at infection control practices within the service. We observed staff using the appropriate personal protective equipment (PPE), such as disposable gloves and had access to hand washing facilities. The provider ensured that policies and procedures were comprehensive and reviewed as required.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in November 2016 we rated Effective as Requires Improvement. At this inspection, we found the service people received still needed to improve and therefore, we have continued to rate Effective as Requires Improvement.

At our previous inspection, we found the provider had not ensured that staff had completed the necessary training to support people safely and effectively. This had resulted in a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. At this inspection, we found that sufficient improvements had not been made, and that the provider continued to be in breach of this regulation.

Staff we spoke with told us that they felt the training they received was good. They also told us that they felt they received enough supervision, and that their competency was regularly checked and observed. Supervision and appraisal of staff performance is an important way of ensuring that staff receive the development and support that they need to do their jobs well. However, some staff told us that they were behind in completing all the required training.

We reviewed the service training records and could see that there were significant and widespread shortfalls in staff completing the required training. Of the 25 staff on the services rota, training records only existed for 21 of them. Staff had not completed or updated the training deemed necessary by the provider to support people effectively.

Training in safety specific areas had a very low completion rate. For example, records showed that only 44% of staff had completed training in pressure ulcer prevention, 67% had completed first aid and only 57% had completed food safety. There were also significant shortfalls in the number of staff who had completed role of the care worker specific training. This included carers awareness, of which 25% of staff had completed, and dignity and respect which had a completion rate of 68%. Most people at Docking House are living with advanced dementia, and some people have behaviours that can challenge others. The records showed that only 57% of staff entered on to the training system had completed basic training in this area.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014

At our previous inspection, we found the provider had not ensured that the monitoring of people who were at risk of not eating or drinking enough was adequately managed. This had resulted in a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. At this inspection, we found that sufficient improvements had not been made, and that the provider continued to be in breach of this regulation.

A number of people living at Docking House were at risk of not eating or drinking enough in order to remain healthy. People's care records identified where they were at risk, and what staff needed to do to reduce this. This included setting target amounts for people to eat and drink, and regular weighing so that any weight loss could be identified. We saw that for some people, daily records were to be kept of everything that they

ate or drank that day. At the end of each day this was to be reviewed by one of the home's nutritionists. However, we saw that these records were not always filled in, or reviewed by the homes nutritionists so that any actions could be taken if required. On the first day of our inspection, we had observed the person not to have had lunch that day, as they were walking around the home, and staff did not provide them with a meal. No staff member was allocated to ensure that the person was provided with a meal. On the second day of our inspection, we reviewed the person's records and saw they did not have any entry for lunch or breakfast on the first day of our inspection. The person's intake of foods had not been reviewed and it had not identified that they had missed two meals.

We observed the lunchtime meal on both days of our inspection. On the first day, we saw that the mealtime experience for people was poor. The management and deployment of staff to support people was not organised well, and staffs interaction with people to support them was task led. Staff did not interact with people when supporting them to eat, such as explaining to them what was on the plate, or engage in conversation. We saw that people were left waiting for periods of time for their food, and the food would of likely gone cold in the period of time they had to wait for support. We saw one person call out for help to eat their dinner, but no help was provided. A member of staff later took their full plate away and said, "You did well." They had not noticed that the person had not had anything to eat.

People's meals were all pre-plated and served from a trolley that was taken around the home. This trolley did not allow the meals to be kept warm, and plates of food did not have covers. We saw that the trolley was pushed around all areas of the home to deliver meals. Some meals were not delivered to the person until in excess of 20 minutes after leaving the kitchens, which meant people were served with cold food. There was also the possibility of cross contamination affecting uncovered meals.

We saw that people were not all offered drinks with their meal, and jugs of drinks were not available on tables. The tables in the dining room had damaged surfaces from excessive wear, and people were not provided with napkins or condiments to go with their meal. Menus were not provided on tables, but on a notice board where the four week rolling menu was listed. It was not possible to identify which week of the menu was currently being served unless staff were asked. Pictorial menus were not available to help people living with dementia to choose which option they would prefer.

On the first day of our inspection, the menu stated that one option was spaghetti bolognaise, which a number of people had chosen. However, when the meal arrived, a different option of tinned corned beef, spaghetti hoops and bubble and squeak was provided. People living at the home were not informed of the change or given the choice of the other option. We asked the homes cook about this change, which did not appear on any day of the rolling menu. They told us that they had made an oversight with supplies so had to put this option together.

We saw one person eating with their fingers, but had not been provided with an option that would be easier to eat. They were sat in an armchair in a sitting room, so were using one hand to hold the plate, and one hand to eat. They were unable to hold the plate still, so had spilt much of it on themselves. We spoke to the senior care worker on duty about this, who told us that the person should have been assisted to the dining room to eat at a table which is their usual preference. We reviewed the person's care records and they did not have an eating and drinking support plan, which would of enabled staff to have supported them appropriately.

We provided direct feedback to the provider's operations manager of our observations from the first day of our inspection. When we returned for the second day, we saw that some improvements had been made, such as the provision of condiments and drinks to people. However, meals were still served from an

unheated trolley and some plates of food remained uncovered. We asked if any audits of the mealtime experience for people was undertaken, but we were informed that this was not completed in any formal way or recorded.

We received negative feedback on the quality of the food provided. One relative told us, "The food is rubbish, poor quality and the cheapest ingredients. The menu is boring and the food never looks nice." Most people living at the home did not wish to offer an opinion on the quality of the food provided, but did tell us that they had access to drinks when they wanted them, and were able to eat where they wanted to.

We concluded that the oversight and monitoring of people who were at risk of not eating or drinking enough had not improved sufficiently. People were still at risk of not eating or drinking enough, and staffs oversight of this was poor. The mealtime experience and quality of food on offer was of insufficient quality.

This is a continued breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA 2005. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found the provider had policies and procedures on the MCA but the majority of staff had not completed or updated their training in this area. We reviewed the providers training records which showed that only eight out of 25 staff had completed the training. The records also showed that the registered manager and three of the six senior staff had not completed this training.

Staff we spoke with did not have an understanding of the principles of the Act. They understood how to support people to make certain decisions, for example showing them clothes to wear so that they could make a choice. However, where people did not have capacity to make decisions, staff where unable to describe how they should support a person in their best interests.

We saw that in people's care plans that assessments of people's capacity had been completed. However, not all of these were sufficiently detailed. For example, they would identify that a person had a lack of capacity, but this was not decision specific, such as for the use of a sensor mat to monitor a person's movements.

Staff told us they asked for people's consent before providing care, explaining the reasons behind this and giving people enough time to think about their decision before taking action. However, we observed that staff did not always ask people for consent before performing certain tasks and did not always offer choice, such as supporting them to eat a meal. Some staff practice we saw demonstrated that staff may have assumed the person could not consent. This was because we observed some of them making decisions for people without asking them or supporting them to make a decision. For example, we saw a person being taken through the main dining area to another area of the home to eat their meal. They were not asked if

this was their choice. We saw that nearly all people had a plastic apron placed over them at lunchtime without being asked if that was what they wanted.

We concluded that staff did not always seek peoples consent before providing them with support. The majority of staff and leaders had not undertaken training in this topic. Where staff had undertaken training in the principals of the MCA, their knowledge was not sufficient to ensure that these principals were always followed.

This was a breach of Regulation 11 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Where an application for a DoLS authorisation was required, this was made. We saw that conditions issued as part of the authorisation, where adhered to. This ensured that people were not unlawfully being deprived of their liberty.

The service had some adaptions made for the benefit of people living with dementia. These included painting doors for bedroom and bathrooms of a contrasting colour to aid identification. Some equipment had been provided to stimulate and entertain people living with dementia, such as wooden boxes with door bolts, levers and chains. There was an enclosed central garden with artificial grass and life-size model animals that people could enjoy but remain safe. People also had access to computer tablets so that they could watch reminiscence items on social media channels such as you tube. These were also used for people to video call their relatives if they wished too.

The homes four communal areas were open plan, with three of them interconnecting. This meant that at some points noise levels could be high, causing some people distress. Opportunities to sit in smaller quieter areas were limited, and staff did not offer the chance to move to a quieter area when people were became upset sitting near a person making a lot of noise.

People using the service and their relatives confirmed that health care from health professionals, such as the GP or dentist could be accessed as and when required. Records showed people were registered with a GP and received care and support from other professionals, such as the chiropodist and the district nursing team, as necessary. A relative told us, "My [relative] had a fall last Saturday. The home called for a doctor and told us right away."

Requires Improvement

Is the service caring?

Our findings

At our last inspection in November 2016 we rated Caring as Good. At this inspection, we found that the service people received had declined. Therefore we have rated Caring as Requires Improvement.

At this inspection, we received positive feedback from people and their relatives about how caring the home was. One person told us, "Staff are always accommodating." A relative told us, "We are happy with the care that [relative] is getting." However, we found that staff did not always approach people or carry out support in a caring manner. We observed frequent incidences where people's care was task-led. These practices did not uphold people's dignity or show respect to them. Staff we spoke with were able to tell us about the importance of maintaining people's dignity and treating them with respect, and gave us examples of how they would do this. However, we saw that they did not always provide this in practice when supporting people.

Many of the people living at the home were unable to share their views about the care and support they received, or to be actively involved in the planning of their care, due to advanced level of their dementia. There was variable practice in the way people's views were taken into account in planning their care, with the support of their relatives if this was needed. We did not see any evidence of the involvement of people or their relatives in the development and review of their care plans. We spoke with the provider's operations manager about this who told us that they would address this.

Some staff we spoke with told us that they did not have the time to sit with people, or to carry out their support without having to rush. One staff member told us that they could not get to people to support them when requested in a timely way. They told us that people often had to wait. We saw one person being assisted to walk, but was rushed in doing so, being pulled along with their arms in front. As well as being a risk to people's safety, this also meant that people's dignity was compromised.

Communication with people did not always promote people's rights under the Equality Act. A person who lived at the home who did not speak English did not have a communication plan. Staff were not able to speak the persons language, and alternate means, such as translated phrases on paper were not used to aid communication. We saw that staff did not always speak discreetly or confidentially with people. For example, we saw that staff members would speak to people from one side of a communal room to another in a loud voice, rather than walk across the room and speak directly to the person. We also observed that when staff asked people a question, or gave them a choice, they would walk away before the person was able to answer.

Staff did not always ensure that people's dignity and privacy was maintained. We saw that staff openly discussed people's personal care needs in front of others. We saw in the office area that people's personal and private information was written on a large whiteboard, and was viewable through the office window, or by any person or visitor who entered the office. Staff did not always check with people before providing them with support.

People were not always supported at meal or drinks times in a way that promoted their dignity. We observed that some staff had little or no interaction with the person they were supporting. Staff did not ask people where they wanted to sit for example. We observed staff providing food and drinks for people in the lounge but did not always ask people what they wanted, or give them a choice. They prepared them and placed them on the table in front of the person with little or no communication. On one occasion, we saw a staff member go around the dining room and put a plastic apron on each person in the dining room, without speaking to them or asking them first. This included putting on an apron on a person who had already finished their meal.

We saw that support with personal care given by staff did not promote people's dignity. One person was wearing very dirty clothes, but was not offered the chance to change them after meals. We saw another person was assisted to stand by staff, but staff pulled them up using the back of their trousers, which meant the persons trousers remained in an uncomfortable and undignified position as they walked away.

People were not always encouraged to be independent where they could be. We saw that some people's walking frames, or cups of drink were left out of reach. We saw that another person had their electric wheelchair switched off by staff, and pushed the person to the dining room, rather than allow the person to drive themselves. We saw that after their meal, the person tried to move themselves away from the table to leave the dining room but couldn't. They became upset about this, and our inspector asked for a member of staff to engage the person's wheels again. The person then smiled and thanked the inspector.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in November 2016, we rated Responsive as Requires Improvement. At this inspection, we found the service people received still needed to improve and therefore, we have continued to rate Responsive as Requires Improvement.

At our last inspection, we found that the care provided was task-based and did not always meet people's individual needs. We found gaps in the recording of people's daily interventions. Care records did not detail the care people required so that staff could provide this. We told the provider they needed to improve the quality of care provided within this area and they submitted an action plan to show us how they would address this. However, at this inspection the required improvements had not been made.

Care plans were in place and provided basic information about peoples support needs, but all of the appropriate information regarding how these needs were to be met had not been recorded. This is important so staff have correct and appropriate information available on how to meet people's needs. When people refused personal care or had behaviours that others may find challenging, care plans did not provide guidance for staff on how to respond. For example, one person's communication care plan stated they could be physically aggressive toward other people. There were no strategies for managing the situation or how to respond to the person.

We found significant gaps in times and dates between entries generally in people's daily records. We saw that one person had not had an entry recorded about how much they had to eat and drink for a period of 24 hours. Where people had been deemed as being at risk of not eating or drinking enough, or at risk of developing pressure ulcers, these had not been reviewed for more than four months.

We concluded that peoples care had not always been planned and delivered to meet people's individual needs. Inconsistent recording of care given by staff had not been identified.

We saw that some people spent long periods in the same areas such as the communal lounge. They had little stimulation and spent most of their time staring around the room. Staff did not ask people what they wanted to do or if they wanted to move to another area of the home. We saw that when some people had finished their meal, they waited for 30 minutes before being attended to.

At our last inspection in November 2016, we found that although people could engage in various activities, these were not sufficiently planned and organised. This meant that people did not know what activities they could partake in each day and could not plan for this. At this inspection, we found this to have not changed. We asked senior staff what the activities plan was for that week, and they told us that one had not yet been organised. Senior staff told us that when activities were organised, it included quizzes, watching items on You Tube and writing letters.

We received mixed feedback from staff about the level of activity for people in the home. Some staff felt there was enough for people. Other staff felt there was not. One staff member told us that, "There's

absolutely not enough for people to do." They went on to tell us that they believed that this was a contributing cause of increased challenging behaviour for some people. We concluded that although some activities took place, these were not sufficiently planned and organised. Most activities that were provided were not suitable for people living with advanced dementia.

The home did benefit from an activities person for one session per week, although staff on duty could not tell us when they were due to visit. They did however come to Docking House on the first day of our inspection, and organised a singing and dancing session. We saw that this was very well received by people, with many participating and clearly enjoying themselves by smiling and laughing. The home also arranged events to which relatives and friends were invited, including a summer BBQ. We saw a card from a relative thanking staff for making a video of their relative enjoying this, and sending it to them as they lived overseas and could not attend.

We looked at how the service managed complaints. People told us they would feel confident talking to a member of staff or the registered manager if they had a concern or wished to raise a complaint. Relatives told us they would be happy to approach the staff or the registered manager in the event of a concern. Staff confirmed they knew what action to take should someone in their care want to make a complaint and were confident the registered manager would deal with any given situation in an appropriate manner.

The service had a policy and procedure for dealing with any complaints or concerns, which included the relevant timescales. The policy included timescales and the response they should expect. For example, it described how their complaint would be acknowledged and what would happen next. We saw there were systems in place to investigate complaints. We saw records that indicated the matters had been investigated and resolved to the satisfaction of the complainant. This meant people could be confident in raising concerns and having these acknowledged and addressed.

We saw that people were supported to make plans and advanced decisions about how they wished to be cared for at the end of their lives. People's families were included and supported through this process. The provider's operations manager and senior staff told us that throughout this time for people, it was essential to provide flexible and dignified care to people. They explained that relatives could stay as often as they liked, and that they were provided with meals and emotional support. We saw cards and letters had been sent to the service, which thanked staff for the care they had given to people at the end of their lives and support for their families.

Inadequate

Is the service well-led?

Our findings

At our last inspection in November 2016, we rated Well Led as Requires Improvement. This had resulted in a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. At this inspection, we found that systems in place remained ineffective at ensuring the service provided high quality care to people. Therefore, we have rated Well Led as Inadequate.

After our last inspection in November 2016, the provider wrote to us and said they would be meeting the five breaches of legal regulations by 16 November 2016. However, at this inspection we found the governance systems in place to drive this improvement had not been effective at doing this and they remain in breach of all five of them. We have also found three further breaches of the regulations. This demonstrates a failure to pro-actively drive sufficient improvement within the service to ensure that people consistently receive good quality safe care. Action taken to address previously identified breaches of the regulations had not been sufficient and the home remained in continued breach of all of them.

There was a registered manager in post. The same registered manager was in post at our previous inspection in November 2016. During the most recent inspection, they were on annual leave and not present in the service.

The systems and processes put in place by the provider since the previous inspection had not been effective in supporting the registered manager to ensure the service was safe, effective, caring, responsive or well led. We spoke with the provider's regional operations manager, who had initially provided support to the registered manager after this inspection. They told us that they had been unable to spend as much time at Docking House as they wished due to other priorities within the provider's other registered locations.

There were systems in place to monitor the service. These included a range of audits completed by the senior staff and the provider's operations manager. The audits covered areas such as medicines, care planning, tissue viability, incidents, accidents and nutrition and hydration. Whilst we found some of these audits were identifying shortfalls in the service and the action required to remedy them, the systems in place were not effective in identifying all of the shortfalls we found during our inspection. The provider's operations manager told us checks against the action plan to address the shortfalls found at our previous inspection were completed in September 2017. However, no further checks had been undertaken at the service since then.

The systems for assessing, monitoring and mitigating risk were ineffective. For example, some staff did not understand the need to record incidents between people living at the service, and the risk of this occurring had not been identified in peoples care plans. This was not identified through checks and audits undertaken. We also saw that obvious errors made in the calculation of tools used to monitor people's weight had not been identified. Where people had not had anything to eat or drink for a period of time, this was not always noticed with actions taken.

Systems to ensure people received the care they needed were ineffective. Care planning audits had not

identified shortfalls in relation to the care people received. We found shortfalls in the numbers of staff deployed to support people and people were not always receiving social stimulation. There were no formalised systems to engage with people who used the service and their family and friends. The service did not have links with the local community and did not have a plan to engage with them. Information gathered from people in other informal ways, was not used to promote the improvement of the service.

Systems to ensure staff were adequately trained and supported were ineffective. Staff had not received all of the training they required to meet people's health needs. Training identified by the provider in response to meeting the shortfalls found at the inspection in November 2016 by the Care Quality Commission, had not been completed despite assurances that it would be. Some staff did not think they had all the support and training required to carry out their role effectively. The systems had not ensured all staff had the skills and knowledge to be able to care for people living with dementia.

Systems to ensure people received consistent caring and compassionate support were ineffective. People were not consistently treated with dignity and respect and their privacy was not always considered. Staff did not always refer or respond to people in a dignified way and people were not always supported in line with their preferences. Systems for ensuring people had a good quality of life that responded to their individual needs and received person centred support had not been effective.

The systems in place had not ensured all of people's individual health needs were assessed and planned for which impacted negatively on people. Systems for ensuring that people were supported to have their human rights upheld had not been effective in ensuring people's rights were fully protected. People's rights were not fully protected because the principles of the Mental Capacity Act 2005 were not always met.

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

Most of the people and their relatives we spoke with told us they were happy living at Docking House and felt there was an open culture where they could raise concerns without fear. A relative told us, "We're made to feel welcome and offered tea and biscuits whenever we visit." All of the staff we spoke with told us the senior staff, including the registered manager, were approachable and open. They felt they could raise concerns and that these would be listed to and dealt with. We received mixed feedback from staff in relation to their morale. Some described it as good but others said it was up and down. We saw that some staff worked very long hours each week, and appeared tired when supporting people. Staff were not always cheerful when at work, and their interactions with people were task led and functional rather than relaxed and friendly.

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 11 HSCA RA Regulations 2014 Need for consent Staff did not always seek peoples consent before providing them with support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems for managing and minimising risks and the monitoring of this did not properly contribute to people receiving safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered persons did not take the appropriate action to make sure incidents were referred to outside agencies and investigated properly. Regulation 13 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Peoples nutritional and hydration needs were not always met. Action was not taken when a persons health was at risk from not eating or drinking enough.

Regulation 18 (1) and (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems for monitoring and improving the quality and safety of the service, having regard to the accuracy of records and for acting upon the views of others, were not operating effectively. Regulation 17 (1) and (2) (a). (b) and (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment processes were not robustly applied to contribute to protecting people from the employment of staff who were not suitable to work in care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The providers assessed level of staffing did not always ensure people's needs were met in a timely way that promoted their safety. Staff did not receive regular supervisions, and competency of their practice was not assessed within the period set by the provider. Most staff had not completed the training deemed necessary by the provider.