Dr Neelani Nackeeran & Mr Pathmanathan Nackeeran

Alexandria's Residential Care Home

Inspection report

147 Wrotham Road
Gravesend
Kent
DA11 0QL

Tel: 01474534539

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection was carried out on 06 June 2017. The inspection was a focused inspection because of concerns received about the service, we looked at Safe, Effective and Well led domains during this visit. We decided to go back to the service to get a full picture and inspected the Caring and Responsive domains on 20 June 2017 which turned the inspection into a full comprehensive inspection.

Alexandria's Residential Care Home is a care home providing personal care and accommodation for up to 18 older people. Some were older people living with dementia, some had mobility difficulties and sensory impairments. Accommodation is arranged over three floors. There is a lift in place to enable people to access the first floor. There is a stair lift in place on the first floor to access bedrooms and a bathroom on the top floor. There were 17 people living at the home during our inspection.

At the time of the inspection registered manager had left the service, they were in the process of cancelling their registration. A registered manager is a person who has registered with the Care Quality Commission to manage the home. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The provider had employed a new manager who had not started their role on the first day of our inspection, but was in post on our second day of inspection. The new manager was in the process of applying to become the registered manager.

At this inspection people gave us mixed feedback about the service they received. People told us they felt safe and well looked after. However, our own observations and the records we looked at did not always match the positive descriptions people had given us. Most of the relatives who we spoke with during our visit were satisfied with the service.

Medicines had not been administered, recorded, stored or monitored effectively. People had not received medicines that had been prescribed for them which put them at risk of harm. We reported this to the local authority safeguarding team.

There was not enough staff deployed to meet people's care and support needs. The provider did not have an effective system to assess how many staff were required to meet people's needs and to arrange for enough staff to be on duty at all times.

The provider did not follow safe recruitment practices. Essential documentation was not available for all staff employed. Gaps in employment history had not been explored to check staff suitability for their role.

Risks to people's safety and wellbeing were not always managed effectively to make sure they were protected from harm. Risk assessments had not always been reviewed and updated when people's health needs changed.

Staff had a good understanding of what their roles and responsibilities were in preventing abuse. The safeguarding policy did not give staff all of the information they needed to report safeguarding concerns to external agencies.

Fire escape routes were not suitable for people living in the home, one fire escape was blocked with a chair, and items had been stored in the stair well. We reported our concerns to the fire service.

Several areas of the home smelt of stale urine. The home was dirty and required redecoration and maintenance to meet a satisfactory standard.

Decoration of the home did not follow good practice guidelines for supporting people who lived with dementia.

Staff had not received all the training they needed to meet people's assessed needs. The provider had not followed good practice guidance to ensure that new staff received a comprehensive induction.

People's healthcare needs had not always been met in a timely manner which had led to delays in receiving treatment for pressure ulcers placing them at harm of further skin damage.

The provider did not have good systems in place to monitor the quality and safety of the service provided. The provider had undertaken quality audits in some areas but these had not been robust enough to capture the action required to improve the service. None of the issues we found during our inspection had been picked up by the provider. Lessons had not been learnt from accidents and incidents in order to prevent further concerns and to strive for improvement.

Accurate records were not kept to ensure good communication and the safety of people being supported.

People were not always treated with dignity and respect because people were not always spoken with in a pleasant manner. Staff did not always respect people's privacy, staff entered people's bedrooms without knocking first. Care records were not stored securely to maintain confidentiality.

People were not always provided with personalised care. They were not provided with sufficient, meaningful activities to promote their wellbeing.

People had opportunities to voice their views and opinions about the service through surveys and through meetings. However, their views had not always been taken into account to make improvements.

The provider's complaints procedure did not give people all of the information about who they could raise concerns with. We made a recommendation about this.

Staff had received regular supervision with their line manager and felt confident that they could raise issues at staff meetings.

People had choices of food at each meal time. People were offered more food if they wanted it.

There were procedures in place and guidance was clear in relation to the Mental Capacity Act 2005 (MCA) that included steps that staff should take to comply with legal requirements. Staff had a good understanding of the MCA 2005 to enable them to protect people's rights.

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.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not enough staff to meet people's needs. The provider had not always followed safe recruitment practices.

Risks to people's safety and welfare were not managed to make sure they were protected from harm. The provider had not always taken action in relation to accidents and incidents.

Medicines had not been appropriately administered, recorded and stored. Medicines were not monitored effectively to ensure that they had been kept at the correct temperature.

Staff understood the various types of abuse to look out for to ensure people were protected. However, the safeguarding policy available to staff was out of date and did not contain up to date numbers of the local government and other agencies.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received the training and support they needed to meet people's needs. Staff had not received a comprehensive induction to ensure they had the skills and knowledge to carry out their roles.

Deprivation of Liberty Safeguards (DoLS) applications had been made to the local authority by the provider. People confirmed they made their own decisions.

Alexandria's Residential Care Home was not decorated effectively to support people living with dementia.

People were not always well supported with their health care needs. People saw healthcare professionals when they needed to; however, some people experienced delays in treatment placing them at harm.

People had choices of food at each meal time and access to plenty of drinks.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect.

Staff did not always respect people's privacy.

Most staff were kind, caring and patient in their approach and supported people in a calm and relaxed manner. Staff were discreet in their conversations with people, relatives and other staff.

Relatives were able to visit their family members at any reasonable time.

Is the service responsive?

Requires Improvement

The service was not responsive.

People were not always provided with personalised care and did not have access to activities to meet their needs.

People had opportunities to feedback about the service they received. However, this was not always listened to.

Information was on display about how to complain, however this did not give people all the information they needed to raise a complaint with external organisations.

Is the service well-led?

Inadequate

The service was not well led.

Systems to monitor the quality of the service were in place, however these were not effective. Audits had not picked up the concerns we found during the inspection.

Staff were aware of the whistleblowing procedures and were confident that poor practice would be reported appropriately.

Records relating to people's care and the management of the service were not well organised or complete. Care records were not stored securely to maintain confidentiality.

The provider had not reported incidents to CQC.

Alexandria's Residential Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 06 June 2017 and 20 June 2017 and was unannounced.

On the first day of the inspection the team included one inspector and an expert-by-experience who had personal experience of caring for older people and people living with dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. One inspector carried out the second day of the inspection.

Before the inspection we reviewed information of concern that we had received from health and social care professionals. We also reviewed notifications of deaths we had received and previous inspection reports. A notification is information about important events which the service is required to send us by law.

During our inspection we observed care in communal areas. We examined records including staff rotas; management records, care records for nine people, medicines records for 17 people and four staff files. We looked around the premises and spoke with five people and eight staff including the cook, cleaner and the provider. We spoke with the newly appointed manager on the second day of our inspection. We also spoke with three relatives and two visiting nurses. We requested information from the local authorities commissioning team and a GP.

We asked the provider to send us training records after the first day of the inspection, however the training records were not sent through by the deadline given and we only received a copy following repeated requests. We also asked for the provider to send us their updated statement of purpose and records relating

to people on the second day of our inspection. These were sent to us in a timely manner.

The service was last inspected on 29 December 2016 and it was rated good in all areas.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living in the home. Comments included, "I have got no problems here, I get my meal on time and a black tea, I am happy here"; "I do feel safe, I like it here because of the company but it is not like home unfortunately"; "I feel safe"; "Yes it is OK, people are alright. When I am in pain they give me Paracetamol" and "I am not used to living here yet, but at night I feel nervous going to my room but it's just me I think".

Relatives told us their family members received safe care. Comments included, "Yes I think she is very safe here, I am not concerned about her safety at all"; "Yes, she's safe here, they are also very good with my wife, apart from the couple falls she has had, but they always keep me well informed" and "Very safe yes".

Medicines were not well managed in a way that kept people safe. People were at risk as they were not receiving their medicines as they had been prescribed by their Doctor. Medicines records did not detail the times of day that people received their medicines, which meant there was a risk that people would receive their next dose too close together and cause an adverse reaction. For example, pain killers should not be administered too close together as this could cause an overdose if too many were administered over the course of a 24 hour period.

Bottles of liquid medicines, solutions and eye drops had not been dated when they had been opened, there was a risk of staff administering them beyond their safe use by date which meant that the medicines may be less effective. These medicines had short use by dates and should be used within 28 days of opening to ensure maximum efficiency.

We found medicines for four people still in the multi-dose compliance aid packs for weeks one and two, when the medicines cycle was in week three. Medicines records confirmed that the medicines left in the packs had not been administered. No notes had been made as to why these medicines had not been administered. This meant that these four people had not had their medicines, and that people's medical needs were not being met to maintain their health and wellbeing. Gaps in administration records were found on the MAR charts for a number of other people, which meant it was not possible to check that people had received their medicines at the correct times.

We counted medicines and found that the balances did not tally with the amount of medicines received and the amount given. Medicines that were classed as controlled drugs (CDs) under the Misuse of Drugs Act 1971 had not always been recorded appropriately. The CD register showed that one person's medicine was in stock. However, the staff member told us that the medicine was no longer in stock as the person was no longer at the home. The register had not been amended to show these had been returned to the pharmacy. Another person's CDs did not tally with the balance in stock. They were prescribed 5mcg Butrans patches; there should have been two in stock however only one was in the box. Another person was also prescribed 5mcg Butrans patches, they should have had four in stock but they had five. This meant that the provider had failed to comply with the Misuse of Drugs Act 1971. A staff member told us they thought that the wrong person's medicated patch had been put in the wrong box.

Medicines were not always securely stored. One person's prescribed Zero base cream was found in another person's bedroom. There were a number of shared bedrooms in the home; one shared room with an en-suite toilet contained prescribed creams for one person which had been left on the side, which meant that both people sharing the room could access the creams.

The keys to the medicines cupboards and trolley were not securely stored away. This included the keys to medicines which required safer storage by law. At various points during the inspection we found the keys to the medicines cabinets left unattended. This meant that medicines could be accessed by unauthorised staff or people living in the home.

Temperatures of medicines storage areas were not effectively monitored. The temperature record for May 2017 showed that 13 days had not been recorded at all. The monitoring sheet for June 2017 also showed three days where the temperatures had not been monitored. Temperature records showed eight dates (four of which were on consecutive days) where the temperatures were above 25 degrees centigrade. There was no facility in place to cool the medicines storage room. Medicines stored in a separate cupboard near to the kitchen were not temperature checked at all. Storing medicines outside of the manufacturers recommended range for a long period of time will affect the efficacy of that medicine and might mean they were not effective.

Photographs were not in place on all MAR charts to assist staff to identify people when giving medicines. There were people with the same first name. This may lead to people being mistaken for others.

Most people were in receipt of as and when required (PRN) medicines. There were no PRN protocols in place to detail how each person communicated pain, why they needed the medicine and what the maximum dosages were.

Body maps were not in place to detail where prescribed creams should be applied on the body. Staff did not have guidance about where and how often to apply topical creams. This meant that people's treatment for conditions was not effective or their skin integrity may not be maintained.

Some people had pain relief patches prescribed and one person was receiving hormone replacement therapy (HRT) through patches which were applied to the skin. There was no system in place to ensure that these were administered on to different areas of the body as recommended by the manufacturer and people were at increased risk of skin irritation from pain patches and HRT patches repeatedly administered to the same site.

This failure to ensure that medicines were suitably stored, administered and recorded was a breach of Regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from potential harm by adequate risk assessment'. Some risk assessments were incomplete. Risk assessments had not been reviewed and updated when risk levels had changed. For example, following falls that people had in the home or when people's health had changed. Some people had personal emergency evacuation plans (PEEPs) in place which were not individual to them. PEEPs were not in place for all people to detail what support each person would need to evacuate the home during a fire. This meant people were at a higher risk of harm if a fire broke out. Medicines risk assessments had not been fully completed to detail which medicines people were prescribed. One person's care records showed that they had been violent and aggressive towards staff and other people. Risk assessments had not been carried out to provide staff with guidance and instructions on keeping the person, themselves and other people safe. We spoke to the provider on the first day of our inspection about risks to a person's safety that

we had observed. On our second day of inspection the risk had not been reduced. The person fell as a result and was admitted to hospital.

One person was at risk of harm because advice from health professionals had not been documented, which had resulted in things being missed. The person was prone to urine infections. Healthcare professionals had requested that the staff tested the person's urine on a fortnightly basis to manage this. This had not been documented and had not happened, which had resulted in the person being admitted to hospital for a short period with a urine infection.

The provider had an accident and incidents policy which they were not following. The policy stated that 'All accidents must be reported, using the forms in the accident book. Completed forms must be passed to the manager. This applies to accidents resulting in injury or damage to property'. We observed one person with significant bruising to their face and eye. Staff told us that the person had been in an altercation with another person. There were no completed incident or accident reports relating to this. The provider could not evidence that the incident had been investigated and what actions had been taken to minimise future occurrences. This meant that the person could be at continued risk of injury or harm. We spoke with the provider about this, later in the day a staff member gave us an accident form which detailed that the person had injured themselves by falling over on 30 May 2017. The member of staff confirmed that they had only just completed the form as there were no blank accident sheets in the accident book. The written account did not match the verbal account of the incident by four staff. The staff had reported the injury to the provider, but the provider had not reported the injury to the local authority and had not sought medical advice in relation to the person's injury. People were not protected from effective and consistent responses to risk.

The provider's bathing policy detailed that staff should check and record the water temperature before a person gets in the bath. One staff member confirmed there was a thermometer in place, however staff told us they do not check or record the temperature of bath water when supporting people to bath. This meant people were at risk of being scalded.

The provider had an emergency bag next to the front door which should have detailed who was living in the home and essential telephone numbers. We checked the bag and found this had not been updated for a long time. The list of people living in the home was not up to date, only 13 people were listed. We found that one fire escape was blocked by a chair and a stair well had been used to store unwanted items. People were at risk of harm because there was no safe way to exit the service. A number of doors which had automatic door closing devices were propped open with items such as laundry baskets and bins. We checked and found that the automatic door closing devices were not working properly in these areas. This meant that the fire could spread through the home because the doors would not automatically close, which put people at increased risk of harm.

The home smelt strongly of stale urine, the flooring in some areas was not suitable for people's assessed continence needs and could not be cleaned effectively. Other areas of the home were dirty. Staff we spoke with told us this was because the previous cleaner had left over a week before we inspected and the new cleaner had only been in place a day. Pedal bins were in place in the bathrooms and toilets but they had been placed at a higher level which meant people had to use their hands to open the bin. This increased the risk of infection.

The failure to ensure care was delivered in a safe way was a breach of Regulation 12 (1)(2)(a)(b)(d)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment practice was not safe. All four staff files did not have photographs to confirm staff identity, and two of the staff files did not have a full employment history. The provider had employed new staff since the last inspection and had not checked reasons for gaps in employment. One new staff member had a gap of 11 years in their employment history which had not been explored. Another staff member's file showed a gap of 27 years in their employment history which had not been explored. The provider had not carried out sufficient checks to explore the staff member's employment history to ensure the staff member was suitable to work around people who needed safeguarding from harm. References had been received by the provider for all new employees. All staff were vetted before they started work at the service through the Disclosure and Barring Service (DBS) and records were kept of these checks in staff files. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Two DBS checks detailed information which did not tally with the staff member's application forms. The provider had not explored this. The provider had not followed their own recruitment policy.

Failure to establish and operate effective recruitment procedures was a breach of Regulation 19 (2)(a)(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was not enough staff deployed to meet people's needs. We observed that people who spent time in communal areas were left for up to 15 minutes at a time without supervision. People received minimal contact from staff unless it was to carry out a task such as assisting with drinking, eating or personal care. One person who was living with dementia took up a lot of the staff time as they frequently walked around the home, they required assistance to make sure they were safe and required constant help and reassurance because they were disorientated and anxious. The staffing levels had not been reviewed or increased to support the people and the staff. Staff told us there was not always enough staff on shift. Staff said, "I think [person] needs one to one" and "[Person] needs one to one at all times, she's becoming a danger to other residents". A person told us, "They aren't too bad, but it could be better, we could have more things to do here and more interactions you know". One person told us, "I think they need more staff if they want to help people better".

The provider failed to deploy sufficient staff to meet people's needs. This was a breach of Regulation 18 (1) of The Health and Social Care Act (Regulated Activities) Regulations 2014.

Cobwebs were visible throughout the home at head height and above. The home was in need of some redecoration and updating, carpets in some rooms including people's bedrooms and the conservatory were worn and paintwork throughout the home was chipped and scuffed. Some furniture was torn. A curtain rail which was in place in the middle of a shared bedroom to give both occupants privacy was loose and broken. Staff told us it had been like this for some time. We spoke with the provider about the need for redecoration and repair. They told us they had a maintenance plan. We asked to see this but they were unable to show us because it was not written down. They told us, "In the summer holidays I will be repainting the laundry, toilets, bathrooms, ground floor corridor and will do the outside garden woodwork and any vacant rooms". They also shared that they would be replacing some more of the flooring in the home, stating "I will do this within six months". Staff told us, "I don't think the home is well maintained. We try and tell [provider] about the home, he tries to do the repairs himself. He should spend a bit of money and get it done properly" and "Maintenance could be updated. It could be improved".

Records showed that regular checks were made on the gas safety within the home, electrical equipment and fire extinguishers. The water was monitored to prevent legionella. Regular fire drills had taken place, however no action had been taken to improve the evacuation times. The records of fire tests showed that a weekly fire test had not been carried out since 17 May 2017. The provider could not provide evidence that

the stair lift had been regularly serviced. When we questioned the provider about the maintenance of the stair lift they told us they did not have a maintenance contract for it but it did get fixed when it broke down. This meant that people were cared for in an environment that had not been suitably maintained.

The failure to clean, maintain premises and equipment was a breach of Regulation 15 (1)(a)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not given clear information about how to report abuse. The provider had an adult protection policy in place. The provider and staff had difficulty finding the policy. The policy detailed the responsibilities of staff to report abuse. The policy linked to the local authority safeguarding adults policy, protocols and procedures which should provide detailed and clear guidance to staff about signs and symptoms of abuse. The policy detailed that institutional abuse 'May be evidenced by lack of care plans, lack of stimulation and bath rotas' as well as a number of other signs. We found bath rotas in place in the home which evidenced that each person was allocated a particular day per week to have a bath. One person liked to have a bath each morning. Bathing records and people's daily records did not detail that baths had been provided to meet their wishes. This bathing rota evidenced that the provider was not following their own adult protection policy and providing institutional care. We found a copy of the local authority safeguarding policy, protocols and procedures in the staff office it was dated 2005. This contained telephone numbers that were no longer in use and out of date information. The local authority rewrote their policy in April 2015. Staff we spoke with had a good understanding of abuse and how to report safeguarding concerns. Staff told us they would report safeguarding issues to the provider, they told us they had confidence that concerns would be reported appropriately. One member of staff said, "I would report to the manager and [provider] I would report to social services". The provider had failed to notify CQC that safeguarding allegations had been made.

This failure to establish systems and processes to safeguard people from abuse was a breach of Regulation 13 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People told us "Well, I look after myself, more or less"; "Yes I don't see why not" and "Quite well" when asked how well staff knew how to look after them. We asked people about the food. Comments included, "I like it, it's not bad"; "It's quite nice, I cannot find any fault with it"; "Oh yes, I like it, I think the chef is good"; "They know I am a vegetarian, so I get all veggie food and it is quite nice too" and "I enjoy it, it is nice".

Relatives told us, "I am sure they [staff] know pretty well how to look after her, but the only problem is her room and the home itself, it's just not clean enough"; "I think they know pretty well, she always looks well looked after, dressed properly and stuff like that you know" and "I think they do their best really, but my concern is that my mother has been here for seven and a half years and now they have been taken patients with dementia which causes distress to mum, the noise and all sorts".

Staff recognised when people were not acting in their usual manner, which could evidence that they were in pain. We observed staff reassuring people who were in pain and discomfort that they had just had a pain killer and it should start to work soon. District nurses visited the home frequently to provide nursing care and treatment to several people. However, people did not always receive timely medical assistance from healthcare professionals to protect their health and wellbeing. Staff had not always picked up changes in people's skin colour and texture, which had resulted in pressure ulcers forming. A visiting nurse was concerned that staff were not seeking advice quickly enough to prevent pressure areas forming. We checked the care records of some people and could see there had been delays in gaining medical advice in relation to this. The provider had failed to follow up on advice given by the district nurses. For example, one person's records showed that they had been seen on 13 April 2017 in relation to pressure ulcers on their back and heels. The person was prescribed pressure relieving footwear for their heel and an air mattress for their bed. We observed that the footwear was in place, however the air mattress was not in place. The provider had not followed this up.

One person had been visited by the local authorities' Deprivation of Liberties assessor. They had written, 'can you kindly request a GP review as she may be becoming depressed'. There was no evidence to show this had been acted upon. One person had been seen by a dietician in relation to their weight loss. The dietician had given specific guidance in relation to textures of food that the staff must follow. This guidance was available in the kitchen for kitchen staff and a copy was in the person's bedroom. However, the person's care plans and risk assessments had not been updated to include the guidance and the information had not been shared with the person's family. One staff member explained that the person's family regularly brought the person crisps and chocolate which didn't follow the guidance which meant that the person was at risk of choking.

This failure to provide care and treatment in a safe way was a breach of Regulation 12 (1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's training records evidenced that staff had not received training to support them to carry out their roles. One staff member out of 19 had attended health and safety training, two staff had completed

dementia awareness training and no staff had attended nutritional awareness training. Only one member of staff had undertaken moving and handling training and infection control training. We observed poor moving and handling practice where people were supported out of chairs by staff using an underarm lift, which could result in injury to people. Staff were not using handling belts and other aids which were available in the home to appropriately support people to transfer. Several staff told us that they had not received any training, one of whom who had not got any previous experience in the care sector. Some staff told us they had completed some courses such as fire awareness, safeguarding and basic first aid training. Staff had not attended training in relation to pressure area care. We observed some poor practice in relation to communicating with people who were living with dementia. We observed staff members speaking to people in a cross or fractious manner because they were having to repeat themselves to the person. People had received poor care in relation to meeting their pressure area needs and their dementia needs, which evidenced that staff had not been given adequate training to meet people's assessed needs.

New staff had not received an appropriate induction to their role or home. There was inconsistent practice in relation to staff induction procedures. Some staffing records showed that staff had had an introduction into people's care routines and routines of the home. One staff file contained a blank induction form, two other files showed no induction records. One staff member told us, "Induction was where [staff member] showed me around". The provider had not embedded the Skills for Care 'Care Certificate' as part of the induction programme to ensure staff has good information and knowledge about their roles. One member of staff confirmed they had not been asked to complete any workbooks or training in relation to the care certificate and had not had their competency to carry out their role assessed.

This failure to provide training and support for staff relating to people's needs is a breach of Regulation 18 (1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had been supported to undertake qualifications relevant to their role, such as diplomas and National Vocational Qualifications (NVQ's) in health and social care. The cook had been supported to undertake an NVQ in food safety.

Staff supervision is a one to one meeting with a manager or senior member of staff. It is intended to enable managers to maintain oversight and understanding of the performance of all staff to ensure competence was maintained. This assists in ensuring clear communication and expectations between managers and staff. Supervision processes should link to disciplinary procedures where needed to address any areas of poor practice, performance or attendance. Staff had received regular supervision with their line manager. Records confirmed this. One member of staff said, "I have had little supervision with [registered manager]."

The environment did not meet the needs of people living with dementia. There were no signs to help people find their way around the home. Bedroom doors had numbers and on, some had names too. Some clocks in the home were not working. The clock in the dining room showed the correct time but it showed people it was 18 February. One person's care plan detailed that they were 'not orientated to time and place' and required assistance to orientate themselves. The provider had not taken on National Institute for Health and Clinical Excellence (NICE) guidance within the changes they had made to the home. Further improvements were required to support people with dementia living in the home.

The premises were not suitable for the needs of people living with dementia. This was a breach of Regulation 15 (1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible,

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

There was a good understanding of the Mental Capacity Act 2005 (MCA) by staff. Staff described how they encouraged people to make choices about their care and life such as choosing clothes and food. We observed people being offered choices throughout the inspection. One staff member told us, "I would show people their clothes; a couple of items. They can make their choice known, even if they don't speak". People confirmed that they were able to make choices and have control over their lives. Staff were not aware of who had a DoLS in place. One staff member told us, "They've all got a DoLS in place. For example, if someone wanted to go out the door but they are unsafe a DoLS is in place". The provider's records showed that two DoLS authorisations were in place and seven had been applied for.

People were asked what they wanted to eat the day before, however people were able to change their mind on the day and ask for other food if they wanted to. People were offered two choices of meals but other alternatives such as jacket potatoes or omelettes were available. Meal choices were written up on a blackboard in the hallway. This was not in an easy to read or pictorial format which may have helped people to understand what the choices were.

People had drinks offered throughout the day and people that were not mobile had drinks placed within their reach. We observed lunch and saw that the portions were generous and there was very little waste. Those with smaller appetites were given portions accordingly. Juices were provided and also tea and coffee if requested. People's requests for drinks during the day were answered, sometimes there was a short delay in meeting requests because staff were busy providing care to others. One person told us, "It takes a long time to get a coffee or a tea, sometimes 10 to 15 minutes; I think it is a long time". People had access to snacks such as biscuits and cakes.

We observed meal times in the dining room. People were able to choose where they sat and what they ate. People were chatting amongst themselves and there was a relaxed atmosphere. Staff chatted with people while they were serving their lunch. People were given drinks with their meals. Some people had their meals in their bedrooms. Staff supported people with their meals when they required it. People were offered more food and drink if they wanted it. Relatives told us, "She eats it, I think she likes it and on Sundays they eat roast dinner" and "Food is good, mum enjoys it, it meets mums needs and expectations".

Requires Improvement

Is the service caring?

Our findings

People told us staff were kind and caring. We observed staff interactions with people during both days. We observed positive and friendly interactions as well as poor interactions. Staff had little time to spend with people, which meant that interactions were often task related such as providing drinks, offering snacks and providing personal care.

People were not always treated with dignity and respect. We observed some staff becoming short tempered and fractious with a person who was confused about their environment. They needed reassurance and support. We heard a staff member repeatedly tell the person to sit down which was said in a direct and over bearing manner.

During day two of our inspection a person fell and injured themselves in the lounge. Staff responded quickly to the person's needs and placed pillows and cushions under the person's head to make them comfortable whilst waiting for the ambulance to attend. They covered the person's bare legs with a blanket to protect them. However, whilst waiting for the ambulance the person had become incontinent of urine. They were clearly distressed about this and kept trying to remove the blanket and their underwear. Whilst some people that had been present in the lounge when the person fell had been escorted to the conservatory and other rooms, one person remained in the room in full view. There was no screen available to protect the injured person's privacy and dignity.

During the inspection we observed staff knocking on doors and asking permission to enter during the morning. One person told us, "They [staff] always knock the door and ask me if everything is OK". However this was not consistent. We observed staff walking in and out of people's rooms at other times without knocking and asking permission to enter. On one of these occasions a staff member walked into a person's room without knocking. We heard the person shout out "ooh you frightened me. Why didn't you call out or something". The staff member said, "I did. I said [person's name], maybe not very loudly". The staff member had not called out to the person. We were standing six feet away from them when they walked into the room.

People were not always treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff members had a good rapport with people. Staff knew people well. They knew their likes and dislikes and preferences, such as what drinks they liked, where they preferred to sit and knew about their relatives and wider family. Most staff were friendly and cheerful and had good communication with people. Staff and people shared humour and general banter between them for example, the cook asked where one person wanted to eat their meal, the person said, "In my mouth". They had a chat and a laugh about it and the person then told the cook where they would like to eat.

We observed that staff promoted people's dignity by ensuring that doors were closed when they provided personal care and that they covered people with towels when supporting them so they did not feel exposed.

We noted from the garden that staff closed the curtains when providing personal care in people's bedrooms.

People told us they had been involved in making decisions and planning their care. Some people had been asked how they want to be cared for and about their likes and dislikes. Some people had signed their care records and others had not. People were supported to be as independent as possible, some people were able to manage some elements of their personal care themselves.

Relatives were able to visit their family members at any reasonable time. We observed staff welcoming relatives and offering refreshments. We observed relatives spending time in people's bedrooms when they visited, which meant that people had space to talk privately with their relatives. Relatives also spent time with their family member in the lounge. One person went out with their family to a local pub.

Requires Improvement

Is the service responsive?

Our findings

We observed that staff were responsive to people's requests. For example, requests for pain relief were answered quickly as were people's requests for drinks.

Relatives told us they knew who to complain to if they needed to. One relative said, "Well, if it was needed I would get on to social services or the CQC but only if it was needed". One relative detailed how staff responded to their family member's needs. They said, "Whenever she wants a cigarette staff take time and help her out". One relative told us, "Also they do not do any activities here, this is the problem, the activity list out there in the front but they never do any".

We observed that no activities took place at all on 06 June 2017 and 20 June 2017. Some people were able to move around the home themselves and provide their own stimulation such as reading, listening to the radio and talking. However, we observed that many people sat in the lounge area or dining area or their bedroom, with no interaction, stimulation or activity to keep them active and engaged. People living with dementia spent long periods of time sitting with no interaction and nothing to do. Activities for people living with dementia had not been considered. There was an activities board on display outside the lounge which listed daily activities such as gentle exercise, board games, old time music, hair dresser, sing a long, knitting, reminiscing, cake decorating, reading books, ball games and, card making. The activities listed on the schedule were not held. People's care records did not detail if people had been involved in activities. We observed that staff did not often have time to spend quality time with people carrying out activities.

We spoke with the provider about the activities and lack of stimulation for people. They told us they planned to recruit a staff member to do activities.

Each person had a clear assessment in place detailing their care needs, these had not been reviewed and updated as and when people's needs had changed. For example, as people's health needs had deteriorated they had not been updated to evidence the person's current care and support needs. For example, one person's care records showed that they had frequently been agitated and distressed which had led them to display behaviours that other people and staff found challenging. There was no care plan in place in relation to this to detail how staff should work with the person. Important information about the person's medical condition which may explain why the person was sometimes agitated, restless and did not like to sit down had not been recorded on their care plan. This meant that staff did not have all the information they needed to provide the person their care.

People's care plans did include information about their skin integrity and what staff should do when they had pressure areas. There were no records in relation to pressure areas in some people's files despite them having pressure areas that the visiting nurses were providing treatment for. We checked the nurses own records to gain information about pressure area concerns. Staff had failed to pass on information to the new manager on the second day of our inspection in relation to one person developing serious pressure areas which were treated by visiting nurses on 19 June 2017.

People's care plans detailed their preferences in relation to bathing, such as whether they preferred a morning or afternoon bath. However, the care plans did not detail how often people liked to have a bath. Daily records and bath temperature records indicated that people were not supported to have baths very often at all.

People's care plans did not always detail their life history and important information about them, which meant that staff did not always have clear guidance about what people's care needs were. For example, details of important events, work history, relatives, favourite sports and activities, places they had lived and important people in their lives.

The provider was not providing care or activities for people in a responsive or person centred way. This was a breach of Regulation 9 (1)(a)(b)(c)(2)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a complaints policy and procedure which included clear guidelines on how and by when issues should be resolved. The complaint procedure was on display in the hallway. The procedure was not in an easy to read format that would enable people living with dementia to understand more clearly. The provider told us there had not been any complaints. The procedure detailed that people should take their complaint forward to the Care Quality Commission (CQC) if they were not happy with the response from the home. This was incorrect, CQC do not investigate individual complaints people should be directed to the local authority or the local government ombudsman (LGO).

We recommend that the provider updates the complaints policy and procedure to ensure people and their relatives have all the information they need to make complaints in a format they understand.

People's views and opinions about the service they received had not been dealt with appropriately. People had opportunities to voice their feedback through completing feedback forms about the service and through 'Residents' meetings. The last meeting had been held on 26 June 2016. People's feedback about the service had not always been acted upon. The meeting records showed that people had stated they would like more interaction and to go out more. People told us during the inspection that they would like more interaction and activities to do. People's care records confirmed that people did not have enough stimulation.

Completed relatives surveys were generally positive. However some relatives had made comments and suggestions to make the service better such as; 'More interaction [between] residents and staff'; Better access to the garden'; 'Sometimes I have found mum in her room and the telly has not been on. With her dementia she needs the stimulation of the telly to keep her focussed' and 'I would like to see mum in the lounge a bit more where she has more company'. Feedback during the inspection evidenced that this had yet to be resolved.

The failure to act on feedback given by people, their relatives and staff was a breach of Regulation 17 (1)(2)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Compliments had been received in the form of thank you cards. We were not able to determine whether these were recent as there was no record of when they had been received. One read, 'May I take this opportunity to thank you all from the bottom of my heart for taking great care of my grandmother'. Positive comments had also been made on completed surveys. Such as, 'We always find everyone very friendly and are always made welcome' and 'I am grateful with all the help and support from all the staff and management for myself and mum'.

Inadequate

Is the service well-led?

Our findings

People knew the staff team and appeared to know the provider. A local authority representative told us 'The home had made some vast improvements to the service and this was mainly due to the manager they had in post. Unfortunately she has now left the service'.

Systems to monitor and improve the quality of the service were not robust. The provider did not have adequate audit systems in place within the home. Therefore they had not identified areas of concern that we found during the inspection. For example, they had failed to capture that the recruitment records did not fully detail each employee's full employment history and reasons for gaps in employment. They were unaware of the concerns relating to risk management, medicines management, maintenance of the premises, safeguarding, decoration and signage within the home, policies and procedures, training, induction processes and care plans.

The provider had carried out checks of the home on a monthly basis such as fire extinguisher checks, emergency lighting checks, water temperatures, nurse call system, door guard (automatic door closing device) and wheelchair checks. The previous registered manager had completed an infection control audit on 03 February 2017 it identified that carpets and walls required further cleaning, dining room needed painting and the laundry room needed cleaning and tidying. This had not been completed.

A medicines audit had been completed in January 2017; this had identified an issue with a member of staff not signing for medicines as required. Medicines audits had not been carried out frequently so the provider had not picked up further concerns with medicines. A room standards audit carried out in March 2017 showed that the general decoration of the home needed to be updated.

Systems were not in place to monitor all accidents and incidents which meant that action taken as a result of accidents and incidents was not always timely or evident which led to risks not being reviewed and mitigated.

Records were incomplete and inconsistent. People's care plans were not complete or updated appropriately. Food and fluid information for those at risk of malnutrition or dehydration did not record what people had eaten or drunk. Daily records did not reflect that people had received care and support detailed in the care plans.

There were a range of policies and procedures governing how the service needed to be run. They were not kept up to date with new developments in social care, which meant that staff did not have all the necessary information to support them in their roles. The provider lacked awareness of the policies and had not identified that staff were not following them.

The management arrangements were not robust as the provider had little operational knowledge of the service. When questioned, the provider repeatedly said, "The registered manager would know this". The provider was unable to find documentation when requested and was unaware of people's changing needs.

We repeatedly reminded the provider that the registered manager had left in May 2017. A local authority representative shared 'I do have concerns regarding the service if [provider] is managing the service as he lacks the knowledge and skills to do this'. The provider had not applied to add the banding of dementia to their 'Service user bands'. The service was clearly providing care and support for people with dementia.

Filing systems were sometime chaotic. The provider and staff spent quite a bit of time trying to find information. We found misfiled information such as one person's care records in another person's file. People's confidentiality was not always respected. People's care records were found in the dining room on the second day of our inspection along with bathing records and handover information for staff. These were placed in easy reach of people but also next to an open window. The home is located on a busy road, which is busy not only for traffic but also pedestrians.

The failure to establish and operate effective systems and processes to monitor the quality of the service and failure to maintain accurate and complete records was a breach of Regulation 17 (1)(2)(a)(b)(c)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have a good understanding of their role and responsibilities in relation to notifying CQC about important events such as deaths, serious injuries and DoLS authorisations. The provider had failed to notify CQC of DoLS authorisations and safeguarding concerns.

Failure to notify CQC of these events is a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

Staff were aware of the whistleblowing procedures and voiced confidence that poor practice would be reported and dealt with appropriately. Staff told us that they would escalate concerns to CQC as well as the local authority. Effective procedures were in place to keep people safe from abuse and mistreatment.

Staff told us that communication between staff within the home was good and they were made aware of significant events. There was a written handover record so staff could share important information about people's health and wellbeing. Staff confirmed that the previous registered manager met with them regularly. Staff felt that they could speak up at meetings and that the registered manager had listened to them. Staff told us the provider listened to requests for equipment and responded appropriately. Staff told us that all the staff worked well together as a team. Staff said, "Staff know each other, we've all worked here years"; "I think the care side is good, we have a good team" and "This place has been a bit neglected. There is a new manager I have high hopes she'll sort things out".

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 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured that people were treated with dignity and respect. Regulation 10

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider has failed to carry out adequate checks on staff. Effective recruitment procedures were not in place. There were gaps in recruitment records. Regulation 19(1)(b)(3)(a)