

Mrs Saima Raja

Victoria Lodge Residential Care Home

Inspection report

138 Thorne Road
Edenthorpe
Doncaster
South Yorkshire
DN3 2LU

Tel: 01302884806

Website: www.braemarcare.co.uk

Date of inspection visit:

15 June 2017

23 June 2017

Date of publication:

27 July 2017

Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

The inspection took place on 15 and 23 June 2017 and was unannounced. The previous inspection was 15 December 2016; the ratings following the last two inspections have been inadequate and we are taking enforcement action in relation to the findings. The service was in special measures at the time of this inspection. This inspection identified some improvements, but also continued breaches in regulations 12 safe care and treatment and 17 good governance. We also identified a further breach in regulation 18, staffing.

Victoria Lodge Residential Home provides accommodation for up to 24 older people who require personal care. It also cares for people who have a diagnosis of dementia. At the time of the inspection there were eight people using the service. The home is situated in Edenthorpe, near Doncaster.

There was a manager in post who had applied to register with the Care Quality Commission and this application was in progress at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The environment was homely and welcoming. People were content in the home and staff were attentive to their needs. People had good relationships with staff who were knowledgeable about their individual needs and personal preferences. Staff promoted people's dignity well in all interactions and were respectful when speaking with or about people.

Individual risks to people were not fully assessed and information in people's care plans did not sufficiently illustrate how care should be managed safely.

Staff felt supported by the manager and there was evidence of training and supervision, however training was not all up to date or effective. There were only three qualified first aid trained staff altogether and this meant they were not always on duty.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. Staff sought people's consent for all aspects of care and support.

People enjoyed their meals and staff had an understanding of people's nutritional needs, although risks around people's nutrition were not effectively monitored. There were snacks and drinks available throughout the day.

Activities were person-centred and meaningful to individuals and staff had a good insight into people's backgrounds, interests and hobbies.

Care plans showed where people's care had been discussed with other professionals and reviewed. However, documentation to support people's care and the running of the home was not all up to date, clear or concise, which meant information was fragmented and not easy to locate.

There were continued weaknesses in the systems and processes for assuring the quality of the service and issues identified through the inspection process were not routinely picked up on within the audits.

We noted the manager and the staff team were working hard to address the concerns raised at the last inspection and they had made positive changes, particularly in relation to people's dignity and activity provision. The manager was very responsive to matters raised at this inspection and took measures to address the issues we raised. However, there were continuing concerns at this inspection in relation to the oversight and management of risk, documentation to support people's care and the running of the home and governance.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that although some improvements had been made, there was not enough improvement to take the provider out of special measures. CQC is now considering the appropriate regulatory response to resolve the problems we found.

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.

You can see what action we told the provider to take at the back of this report.

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.

Individual risks to people were not always thoroughly assessed. Information in people's care records, such as moving and handling risk assessments were not accurate or consistently completed. This was a concern at the previous inspection.

Medicines were managed appropriately, although the medicines trolley was not securely stored.

Staff had a poor understanding of how to prevent the spread of infection.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Staff training was not up to date, such as first aid, and not effective, such as infection prevention and control.

Staff had some understanding of the legislation around mental capacity, although there was some confusion in care records about people's mental capacity and their mental health. There were improvements to best interest decision making, although consent for some aspects of people's care was not always clearly documented.

Improvements had been made to the storage and provision of food. Risks around malnutrition were not always managed effectively.

Is the service caring?

Good ●

The service was caring.

The home was very friendly and welcoming and people were happy and content, but although staff's caring approach was a key strength of the service, there were shortfalls in the quality of the service overall.

Staff promoted people's dignity well and there was a designated

dignity champion.

People enjoyed good relationships with staff who were kind, patient and caring.

Is the service responsive?

The service was not always responsive.

Documentation to support people's care was not always up to date, accurate and consistent.

Activities were person-centred and meaningful for individuals in the home.

People and relatives knew how to complain should they wish to.

Requires Improvement ●

Is the service well-led?

The service was not well led.

Although some improvements had been made in response to the last inspection, there were continued concerns in the quality of the leadership and management and some breaches continued.

Staff, relatives and people felt the home was run well

There was poor oversight of the risks to individuals and documentation to support the running of the home was out of date, inaccurate and ineffective.

Inadequate ●

Victoria Lodge 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 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 and 23 June 2017 and was unannounced. There were three adult social care inspectors on the first day and two inspectors on the second day.

We reviewed information we held about the service, such as notifications, information from the local authority and the contracting team. We displayed a poster to inform people and visitors that we were inspecting the service and inviting them to share their views. We had received 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 looked around the home, in people's rooms with their permission and in communal areas. We spoke with eight people, the manager, three care staff, the activity co-ordinator, the acting cleaner, the maintenance staff, the cook and two visiting doctors. We spoke with three visiting relatives.

We looked at care documentation for five people, two recruitment files and records relating to quality assurance monitoring and the safety of the premises and equipment.

Is the service safe?

Our findings

At the inspection in December 2016 we found the provider had not taken steps they said they would take to ensure people's care was safe following accidents and incidents. At this inspection we saw people's care plans had been updated accordingly when accidents or incidents had occurred. For example, one person had been prone to falls from their bed and the care plan was updated to show this was referred to the falls team and a bed guard was recommended and fitted. There were 'post fall individual environmental checklists' completed following such occurrences.

We spoke with staff about the use of equipment for moving and handling people and we looked at care records in relation to this. Staff knew which equipment to use for each person and where a hoist was required, they knew the type of sling needed for safe transfer and we saw this was detailed in the care plan. However, the method staff should use to assist a person safely was not detailed. For example, one person's care plan said a person would need a bath hoist, but there was no information about how many staff or how this should be used, or whether the person had been assessed for the safe use of the equipment. One person needed a piece of equipment called a rotunda, but their care plan did not contain clear directions as to how the person should be supported safely when using this.

There were risk assessments in relation to people's mobility, although these did not contain sufficient detail for staff to be able to support a person safely. For example, plans stated 'needs the help of two staff' but did not say how the staff should help. One person's care record stated they were at high risk of falls and we saw the fall risk assessment contained 'scores' for each aspect of the person's mobility. However, there was nothing to indicate the significance of each score, how the information was calculated and how the risk was mitigated. Staff we spoke with were not clear what the written risk assessment meant. On day two of the inspection, the manager had provided some information about what the scores meant. We saw there were monthly evaluations but still no indication of any action to be taken to reduce the person's risk.

One person's record stated they were at low risk of falls and they had not had a fall in the last three months, although there was no date on this statement. Yet another part of the care record showed they had fallen from their bed. The risk assessment had not been updated since 30 January 2017 despite the person having fallen.

We saw personal emergency evacuation plans (PEEPs) for people, although these were sparse in information and did not always reflect how staff should support people in the best way for their mobility. PEEPs information was sometimes identical in people's care plans, not individually assessed. One person was deemed to be at high risk of absconding, yet there was limited information in the PEEPs or in their care plan to show how staff would minimise this risk.

People's weight was recorded and the manager showed us a table which detailed all people's weight and nutritional risks. However, we found the risks had not been assessed properly or consistently. For example, one person was deemed to be high risk of malnutrition and should have been weighed weekly but we saw they were weighed monthly. There was no guidance on action to take where a person's risk was high.

These examples illustrate a continued breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because risks were not effectively assessed or mitigated.

People said they felt safe. One person said, "They keep me safe and sorted. They're marvellous". One person's relative said, "I know [person's name] is safe here. There is always at least one member of staff in sight at all times, if not more. Safety is good here".

We saw staff supported people appropriately with moving and handling. Staff enabled people to move at their own pace when standing from sitting. Where people needed support and encouragement, staff were very patient. Staff spoke with people about the ways in which they could help themselves to move safely, such as by using the chair arms for support and by gaining their balance before starting to move. Where people needed a walking aid, such as a zimmer frame or a stick, staff reminded them to use these.

We saw one person was encouraged to move from their wheelchair to the armchair and staff explained the benefits to the person of sitting more comfortably. The person required much encouragement and staff tried many ways to engage them in their own support and maintain their independence. Staff we spoke with said they were following the advice of other professionals involved in the person's mobility.

We reviewed two staff files and saw recruitment suitability checks had been made. One file we saw showed the Disclosure and Barring Service (DBS) check was carried out in 2009, yet the provider's policy stated 'DBS must be completed every three years or as and when changes'. There was no further DBS check completed, although we saw staff were expected to inform the provider of any changes that may affect their suitability to work with vulnerable people.

Staffing levels were seen to meet people's needs on the day of the inspection. We discussed night time staffing levels with the manager. We were told there were two members of staff at night, one of whom was allowed to sleep during the shift. However, we knew there were two people in the home who needed two staff to reposition them and manage their continence needs, which at times required a full change of bed linen at night. We questioned how this was managed if one member of staff was asleep. The manager told us they would be woken up every time the person needed assistance, but sometimes one member staff would reposition the person as they had been shown on their training. On the second day of the inspection the manager told us they had decided to review night staff responsibilities in light of the discussion on day one in order to ensure there were no staff asleep when people needed support.

Staff we spoke with understood the signs of possible safeguarding concerns and what to do if they were worried about a person or if they witnessed abuse. Staff said they had regular training in safeguarding people and we saw this was reflected in the training matrix. The manager told us staff would be supported to follow the whistleblowing procedures if they needed to report poor practice and they understood the safeguarding procedures and how to implement these without delay. The manager told us they were aware of when to report safeguarding incidents and they said they understood the procedures. They said there were no ongoing safeguarding matters at the time of the inspection.

We looked at the way in which medicines were managed in the home. We spoke with the senior member of staff who administered the medicines during the first day of the inspection. They told us they had regular medicines safety training and the training matrix showed their training was completed in November 2016.

We saw the secure storage of controlled drugs and the records to show these were detailed and checked by staff. Room and refrigerator temperatures were recorded daily and the staff responsible knew the safe range for storage. We saw medicines were stored in a locked trolley during the day, but this was not kept securely

in a locked room or attached to a wall as per good practice guidelines. Staff told us the trolley was kept downstairs during the day as the treatment room was upstairs and all residents were downstairs. We had concerns this would compromise the security of the medicines if the trolley was unsecured.

People were supported with enough time and patience to ensure they took their medicines and the senior staff made sure these had been taken as prescribed before recording on the medicines administration records (MARs). We looked at the MARs and found these were completely recorded and up to date for each person. The staff responsible for giving medicines wore a red tabard to indicate they must not be disturbed, yet we saw they were interrupted from administering medicines to support a person to their room.

At the last inspection, we saw there was no prescribed medicines 'as required (PRN) protocol in place for one person, neither did staff record the reasons for administering the medicine and whether it had the desired effect. At this inspection, where people were prescribed PRN medicines, 'there were individual protocols in place and staff recorded when these were given or not given. People who were prescribed PRN medicines for pain relief were asked if they had any pain before staff administered the medicine. Staff told us they always checked and would not give this medicine if it was not needed. We saw one person had been given pain relief twice in the day, but this information had not been written on the person's corresponding care notes. Staff we spoke with said they had been busy and had not had time to do this.

At the last inspection, topical medicines, such as creams, were not all recorded and there was a lack of clarity about how they should be applied. At this inspection documentation was clearer and we saw the records were regularly checked by the manager to ensure people were having these medicines as prescribed. Where staff had not been vigilant in ensuring topical creams were applied, supervision records showed action had been taken to discuss this with staff concerned.

There was evidence the manager had contacted GPs and district nurses for clarity about people's medicines and creams and any phone calls or queries were documented clearly.

Training records showed staff responsible for giving medicine had up to date training. There was a list of staff signatures in the MARs file, although we found there was one acting senior staff member whose signature was not on the list.

Records showed audits of medicines were carried out for each person in the home. The audits were carried out by the manager, although we were not provided with evidence of the manager's competence as although they told us they had completed medicines training, they were unable to provide evidence of this.

We found the premises were mostly safe and staff took steps to ensure a safe environment for people. One person's ground floor window opened very wide and we discussed this with the manager as other people could access this area as the door was not closed or locked. The manager told us none of the people had bedrooms upstairs currently as these were in the process of being refurbished. There was evidence of ongoing decoration in the home and the manager was aware of the areas that required attention. For example, one person's washable floor covering had a tear, which was taped over. Soft furnishings, such as bedding were clean but faded and worn.

The downstairs areas were brightly decorated and there was a homely feel, with photographs of people and art work. People's own rooms were personalised with their possessions and photographs of their life.

We looked in the outbuilding and found this had been organised more effectively than at the last inspection, with more appropriate storage of items, such as activity resources. However we noted the maintenance staff had a range of hazardous equipment at one end of the building and the door was open, which meant

people who were independently mobile could access the area. We asked the manager to make sure this was safe and they promptly did so.

The home was free from mal-odours and visibly clean in most areas, with evidence of cleaning taking place throughout the day although cleaning schedules displayed had gaps in the recording. There was a good supply of personal protective equipment (PPE) and staff used this throughout the day. However, we saw one member of staff did not change their gloves or apron from supporting a person in the toilet to walking through the home. When they removed their gloves we saw they put them in their pocket and then used them again. This meant there was little protection for the spread of infection.

We found some areas were in need of thorough cleaning. For example, we found ingrained dirt on the kitchen floor and debris behind the cooker. The cooker itself was visually dirty with baked on food and stains. The freezer was also in need of defrosting and cleaning and there was no schedule in place for this. We saw there were disposable cleaning cloths used as shelf protectors but these were stained and wet. We asked the manager to come into the kitchen so we could point out our concerns. The manager put on an apron and a hairnet and asked us to do the same; however we had not observed any of the staff use the hairnets during the day, going in and out of the kitchen. We asked the manager if this was standard practice and they told us it should be. The manager acknowledged their audits had not picked up on the issues we found.

We saw during the first morning, the laundry area was not clean and there was a mal-odour in the room which was still evident in the afternoon. There were damp mop heads in a bucket and shelves were not clean. We saw some fabric neck supports which were stained on a shelf. There was a healthcare assistant who was acting as a cleaning/laundry staff. We asked this member of staff whose these were and they said no one used them, but it was unclear why they had not been cleaned or thrown away. When we spoke with this member of staff about temperatures for different washing tasks their responses indicated a lack of understanding about infection prevention and control, yet the training records showed they had completed recent training. Records showed the kitchen and laundry staff had not completed any recent training in infection prevention and control.

These examples illustrate a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because there was poor prevention for the spread of infection and staff did not always have the competence and skills to carry out safe care.

Is the service effective?

Our findings

The last inspection identified some concerns around the provider's compliance with the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards. At this inspection the manager told us they understood the legislation but there were delays with the local authority processing the applications for DoLS for people in the home. The manager told us all eight people living at Victoria Lodge were living with dementia or had memory problems and this was also stated on the provider information return (PIR).

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. The manager told us standard authorisations had been requested for all people, although none of these had yet been approved by the local authority. We spoke with a representative of the DoLS team at the local authority and they confirmed they were in the process of attending to applications, but there was a lengthy delay with them. The manager told us they regularly chased up the DoLS applications with the local authority, although there was no clear evidence of this.

Staff we spoke with were aware there were no authorised DoLS in place but understood applications had been made for individuals and the reasons why. Staff told us they had done training to help them understand the legislation. One member of staff said, "If a person is deprived of their liberty it is to keep them safe, in their best interests they need this extra safeguard". Some staff struggled to explain their understanding of the Mental Capacity Act and one said, "It's just like DoLS, to keep them safe. I've done it (training) but my mind is blank". We found there was some confusion in the manager and staff's understanding of mental health and mental capacity. Information in people's care records was similarly confusing.

People's care records illustrated where their mental capacity had been assessed for individual aspects of their care. We saw there were minor decisions considered in a person's best interest, such as the wearing of spectacles, but information was sparse and inconsistent, such as for the use of moving and handling equipment. For example, one person's records stated they had been assessed for needing support to use a piece of equipment but there was no evidence of a best interest discussion having taken place.

The manager gave us some examples of when best interest decisions may be made if a person lacked capacity to make a decision for themselves. However, there was limited evidence in people's care plans of best interest discussions.

Staff consulted with people and sought their consent before any support with care was given. Staff asked people their preferences, such as where they would like to sit and what they would like to drink and they supported people's choices appropriately.

In the staff files we reviewed there was evidence of induction, although no reference to the Care Certificate. The Care Certificate is the set of minimum standards that should be covered as part of staff induction or as opportunities for staff to refresh or improve their knowledge. We saw staff training records in the staff files, although dates were not always recorded and information did not correspond with the training matrix.

We saw the training matrix and found although training had been undertaken there were shortfalls in areas such as first aid and infection prevention and control for key staff. There was no evidence to support one member of staff had done moving and handling training and the manager told us they were awaiting their certificate. The manager's training was not listed on the training matrix and they sent this to us separately. However, we saw much of the training on their schedule was still to be completed, such as first aid, safeguarding and risk assessment training. We queried this with them and they said the information they had sent was not complete.

We concluded the lack of training in key areas meant there was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff did not always have the competence and skills to carry out their duties.

Staff told us the manager carried out monthly spot checks of their practice in relation to medicines competence. The manager told us they checked staff practice and assessed their competence through working alongside staff. Records showed where spot checks had been carried out, although without evidence of the manager's own training and competence it was not possible to say how valid the spot checks were.

The manager told us staff supervision was every four months. Supervision notes showed staff met with the manager to discuss matters affecting their work, including training needs and performance. Where there were concerns about staff performance we saw this was documented in supervision notes and competency checks were carried out. However, subsequent appraisal documentation did not refer to the errors in practice.

Staff supported people with frequent hot and cold drinks and we saw there was regular provision of snacks in between meals. For example, people had access to the snack trolley which contained fresh fruit and crisps as well as diluted juice. When people chose to sit outside on the warm day of the inspection, staff brought drinks to them in the garden and reminded them of the need to keep drinking these.

Staff offered people the choice of two meals for lunch and patiently explained what each choice was. Staff offered one person 'corned beef or chicken korma' and the person said, "Chicken who?" so staff described what was in the meal and said it would be spicy, although there were no visual choices offered to help the person to decide.

People we spoke with told us they enjoyed the food. One person said, "Marvellous, the meals here, just marvellous. There's everything I want". Another person said, "I like the food, yes it's very tasty". One relative we spoke with said their family member had lost weight and the staff had helped them regain this. Another relative said they often saw the meals and were always invited to stay for a meal if they were visiting.

We observed breakfast and lunch. Staff we spoke with had a good understanding of people's dietary needs

and we saw people were appropriately supported at their own pace if they needed one to one staff attention to eat their meals. However, we noticed two people at lunchtime who could eat independently but had not attempted to eat anything and staff did not encourage them until we mentioned this.

People chose when to get up and we saw breakfast was offered on an individual basis at people's preferred times. We saw one person chose to get up late in the morning and they finished their breakfast at 11.10. However, we saw at 12.00 they were offered their lunch, which meant it was likely they were not hungry. They declined their lunch and staff said they would save this for later.

At the last inspection staff did not have regard for one person whose diet was vegetarian. At this inspection, we found the person with a vegetarian diet was offered a choice of suitable meat-free alternatives and the menus we saw reflected these were regularly available. There were menus on the table for people and staff explained to people what the choices were. However, we found what was on the menu was not being offered.

At the last inspection we had concerns about the monitoring of people's nutrition and hydration. At this inspection people's risks around eating and drinking were recorded in the care plans and there was appropriate referral to other professionals, such as the GP where people were at risk of malnutrition. Staff we spoke with said they were aware of the need to weigh people monthly, but more frequently if there were concerns. Staff gave examples of when they had monitored one person closely until their weight became stable. However, we found nutritional risks were not effectively managed for those who should have been weighed weekly were not. There was no guidance on action staff should follow in people's care records.

We noted one person had a fluid balance chart to monitor how much they were drinking, but there was no fluid target per day for staff to know whether they had had enough to drink.

We spoke with one of the cooks. They were aware of people's dietary needs and individual preferences. They showed us a range of vegetarian food products, which they said had improved since the last inspection. The cook knew which people required soft diets and we saw these were provided according to their needs. The cook showed us food was dated when opened and there were adequate food supplies in the home for people.

We noticed all crockery was made of coloured plastic and asked the manager if they felt this was dignified or person-centred for all people to use these. The manager told us they had considered people's ability to handle cups independently as sometimes these were heavy and difficult to manage. They told us they had chosen light weight plastic in colours that were easy for people to identify for people who may be confused, in order to encourage and promote people's hydration. However, they said they would consider a more individual approach and give people choices of different crockery.

Staff communicated well with one another to meet people's needs. Staff we spoke with told us there was effective teamwork and we saw the manager was actively involved in people's care and support, working alongside the staff. For example, when one person needed encouragement to move from their chair, staff invited the manager to offer encouragement as a different face. When one person asked for a drink, the manager offered prompt support.

We heard part of a staff handover between shifts and this was informative so the staff coming on duty were briefed about people's needs. Staff said if they had been off work they always checked whether there had been any changes to people's needs when they came on duty.

Staff meetings were regularly held and there were minutes of these, illustrating staff discussed practice issues and ongoing improvements to the home and people's care.

Is the service caring?

Our findings

There was a friendly and homely atmosphere with evidence of good relationships between people and staff. People were treated as individuals and staff demonstrated an understanding of their personal preferences for care. People approached staff spontaneously for hugs and staff responded with warmth and affection. When staff spoke with people they positioned themselves at face level with good eye contact and allowed time for people to respond.

People enjoyed friendly banter with staff who laughed with them. One person said, "We never stop laughing do we? It's marvellous here". Another person said, "Oh I am happy you know". Another person said, "They kill me with kindness". One relative we spoke with said their family member was very happy living in the home and they 'certainly felt it was home'. Another relative told us, "They don't just care for my relative but for all of us too". They told us how the staff had facilitated a wedding anniversary party in the home and organised a singer and a buffet, so all the person's family could attend. Another relative said, "It's a really friendly and homely place. All staff make you feel welcome. You feel like they are friends".

All staff we spoke with said the care at Victoria Lodge would be good enough for their own relatives. Staff involved people with good explanations when supporting them with care tasks. At the last inspection we had concerns about people's privacy and dignity and staff did not always speak appropriately within people's hearing range. At this inspection we found people's dignity was respected, staff spoke discreetly in people's ear when asking them if they needed any support and knocked on doors before entering bedrooms and bathrooms. People were appropriately dressed in clothing that was clean and smart and staff supported people to maintain their dignity, such as helping them to adjust their clothing if it became ruffled.

The activities coordinator was also the designated dignity champion for the home and they understood the importance of ensuring people's dignity and privacy were promoted. They told us they had done some online dignity champion training as well as carrying out some research into good practice for dementia care. This had helped them to develop a dignity tree which was displayed in the home and showed examples of how people's dignity could be supported.

People's independence was supported and encouraged. Staff spoke with people about how they could assist themselves with their mobility and people were encouraged to do as much for themselves as they were able.

The manager told us one person's health had deteriorated recently and they were expected to be at the end stage of their life, although they had regained some good health and shown signs of improving. Their care plan recorded they did not wish to discuss their end of life wishes.

People's diverse identity needs were recorded in their care records and detailed in their life stories. Staff's caring and committed approach was a key strength of the service, in spite of the shortfalls in all of the other domains and the weaknesses in the leadership and management of the home.

Is the service responsive?

Our findings

At the last inspection we found activities required improvement. At this inspection we found people were meaningfully engaged in activities relevant to their interests of their backgrounds. Staff told us positive stories of engagement and we saw practice reflected what staff said. For example, one person had worked in education in their working life and staff told us they had been concerned at the person's withdrawal from communication. They had used their knowledge of the person's work history to introduce some story books and a doll. We saw the person engaged extensively with the doll during the inspection, read to it and chatted constantly during the day.

Another person was interested in gardening and we saw there were fresh flowers delivered for them to arrange. We also saw the maintenance staff brought some lavender in from the garden and staff encouraged people to smell this, which triggered some conversation.

In the lounge area the television was playing, although no one was watching this. We saw the activities coordinator sat with one person and massaged their fingers; the person said they had an ache in their hands and fingers and said they felt better afterwards.

In people's activity files we saw there were individual pen pictures as well as details of the activities they had been involved in. People's life story books and personal interests were recorded as well as information about the important people in their lives and their fondest memories. The activities coordinator was knowledgeable about this and used this information to plan purposeful activities, including for times when they were not on duty, such as weekends. Where additional support was needed for outings, such as a planned barge trip, families and staff were asked to provide this. The activities staff told us one person used to play in a brass band and so they had done some fundraising to enable a brass band to play.

Staff engaged with people in conversation about their previous work, such as in the coal mines. People were offered newspapers and staff sat with them to discuss the day's headlines. Staff reminded people what was topical in the news the day before and then read an update from the local newspaper.

It was warm and sunny during the inspection and staff opened the garden doors so people could go outside. We saw some people sat outside under a parasol and had sunhats on whilst a member of staff offered to walk round the garden with another person. One person told us they liked to see the washing on the line. Whilst people were outdoors, staff brought them drinks and checked they were comfortable.

Staff told us they were designated key workers for named people. Staff said they tried to read people's care plans to keep up to date with information. We looked at five care records in detail. We found information about individual people in their care plans was written in the first person and where people's care needs changed their plan was updated. However, some information did not relate to the plan it was written in. For example, one person's mental health care plan had information about their catheter care. We found information was unwieldy, fragmented and cumbersome with separate files of information; some information was updated in one record but not in another. It was not always clear what dates referred to,

whether information was completed or reviewed. This meant there was a risk people's needs could be overlooked.

Information in care plans was at times conflicting. For example, one person's care plan stated 'I am a little deaf', yet further stated 'I can hear well'. We also noticed inaccuracies which were, as at the last inspection, in keeping with copying and pasting information. For example, in one person's record it stated the wrong name. In one person's moving and handling assessment, there was no date of when this had been done. One person's record said they were in room 17, but they were in room 21. Another person's record contained information at the front of the file, which did not relate to the subsequent care plans. For example, it stated, "I have a pressure care mattress", yet this was not referred to in the care plan or in place.

Where people had specific health needs, such as diabetes or epilepsy, there was no detailed care plan for staff to know how to manage people's care and respond to concerns should they arise. Where people were at risk of pressure ulcers it was not always clear from daily records when their skin integrity had been checked, although staff assured us regular checks were made and we found this information in another file.

There were statements in the care plans which said these would be evaluated on a monthly basis, and although we saw evidence of some monthly audits, this was not consistently done.

We concluded there was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because records relating to the care and treatment of each person were not always fit for purpose.

At the last inspection we found information about how to complain was not accurate for people or visitors to raise any issues. The manager told us there had been no complaints since the last inspection. At this inspection we saw there were no recorded complaints and the complaints procedure was displayed in the entrance for people and visitors. Staff told us they would always make sure people were supported to complain if they were unhappy and they would bring any complaints, no matter how minor, to the manager's attention. The manager told us that people's views were taken seriously and if there was even a minor grumble voiced by any of the people, this would be recorded and responded to in line with the complaints process.

Is the service well-led?

Our findings

At the last inspection we raised concerns the manager had not put an application to CQC to become the registered manager. At this inspection, the manager's application was in progress and they had been interviewed by a CQC registration inspector and they were awaiting the outcome.

Also at the last inspection we identified weaknesses in the quality assurance processes in the home. At this inspection we looked at documentation relating to the running of the home and the provider's quality assurance processes.

We found although there were audits in place, these were still not all robust enough to identify weaknesses we had found at the inspection. For example, the environment audit for the kitchen and the laundry did not address areas in need of deep cleaning. The kitchen audit was repeatedly rated 'green' using a red, amber, green system (green meaning no action required, amber, some action and red, immediate action), but it was not evident who had carried out this check.

The manager told us audits were regular and the frequency was variable depending on what aspect of quality was under review. The manager showed us an action plan which they had completed in relation to the previous inspection. The provider's statement of purpose had been updated since the last inspection, although there was still a minor reference to the previous manager which had not been updated. We saw maintenance records for the premises and general equipment, including fire safety and precautions. The last fire risk assessment was dated 2015 and the manager said they were waiting for a fire officer visit.

The weekly environment audit dated the week of the inspection, made no reference to the issues found at this inspection. Although there were records stating regular reviews, audits and spot checks were done, we found these were not robust and did not cover all areas.

We saw individual equipment checks were not always consistent with what was written on people's care plans. For example, for one person who required bed rails the care plan stated this equipment was 'checked twice daily', yet we saw the equipment checklist showed only one recorded check each day.

As at the last inspection we found there were still errors, omissions and conflicting information in care plans, none of which been identified by the audits carried out.

Records showed the provider carried out regular visits to the home. The manager told us the provider had visited after the first day of the inspection and had discussed weaknesses in the auditing of the quality of the service. As a result, the environmental audit was delegated to the deputy manager to complete.

Policies and procedures were displayed on the wall in a central area and the manager told us this was improved since the last inspection. However, we found these contained outdated information prior to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We looked at policies and procedures in the office, which were dated 2012 and 2015. The manager acknowledged these were out of

date and said they would check with the provider if they were still required.

Documentation in use was seen to be a combination of adapted examples from other organisations, rather than specific to the needs of the people in the home. For example, the 'post fall individual environmental checklist' was adapted from Southend General Hospital, general risk assessments had headings from one of the provider's other homes. The policies and procedures were generic and devised by an online consultancy company, for adaptation to the needs of the service. The manager confirmed an external company was used to provide policies and procedures and they sent us an online link to these, which we looked at.

The manager was very visible in the home and had a good understanding of each person and their needs. They were actively and enthusiastically involved in people's care and spent time involved in care tasks alongside staff. However, we found there was a lack of clear and knowledgeable management oversight of the quality of the provision and the systems and processes needed to drive and sustain improvement.

Staff we spoke with told us there had been improvements in the way the home was run. One member of staff said, "We have a really good team at the moment, in the last 12 months. We can approach the manager or deputy and they listen to us and respond". Another member of staff said, "We work well together and the manager supports us, gets involved in people's care. The home is run well, getting to be loads better". Staff said there had been poor publicity for the home since the previous inspection and one staff member said, "We're working really hard and hopefully we do move forward".

Staff said there was an open and honest culture in the home. They made comparisons between the way the home was previously run and reported not having been listened to prior to the current manager being in post. They told us the manager was very responsive and 'always available'. One member of staff said, "We can always contact [manager's name] and they are there whenever we need them". Another member of staff said they were actively encouraged to raise issues and seek advice.

We spoke with two visiting doctors who said they were made to feel welcome and staff were responsive to any advice and support offered regarding people's care. One relative we spoke with said there had been a 'noticeable improvement' in the way the home was run. Another relative said, "I can't fault it, they involve us".

We noted the manager and the staff team were working hard to address the concerns raised at the last inspection and they had made positive changes, particularly in relation to people's dignity and activity provision. The manager was very responsive to matters raised at this inspection and took measures to address the issues we raised. However, there were continuing concerns at this inspection in relation to the oversight and management of risk, documentation to support people's care and the running of the home and governance.

We concluded there was a continued breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because there were weaknesses in the leadership and management in the home.

There is a requirement for the registered provider to display ratings of their most recent inspection. We saw a poster displaying the ratings from the previous inspection was on display within the home. There was no website for the ratings to be displayed.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not effectively assessed or mitigated. There was poor prevention for the spread of infection and staff did not always have the competence and skills to carry out safe care.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records relating to people's care were not consistent or accurate. There were continuing concerns at this inspection in relation to the oversight and management of risk, documentation to support people's care and the running of the home and governance.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not have the skills and competencies to carry out their roles.