Cleveden Care Limited

# Teesdale Lodge Nursing Home

## Inspection report

Radcliffe Crescent
Thornaby
Stockton On Tees
Cleveland
TS17 6BS

Tel: 01642612821
Website: www.cleveden-care.co.uk

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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

This inspection took place on 15 November 2017 and was unannounced. This meant the provider and staff did not know we would be visiting. A second day of inspection took place on 7 December 2017, and was announced.

The service was last inspected in June and July 2017 and was rated 'Requires Improvement'. At that inspection we identified four breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014, namely, Dignity and respect, Safe care and treatment, Good governance and Staffing. These breaches related to medicines management, risk assessments, fire safety, good governance, staffing levels, training records, treating people with dignity and respect and preventing social isolation.

In relation to the breach of Regulations 12 (Safe care and treatment) and 17 (Good governance), we took action by issuing warning notices requiring the provider to be compliant with these regulations by 15 August 2017. When we retuned for our latest inspection we found that the provider was still in breach of these two regulations in relation to medicines management and quality assurance processes. We found that improvements had been made in relation to risk assessments and fire safety, but that further and sustained improvements were needed in relation to risk assessment reviews.

In relation to the breaches of Regulations 10 (Dignity and respect) and 18 (Staffing) we took action by requiring the provider to send us action plans setting out how they would address these issues. When we returned on our latest inspection we saw improvements had been made in relation to addressing social isolation and training records. However, we identified that further and sustained improvements were needed. We also found that the provider was still in breach of Regulation 18 in relation to staffing levels.

Teesdale Lodge Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection 25 people were using the service.

The service 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.

Medicines were not managed safely. Records were not always in place for the management of ointments and 'as and when required' (PRN) medicines. The provider was not effectively monitoring staffing levels and these were not based on the level of support people needed. Good governance processes were not in place. Action plans submitted following our last inspection had not always been completed and audits had not identified the issues we found at this visit. We made a recommendation about making the premises more dementia friendly.

Risks to people were assessed and plans put in place to reduce the chances of them occurring. Accidents and incidents were monitored, and plans were in place to support people in emergency situations. Infection control policies and procedures were in place. Policies and procedures were in place to safeguard people from abuse. The provider's recruitment processes reduced the risk of unsuitable staff being employed.

Staff were supported with training, supervisions and appraisals. Decisions taken under the Mental Capacity Act 2005 were not always fully recorded. People were supported with food and nutrition. People's care records contained details of appointments with, and visits by, health and social care professionals involved in their care.

People and their relatives said staff were too busy to have any meaningful engagement with them. Staff told us they were committed to providing high quality care but did not always have time to get to know the people they were supporting. People and their relatives described staff as kind and caring, and spoke positively about the support they received. We saw that staff treated people they supported with dignity and respect. People's confidential information was safely and securely stored. People were supported to access advocacy services where needed.

People had access to some activities at the service, but further and sustained improvements were needed. Since our last inspection the registered manager and staff had been working to improve and personalise people's care plans. Policies and procedures were in place to respond to complaints. People were supported to access end of life care where this was needed.

Feedback was sought from people and their relatives. Policies and procedures were in place to investigate and respond to complaints.

Staff we spoke with gave mixed feedback on the management of the service and the provider's culture and values. The registered manager had informed CQC of significant events in a timely way by submitting the required notifications. This meant we could check that appropriate action had been taken.

We found three on-going breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014, in relation to safe care and treatment relating to medicine management, staffing levels and good governance. You can see what action we took at the back of the full version of this report.

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' overall, or in any one key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

Medicines were not managed safely.

Staffing levels were not effectively monitored to ensure they were safe.

Risks to people were assessed and acted on.

Emergency plans were subject to regular review.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

We made a recommendation about making the premises more dementia friendly.

Decisions taken under the Mental Capacity Act 2005 were not always fully recorded.

Training was effectively planned and recorded and staff were supported with regular supervision and appraisal.

People were supported with nutrition and to access external professionals.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

Staff did not have time to have meaningful interactions with people.

People's dignity was protected.

People were supported to access advocacy services.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Activity provision had improved but was still limited.

Care plans were based on people's needs and preferences.

Procedures were in place to respond to complaints.

Procedures were in place to support people to access end of life care.

## Is the service well-led?

**Inadequate**

The service was not well-led.

Quality assurances processes were ineffective at monitoring and improving standards.

The provider had not completed an action plan submitted to CQC following out last inspection.

Staff gave mixed feedback on the leadership of the service.

# Teesdale Lodge Nursing Home

**Detailed findings**

## Background to this inspection

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

This inspection took place on 15 November 2017 and was unannounced. This meant the provider and staff did not know we would be visiting. A second day of inspection took place on 7 December 2017, and was announced.

The inspection team consisted of one adult social care inspector, a pharmacist inspector, a specialist advisor and an expert by experience. The specialist advisor was a nurse. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service

Prior to our inspection we reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

The registered provider also 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 contacted the commissioners of the relevant local authorities, the local authority safeguarding team and other professionals who worked with the service to gain their views of the care provided by Teesdale Lodge Nursing Home.

During the inspection we spoke with six people who used the service. We spoke with two relatives of people using the service. We also carried out observations using the short observational framework for inspections (SOFI). SOFI is a tool used to capture the experiences of people who use services who may not be able to express this for themselves.

We looked at four care plans, 11 people's medicine administration records (MARs) and handover sheets. We also looked at documentation involved in the day to day running of the service. We spoke with eight members of staff, including the registered manager, administrator, nursing, care and domestic staff. We looked at two staff files, which included recruitment records.

Requires Improvement

# Our findings

At our last inspection of the service we found the provider was not managing medicines safely. This was a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014 entitled Safe care and treatment. We took action by issuing a warning notice requiring the provider to be compliant with this regulation by 15 August 2017. When we returned for our latest inspection we found medicines were still not managed safely.

We looked at the medicine administration records (MARs) for eleven people across the home. We found residents had a photo, their GP details and their allergy status recorded which helped to keep them safe. One person was self-administering their medicines. For this person we saw that assessments were completed so that the provider could ensure that the individual knew when and how to use their medication and could use it safely.

We found the administration of people's prescribed oral medicines were clearly recorded and non-administration codes were used correctly. However for some people where care staff applied prescribed creams and ointments as part of personal care or when people first got up or went to bed, there was no guidance or records in place and other records were not fully completed. We also saw that some records showed that staff had not applied some creams at the frequency prescribed. These records help to ensure that staff apply people's prescribed creams and ointments appropriately.

We found the individual guidance, to inform staff about when medicines prescribed to be given only when needed, was not always available or was not person centred. This information would help to ensure that people were given their medicines in a safe, consistent and appropriate way. In addition, we found staff did not always record the reasons for administration or the outcome after giving the medicine, so it was not possible to tell whether medicines had had the desired effect.

We looked at records for residents who received their medicines covertly, hidden in food or drink. There was documentation showing this had been agreed as being in their best interest, but there was no record of input from a pharmacist to advise the home how to disguise each medicine without reducing its effectiveness. For medicines that staff administered as a patch, a system was in place for recording the site of application for pain relief patches. This is necessary because the application site needs to be rotated to prevent side effects.

We looked at how medicines were stored. Appropriate checks had taken place on the storage, disposal and

receipt of medication. Staff knew the correct procedures for managing controlled drugs. We saw that controlled drugs were appropriately stored and signed for when they were administered. Eye drops, which have a short shelf life once open, were marked with the date of opening. This meant that the home could confirm that they were safe to use.

We looked at how medicines were monitored and checked by management to make sure they were being handled properly and that systems were safe. We found that the provider had completed medication audits and identified some issues however these had not identified all of the issues we found.

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

At our last inspection we found the provider did not effectively monitor staffing levels to ensure they were sufficient to keep people safe. We took action by requiring the provider to send us an action plan setting out how they would address this issue. When we returned for our latest inspection we found the provider was still not effectively monitoring staffing levels.

Daytime staffing levels during the week and at weekends were one nurse, one senior care assistant and four care assistants. An additional care assistant was also employed during the day to assist with breakfast and snacks. Night staffing levels were one nurse and three care assistants.

When we attended for the first day of our inspection we asked the registered manager how they were monitoring and planning staffing levels. They said they had been given a staffing tool by commissioners of the service but had not yet adapted it so that it was relevant to Teesdale Lodge Nursing Home. We looked at the tool and saw it had only been used once since our last inspection, and only for half of the people using the service. A 'dependency score' had been calculated, but there was no explanation of what this meant or the staffing levels needed as a result. We asked the registered manager how they used the tool, who said, "It still needs looking at as I don't understand the end score." When we attended for the second day of inspection we saw the provider had returned to setting staffing levels on the basis of the number of people living at the service without considering people's levels of dependency or the layout of the building. The registered manager said, "The new one (staffing tool) doesn't make a lot of sense at the moment. I'm carrying on with the old one until we can make sense of it."

When we looked at care records we saw dependency assessments were not completed for people as individuals to help ensure that staff had the capacity and skills to provide appropriate care to meet people's needs.

People, relatives and staff all said they did not think there were enough staff at the service. One person told us, "To be fair the carers are kind and some very thoughtful, but they are under pressure all the time." A relative we spoke with said, "The care home is ok but I think they need more staff." Another relative said, "Need more staff, they have no time to chat."

A member of staff we spoke with said, "I feel unsafe rushing from one thing to another, frightened I will not see something." Another member of staff said, "There are not enough staff here. I don't even think we're working on a dependency tool, which is a concern. I think the owner and registered manager just go on heads (number of people using the service)" and "The rota is very inconsistent. Yesterday we had six staff, today it is four. People are left in their rooms and in bed as we don't have the staffing to help." A third member of staff said, "I don't think there are enough staff here. We are struggling all of the time, with no support at all. They're always expecting more. We're all trying our best, but because of a lack of staff we can't

do everything in time." A fourth member of staff told us, "The basic needs of residents are covered as best we can, but not everything can be covered." A fifth member of staff said, "Not enough staff, just not enough. Some days you'll get four staff and be expected to cover everything, other days it will be six. Weekends are the same, or even worse sometimes. We always bring it up with the manager and she says we have enough."

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

At our last inspection of the service we found the provider was not effectively assessing risks to people or acting on them, and in addition, we identified concerns linked to fire safety. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took action by issuing a warning notice requiring the provider to be compliant with this regulation by 15 August 2017. When we returned for our latest inspection we found that risk assessments had improved and the provider was no longer in breach of regulation in relation to them. However, we also found that further and sustained improvements were needed.

Risk assessments were completed including for the use of wheelchair/lap belts, bathing, dressing, self-neglect, moving and handling, mobility, falls, use of bed rails, nutrition and hydration, continence, skin integrity and medication administration. Recognised tools such as the Braden pressure ulcer risk assessment and Malnutrition Universal Screening Tool (MUST) were used, which helped identify the level of risk. The Braden scale is used to assess people's risk of developing pressure sores. Most risk assessments were regularly reviewed and updated to ensure they reflected people's current level of risk. However, we saw that three people's risk assessments had not been reviewed since September 2017. We told the registered manager about this, who said they would be reviewed immediately as they should have been reviewed monthly.

At our last inspection fire drills were not regularly carried out. When we returned for our latest inspection we found that four fire drills had been carried out since our last inspection and more were planned. Regular checks of the premises and equipment were undertaken to ensure they were safe for people to use, and required test and maintenance certificates were in place. Plans were in place to support people in emergency situations. Accidents and incidents were monitored to see if improvements could be made to improve people's safety. This showed us staff in the service were able to learn lessons and make adjustments to the service.

Infection control policies and procedures were in place. There was an infection control 'champion', who had attended a training event on national best practice at a local hospital and shared this learning with other staff. An infection control audit tool was used that had been provided by an infection control nurse, and the registered manager subscribed to a monthly infection control newsletter. We saw that the premises were clean and free from odour, and throughout the inspection observed staff washing their hands and wearing personal protective equipment (PPE) where appropriate. One relative we spoke with said, "The care home is clean enough"

Policies and procedures were in place to safeguard people from abuse. Staff had access to a safeguarding policy that provided guidance on the types of abuse that can occur in care settings and how staff could report them. Staff said they would not hesitate to report any concerns they had. One member of staff told us, "I would act on anything that I was uncomfortable with." Records confirmed that where incidents had been raised they had been investigated and referred to the relevant authorities.

The provider's recruitment processes reduced the risk of unsuitable staff being employed. Applicants for

jobs were required to provide their employment history, proof of identity and written references. Disclosure and Barring Service (DBS) checks were also carried out. The DBS carry out a criminal record and barring check on individuals who intend to work with children and adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with vulnerable children and adults. Checks were also made with the Nursing and Midwifery Council (NMC) on the registration status of nursing staff. The NMC is the professional regulatory body for nurses and maintains a register of nurses and midwives allowed to practise in the UK, including any restrictions that have been placed on the individual's practice.

Requires Improvement

# Our findings

At our last inspection we found procedures were not in place to ensure staff received the training they needed to support people effectively. We took action by requiring the provider to send us an action plan setting out how they would address this issue. When we returned on our latest inspection we saw training records had improved such that the provider was no longer in breach of regulation in relation to them. However, we identified that further and sustained improvements were needed in relation to training.

All mandatory training was now recorded on a single chart. Mandatory training is the training and updates the registered provider deems necessary to support people safely. We reviewed this chart and saw that it was used to monitor and plan training. The chart showed that most staff had completed mandatory training but some had not. For example, eight out of 44 staff had never completed first aid training or manual handling training. 23 staff had either no, or overdue fluid and nutrition training recorded. Where gaps were identified the registered manager told us training was being arranged, for example in end of life care. Refresher training was also recorded on the chart. This meant the registered manager could see when staff might need to refresh their training to ensure they were working to current best practice. The chart showed that some refresher training was overdue, and the registered manager said they were working with the local authority commissioners to address this. In this way the registered manager said they hoped to ensure staff were aware of, and worked to, current guidelines and best practice.

Staff spoke positively about the training they received. One member of staff said, "Training isn't bad. It has been going on. They (the registered manager) have recently been encouraging everyone to do the Gold Standard Framework." The Gold Standard Framework (GSF) is a model of good practice that enables a 'gold standard' of care for all people who are nearing the end of their lives. Another member of staff said, "We have been doing diabetes training. You could always ask for extra training here. We do all of the mandatory courses."

The service was provided in purpose-built, single story premises. People's rooms were located in corridors that radiated out from a central hallway. There was a main lounge and dining room near this hallway, and two lounges at the end of corridors. At the last inspection we found that the environment was not always suitable for people living with a dementia. Corridors looked identical which meant it was difficult to orientate yourself when you walked down them. Signage and directions around the building were limited and not always dementia friendly. There was limited personalisation of communal areas, which meant the service had a clinical atmosphere. When we returned for this inspection we found no changes had been made to adapt the premises, which still had a clinical atmosphere.

We recommend that the provider seeks advice and researches guidance from a reputable source, about making the premises more dementia friendly.

Staff said they received supervisions and appraisals, and found these supportive. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. One member of staff we spoke with said, "We get supervisions and appraisals here. They're okay. They listen to what you have to say." Records showed that all staff had received at least one supervision or appraisal since our last inspection, and that they were used to discuss any support needs staff had.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

At the time of our inspection 17 people were subject to DoLS authorisations. These were clearly recorded to ensure any applications for a further authorisation could be made in a timely manner.
Mental capacity assessments and best interest decisions had not always been carried out in line with the principles of the MCA. For one person who did not always have capacity, there were mental capacity assessments for assistance with meals and for the person to be weighed monthly. However there was no record of the people who had been consulted regarding these best interest decisions. For another person, mental capacity assessments had been carried out in relation to activities of daily living even though the person had capacity to make such decisions for themselves.

This meant people's rights to make particular decisions may not have been upheld and their freedom to make decisions may not have been maximised, as unnecessary restrictions may have been placed on them. We discussed this with the registered manager, who said staff understanding of the principles of the MCA would be reviewed.

People were supported with food and nutrition. Systems were in place to ensure people who were identified as being at risk of poor nutrition were supported to maintain their nutritional needs. The Malnutrition Universal Screening Tool (MUST) was used to complete individual risk assessments in relation to assessing the risk of malnutrition and dehydration. MUST is a screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan. Food and fluid charts were used to monitor people's nutritional health, though we saw that fluid intake goals and totals were not recorded.

People spoke positively about food at the service. One person said, "The food is fine. Good ingredients, cooked well." Another person told us, "If I do not like the food on offer I ask for something different."

People's care records contained details of appointments with, and visits by, health and social care professionals involved in their care. Staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. These included General Practitioners (GPs), Community Matrons, physiotherapists, Multiple Sclerosis Specialist Nurses and dentists.

Care plans reflected the advice and guidance provided by external health and social care professionals. This meant people were supported to access healthcare professionals to maintain and promote their health.

Requires Improvement

# Our findings

At our last inspection we found procedures were not in place to protect people's privacy and dignity. We took action by requiring the provider to send us an action plan setting out how they would address this issue. When we returned on our latest inspection we saw that people were treated with dignity and respect and the provider was no longer in breach of the relevant regulation. However, we identified that further and sustained improvements were needed.

People's confidential information was safely and securely stored and not visible to people in communal areas. As we walked around the building we did not see any examples of people's privacy and dignity being compromised. We also saw staff acting to protect people's dignity. For example, one person fell asleep on a chair in a lounge and as they slouched their top moved up and exposed their stomach. A member of staff saw this, and pulled the person's jumper down to cover this area. Rather than waking the person up, the member of staff then regularly returned to the lounge to see if the person's jumper needed moving again.

However, people and their relatives also said staff were too busy to have any meaningful engagement with them. The provider did not have effective systems in place to ensure there were sufficient staffing levels for people to have meaningful engagement with staff. One person said, "They should know me by now but it is hard for them to sit and chat they are always on the go." Another person said, "Some staff listen more than others. They are so, so, busy." Another person told us, "Staff are too busy to sit and talk. Sometimes they pop their head in the door but usually they are just working hard."

Staff told us they were committed to providing high quality care but did not always have time to get to know the people they were supporting. One member of staff said, "We don't have time to sit and chat with people." Another member of staff said, "There is not really the time to chat with people. We would love to." A third member of staff said, "You can make the time to get to know people here, but it depends which staff you have on shift."

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

During the inspection we saw lots of individual examples of staff providing caring and kind support. For example, we saw a member of staff asking a person if they would like a cup of coffee. The person seemed reluctant at first, but after changing their mind the member of staff sat with them and patiently supported them to drink it. This led to them having a chat that both clearly enjoyed. In another example we saw staff

supporting a person to stand using a mobility hoist. They explained to the person what they were doing at each stage of the process, and offered kind reassurance when the person looked worried. We saw some staff singing as they moved around the building, and popping into the lounge and chatting with people whenever they could.

People and their relatives described staff as kind and caring, and spoke positively about the support they received. One person told us, "Lovely, lovely place. Cannot fault it at all." Another person said, "Very well looked after and always feel safe with the staff." One person also told us how staff encouraged them to maintain their independence, saying, "They encourage me to do what I can. They are there to keep me on the right path."

The registered manager told us that everyone living at the home had a similar ethnic background and religious beliefs and there was nobody with an obvious diverse need. Records showed positive plans were made to ensure people's needs were met in a way which reflected their individuality and identity.

Staff had undertaken equality and diversity training, which had provided them with the knowledge to promote this in their work. Some staff were overdue equality and diversity refresher training, but plans were in place to arrange this.

At the time of our inspection one person was using an advocate. Advocates help to ensure that people's views and preferences are heard. The registered manager was able to explain how the advocate was involved in the person's care.

Requires Improvement

# Our findings

At our last inspection we found people were at risk of social isolation due to a lack of meaningful activity available at the service. We took action by requiring the provider to send us an action plan setting out how they would address this issue. When we returned on our latest inspection we saw that action had been taken to improve activities and the provider was no longer in breach of the relevant regulation. However, we identified that further and sustained improvements were needed.

Following our last inspection the provider employed an activities co-ordinator. Records showed that they had met with people, asked what activities they enjoyed and included them in planning events such as parties and a Christmas pantomime. A 'wish of the day' scheme had been introduced, where one person was asked each day to name one thing they would like to do and the activities co-ordinator tried to arrange this. However, people said that when the activities co-ordinator was not present no activities took place. One person said, "The [activities co-ordinator] seems really good but she is off just now so nothing happens." Another person said, "It would be nice to have something to do. It is a long day in here." A third person told us, "Television is ok for a while but there must be other things to do!" Another person said, "It would be nice to do things whilst I still am able to go out."

When we returned for the second day of our inspection the registered manager told us the activities co-ordinator had left the service and the provider would recruit a replacement. Some staff we spoke with said they would not have time to provide activities in the absence of an activities co-ordinator. One member of staff said, "We don't have an activities co-ordinator, so we're told to do that but we don't have the time. It's lovely that we have 'wish of the day' but sometimes their only wish is that we can sit down and talk with them, and we don't always have time to do that." Other staff told us that people had access to enough activities. One member of staff said, "I think people have enough to do. Most people are unable to participate." Another member of staff told us, "People have enough to do. They don't always want to do them (activities)."

Since our last inspection the registered manager and staff had been working to improve and personalise people's care plans. People's records contained a pre-admission assessment to assess people's needs before they moved into the home. This was designed to ensure that staff could meet people's needs and that the service had the necessary support equipment in place.

People's care plans had been written in a person-centred way and emphasised the need to involve people in decisions about their care and to promote their independence. Person-centred planning is a way of helping

someone to plan their life and support, focusing on what's important to the person. Care plans were developed for people's daily needs such as physical well-being, diet, mobility and personal hygiene. These gave specific information about how people's needs were to be met and gave staff instructions about the frequency of interventions. Care plans had been reviewed regularly since our last inspection to ensure they reflected people's current support needs and preferences.

Care records also contained 'All About Me' documents, which included details about the person's life history and things that were important to them, such as particular events or family information. This allowed staff who had not supported the person before to familiarise themselves with that person's personal preferences. People's care records contained information on any sensory loss or disability that affected them and how this might impact on how they communicated. We saw staff using effective and personalised communication techniques during the inspection, for example leaning in close to speak with people who had hearing loss.

People and their relatives said steps had been taken to involve them in care planning. One person said, "My care is discussed with me." Another person told us, "Relatives look after the care side of things." A relative we spoke with said, "I try and involve [named person] in the care plan but they are not that bothered, but I am on their behalf."

Since our last inspection the registered manager had introduced a daily meeting with staff from all departments at the service. This was designed to improve communication between staff. Daily communication notes were kept for each person. These contained a summary of support delivered and any changes to people's preferences or needs observed by staff. This helped ensure staff had the latest information on how people wanted and needed to be supported. Handover records showed that people's needs, daily care, treatment and professional interventions were communicated when staff changed duty at the beginning and end of each shift. One member of staff told us, "We have a handover when we come onto shift. It gives us everything we need to know."

Policies and procedures were in place to respond to complaints. The provider had a complaints policy, which set out how complaints would be investigated and the timescale for responding. Three complaints were recorded since our last inspection, and these had been dealt with in line with the provider's policy. People and relatives we spoke with said they knew who to complain to if they had any issues. One person told us, "I do know how to complain and would go to the manager." Records confirmed that where issues had been raised they were investigated and responded to following the provider's policy and remedial action taken.

No one was receiving end of life care at the time of our inspection, but policies and procedures were in place to arrange this where needed based upon the Gold Standard Framework. The Gold Standard Framework is a systematic, evidence-based approach to optimising care for people approaching the end of life. We did see that not everyone had end of life care plans in place. The registered manager said these would be drawn up should people need them, and where they were able, consent to them.

Inadequate

# Our findings

At our last inspection of the service we found the provider did not have procedures in place to assess, monitor and improve standards at the service. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. We took action by issuing a warning notice requiring the provider to be compliant with this regulation by 15 August 2017. When we returned for our latest inspection we found that good governance processes were still not in place.

Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations.

The manager and provider carried out some quality assurance checks at the service. However, these checks had not identified the issues we found at this inspection in relation to medicine management and staffing levels. Audits were not always carried out in a systematic or planned way, or used to plan and monitor remedial action. For example, the registered manager told us six care plans were audited every month. When we asked them how they identified people's care records for auditing purposes, they told us that they "randomly choose different people". This meant there was no way of ensuring that every person's care plan was audited at some point. The provider's care plan policy stated, 'All care plans are audited at least twice yearly, all files are audited by the manager on a schedule". There was no schedule in place, and the provider was not ensuring that this policy was followed.

Where audits were carried out and had identified issues there was no record of whether or how remedial action had been taken. For example, one person's care plan audit from September 2017 identified that the person's activity preferences needed to be updated and their family needed to be involved in this. There were no specific timelines set for doing this or record of whether it had been completed.

The provider carried out a 'monthly visit' to the service but the last one recorded was in July 2017. The registered manager said they had been in once since then and would request the written reports.

Following our last inspection we required the provider to send us action plans setting out how they would improve and meet the requirements of relevant regulations to ensure people were treated with dignity and respect and to effectively monitor staffing levels. The provider submitted action plans committing to a number of actions, including introducing an effective staffing tool and sleep profile care plans by the end of October 2017. When we returned for this inspection we saw not all of the actions contained in the provider's

action plan had been completed. For example, not all people using the service had sleep profile care plans and there was no effective staffing tool in place. This meant procedures were not in place to assess, monitor and improve standards at the service.

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

Feedback was sought from people using an annual questionnaire. The activities co-ordinator had been asked to complete this since our last inspection, but had not done so before leaving the service. The registered manager said it would be completed as soon as possible. A 'resident and relative' meeting had been held in October 2017, which had been used to discuss the findings of the last CQC inspection, fundraising and activities. We also saw minutes of staff meetings, at which staff were encouraged to raise any issues they had.

Staff we spoke with gave mixed feedback on the management of the service and the provider's culture and values. One member of staff said, "We don't see a lot of the provider, but he does come around and speak. The registered manager has a busy, hard job. She will look into things we raise and I would go to her with any problems" and "Residents get good care, they do. I hope we can get back on track. I want to get back on top again. We can get there." Another member of staff told us, "Communication between the manager and staff is missing. In other places... you get the rota at the beginning of the month. It's not like that here. Here things change and we don't know. There's good morale between colleagues. I think more organisation and communication is needed." A third member of staff said, "Staff deserve to be treated with respect, and we don't get it. Residents deserve so much more." A fourth member of staff said, "Morale is very low" and "After the last inspection staff were blamed for everything."

People and their relatives were not always aware of who the registered manager and provider were. One person said, "What manager?" A relative told us, "I know more about the regular carers and other household staff than the manager."

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The registered manager had informed CQC of significant events in a timely way by submitting the required notifications. This meant we could check that appropriate action had been taken.

# 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 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People's medicines were not always managed safely. Regulation 12(1). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Procedures were not in place to assess, monitor and improve standards at the service. Regulation 17(1)(2)(a). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider did not effectively monitor staffing levels to ensure they were sufficient to keep people safe or for staff to have meaningful engagement with people. Regulation 18(1). |