Care Quality Commission

Sudera Care Associates Limited

Ridgeway Nursing Home

Inspection report

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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

Overall summary

This inspection took place on 6 and 13 October 2015 and was unannounced. We had previously inspected the service in December 2014, where we found breaches in the regulations for person-centred care, safe care and treatment, good governance, premises and equipment, dignity and respect, the need for consent and staffing. We set requirement notices for these regulations and the provider sent us an action plan detailing how they were going to meet them. At this inspection we found the improvements we required had not been made.

There was a registered manager in place at Ridgeway Nursing Home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service is registered to provide nursing and residential care for up to 37 older people. At the time of our inspection 33 people were being cared for, including people living with dementia.

Arrangements were not in place to ensure covert medicines were administered safely. Risks at the location were not well managed and appropriate actions to reduce risks were not taken. Parts of the building still had

Summary of findings

insufficient hot water. People did not always experience safe or timely care because sufficient staff were not at all times deployed to meet people's needs appropriately. People told us they felt safe, and staff had been trained in, and understood how to protect people, should they be at risk of abuse.

Not all staff had the skills, knowledge and competence to meet people's needs, even though they had received training. People were at risk of not having their day to day needs met safely because staff did not always show the required levels of competence in their role. The registered manager had not applied the principles of the Mental Capacity Act 2005 to how people consented to their care and treatment. People enjoyed the food on offer and had different menu options to choose from.

People's experience of care varied because a caring approach that supported people's dignity and promoted their independence was not demonstrated consistently by all members of the staff group. We observed some practices which did not support people's dignity or privacy. Although people were asked to sign their agreement and consent to their care plans, some people's views on their care and support were not obtained or recorded.

People did not receive personalised care that was responsive to their needs. Care plans did not always reflect people's care needs accurately. Efforts were made to provide people with activities and support their interests, although not all staff, in the absence of the activities coordinator, contributed to sustaining a stimulating environment for people. People had opportunities to provide feedback on the service, but complaints were not always learned from.

We were concerned that the registered manager and provider had not taken effective action to fulfil their responsibilities to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems and processes in place to check on the quality and safety of services provided were ineffective. When concerns or issues were raised, improvements were not made or sustained. The service was failing in its aims to provide good quality, personalised care.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People were not protected from risks and some people were not protected from the risks associated with medicines.

Sufficient staff were not always available to meet people's needs in a safe or timely manner.

Recruitment processes checked staff were suitable to work at the service and staff had been trained in how to safeguard people using the service.

Inadequate

Is the service effective?
The service was not effective.

Not all staff had the skills, knowledge and competence to meet people's day to day needs effectively.

The registered manager had not always applied the principles of the Mental Capacity Act 2005 to people's decision making processes in respect of their care and treatment.

People had access to sufficient food and drink of their choice.

Inadequate

Is the service caring?
The service was not consistently caring

Not all staff understood and implemented the principles of dignity and respect in their work.

Not all people received care that met with their wishes and preferences.

Some staff, but not all, maintained warm and caring relationships with people using the service.

Requires improvement

Is the service responsive?
The service was not responsive

People were at risk of not receiving personalised and responsive care, as staff did not always follow care plans or ensure such plans accurately reflected people's needs.

Although efforts were made to support people with their interests and hobbies, not all staff contributed to a stimulating environment for people.

People and their families had opportunities to provide feedback.

Requires improvement

Is the service well-led?
The service was not well led

Inadequate

Summary of findings

The registered manager and provider had not taken appropriate actions to fulfil their responsibilities to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems designed to check on the quality and safety of services people received were ineffective.

The service was failing in its aim of providing good quality, personalised care and support.

Ridgeway Nursing Home

Detailed findings

Background to this inspection

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

This inspection was unannounced and took place on 6 and 13 October 2015. The inspection team included two inspectors, a specialist professional advisor, with experience of nursing and an expert by experience, with experience of caring for an older person. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed relevant information, including notifications sent to us by the provider. Notifications are changes, events or incidents that providers must tell us about. In addition, we spoke with health and local and authorities responsible for contracting and monitoring people's care at the home.

We spoke with five people who used the service, however not everyone who used the service could fully communicate with us. We therefore completed a Short Observational Framework (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. During the inspection we also spoke with six relatives of people who used the service. We spoke with nine members of staff, as well as the registered manger and the provider. We looked at five people's care plans at length, in addition we looked at specific details in care plans and risk assessments for other people. We reviewed other records relating to the care people received and how the home was managed. This included some of the provider's checks of the quality and safety of people's care, staff training and recruitment records. We also spoke with three health and social care professionals and reviewed previously written feedback from another healthcare professional.

Inadequate

Is the service safe?

Our findings

At our previous inspection in December 2014, we asked the provider to take action to protect people from the risk of receiving care or treatment that was inappropriate or unsafe, as assessments were not in place to minimise such risks. Also, systems and plans to protect people in an emergency had not been maintained and updated. We also asked the provider to take action to protect people from risks associated with medicines. This was because safe and proper arrangements were not in place to manage covert medicines and medicines that were required 'as and when'. These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On this inspection we found guidelines had now been included for medicines prescribed 'as and when required'. However improvements in the management of covert medicines, actions to mitigate risks to people in an emergency, actions to ensure people received safe, appropriate care and treatment had still not been made.

At this inspection we found a covert medicines contract had been introduced that prompted staff to confirm the treatment plan had been discussed with the GP as well as stating a pharmacist must give advice if the administration of medicines involved it being crushed or combined with food. The policy in place for covert medicines also stated the method of administration should be checked by a pharmacist and that staff should never crush tablet or capsule medicine and mix it with food or drink unless told they may do so by a pharmacist. This is because this practice is potentially dangerous. We found the covert medicines contract had been signed by the GP for one person, but not for the other person receiving covert medicines. In addition, for both people receiving medicines covertly, their care plan stated staff were to mix it with food. However for both people, no pharmacist advice had been obtained, as clearly stated in the service's own policy and covert medicines contract. This meant that the service had not obtained specific pharmacist advice on any potential contraindications of medicines mixed with certain types of food, for example, milk. The service was not following their own policies and procedures for the administration of covert medicines and could not demonstrate they had taken appropriate action to ensure people received their medicines safely.

Relatives we spoke with told us, "[My relative] gets his tablets on time." Another person told us a recent change to their relative's medicine had led to an immediate improvement, saying they were, "Much improved, much better." However, one person told us about an unwanted side effect to their relative's medicine and we brought this to the attention of the registered manager so they could review it. We found guidelines for the administration of medicine required, 'as and when' had been updated to include details of when this was to be administered to people. We found staff recorded medicines given on medicines administration record (MAR) charts. We found that for medicines other than creams and lotions, the MAR charts had been accurately completed. Records of administration for creams and lotions contained gaps where staff had not signed to say these medicines had been given, or if not given the reason why. We were therefore not assured people received medicines as required, as staff did not record the reason why they had not been given.

We also found that people who required the use of equipment to treat their health condition were at risk of not receiving this care safely. This was because there was no care plan to ensure such equipment was used safely and that any risks associated with its use were assessed and mitigated. For example, one person told us they occasionally needed oxygen and we could see they had oxygen and an oxygen condenser available in their room. Records showed the person had been discharged from hospital with oxygen and an oxygen condenser over five weeks before our inspection. The registered manager told us the person did not require oxygen and no care plan was in place, however this was contrary to both what the person told us and how they had been discharged from hospital. On the second day of our inspection a care plan had been put in place however this lacked detail as to when the use of this treatment should be offered to the person. This person was at risk of receiving inappropriate and unsafe care because guidance to staff lacked sufficient detail on how to meet this person's care needs.

Several people had been assessed as being at risk of dehydration and as a result staff were required to monitor their fluid intake. The assessment tool used to calculate whether people were at risk of dehydration stated staff were to total the fluids consumed every 12 hours and if a person drank less than 1.5 litres a day staff were to monitor their urine output. We looked at the records of four people

who had been assessed as needing their fluid intake monitoring. Three out of the four people's records showed they had taken very low levels of fluids the day previous to our inspection. The low fluid intake for these people had not been totalled, nor had it triggered the monitoring of people's urine to obtain a more specific assessment of their hydration levels. We checked the care plan for one of the people recorded as having very little fluid and found that a health professional had recorded they were concerned that this person's oral intake was poor and they were at risk of malnutrition and dehydration. In addition, another person required monitoring of their fluid intake and output to help prevent urinary tract infections. The fluid totals for this person were not totalled and no output charts were in place. No effective monitoring to help prevent urinary tract infections for this person was in place. The provider had not, after assessing people to be at risk, taken all reasonable steps to mitigate those risks to them.

At our last inspection we found an automatic door release (dorguard) was broken and the door was being propped open by furniture. Dorguards are designed to safely hold open a fire door and automatically release the fire door should the fire alarm be activated. During this inspection, two dorguards did not work at all, including the same dorguard identified on our previous inspection. Others were intermittent, and some were making a beeping sound to indicate they had a low battery. Some fire doors were propped open with pieces of furniture. This was unsafe practice as the fire doors would not automatically close in the event of a fire. During our inspection staff struggled to get some dorguards to work resulting in doors being closed that were usually open. This impacted on people using the service. One person was heard to repeatedly ask, "Please can we have that door open a bit, there's no air in here." Staff were not able to open the door safely until later on in the day.

We found another object fitted across a person's bedroom door in the evening would have also prevented the fire door from closing. We also found a hoist left in front of and obstructing a fire escape door. We saw the doors to the linen cupboard were not always kept locked, as instructed, so as to mitigate the risk of flammable materials, should there be a fire. Other fire safety measures were not in place, because special seals on bedroom doors to prevent smoke and fire penetrating were missing. In addition, the keypad to the front door was not working and staff had to fetch a key each time people wanted to leave the premises. Some relatives told us the keypad had been broken for several weeks. We were concerned this could present a hazard should an evacuation of the premises be necessary. This meant people were at risk because actions designed to mitigate the risk of harm to people should there by a fire were not being followed. We notified the fire and rescue authority of our concerns.

We found other risks had not been identified and mitigated. People had call bells by the side of their bed, however for one person the cable was missing and this meant they could not use the call bell. When we looked at this person's care plan it stated that the person had the call bell to use in addition to staff checking on them. When we brought this to the registered manager's attention they were not aware that this person did not have the use of a call bell. An appropriate risk assessment to minimise the risk to this person had not been put in place. These issues were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection in December 2014, we asked the provider to take action as people were not protected against the risks associated with unsafe or unsuitable premises as parts of the building had insufficient heating and hot water. We found that a significant proportion of the people without hot water in their ensuite rooms were given bed baths, and for one of those people their preference had been to have a shower. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On this inspection we found that there was still no hot water at the hand-wash sinks in three out of the four ensuite rooms identified. The water in the fourth ensuite was intermittent. We requested the hot water temperatures for the four ensuite showers and these ranged from 25.1 to 31.3 degrees Celsius. Records for the communal shower room showed shower temperatures in the range of 38 degrees Celsius. Staff told us the water temperature was variable depending on the time of day and the demands being made on the hot water system. People still experienced insufficient hot water in their ensuite rooms. We were also concerned that the lack of hot water could affect the effective control of legionella disease. We notified the health and safety executive of our concerns. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Inadequate

Is the service safe?

In addition, some areas of the service were in need of repair and maintenance. We showed the registered manager areas of flooring in a communal bathroom that were torn and they could not tell us what plans had been made to repair or replace the flooring. We found other areas of disrepair around the service, including broken bath panels and rust on some equipment. We were not assured that the registered manager knew about these or had an action plan in place to secure improvements.

At our last inspection we asked the provider to take action as people's health, safety and welfare was not safeguarded. This was because appropriate steps had not been taken to ensure that, at all times, there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed. Suitable arrangements were not in place to ensure staff delivered care and treatment to an appropriate standard by receiving training, professional development, supervision and appraisal as necessary for them to carry out their duties. These were breaches of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. On this inspection we found sufficient improvements had not been made.

One person told us the staff were, "Very nice normally, but at the moment they are very short of staff. They don't come quickly when you ring the buzzer; they come when they come, but all are nice." Another person told us, "You have to wait a long time for staff to come." Although on the day of our inspection we observed staff responding to call bells in a timely manner, we found evidence this was not always the case. Minutes from a staff meeting showed members of staff had raised concerns about the high percentage of less experienced staff on shifts in July 2015. In this meeting staff reported to the deputy manager that it was taking some staff 42 minutes to answer a person's call bell. There was nothing recorded to say what action would be taken in response to this excessive and unsafe response time. We found other examples where staff were not meeting people's needs in a timely manner. During our inspection we observed one person who was in their room. The person was not able to tell us their preferences, however staff told us they sometimes liked to get up and be taken into the lounge. However at 11.30am the person was still in their room and staff had not had the time to spend with this person and ascertain whether they would like to get up and spend time elsewhere in the service. Therefore we were not assured that sufficient numbers of suitably competent and experienced staff were being deployed to meet people's needs.

In addition, we saw written feedback from some relatives who were concerned that at times there were no staff present in the lounge area. People using the lounge area were at risk of falls and would therefore need prompt attention from staff. We found that a person had fallen in August 2015 and, as part of the accident review, an action to mitigate future risk stated, 'always ensure the staff member allocated for the lounge does not leave residents alone.' During our inspection we observed a period of time when no staff were present in the lounge area and therefore the action identified to mitigate any further risks to people was not being followed. People were at risk because staff were not, at all times, deployed in sufficient numbers to meet their needs and ensure their safety.

We were also aware of some people using the service who required the assistance of two members of staff to help them move around. We were made aware from speaking with these people directly, or their relatives, that there was not enough staff to assist them to go outside. Being able to go outside was an identified preference for both these people and their opportunity to do so was significantly reduced by inadequate staffing levels.

The registered manager told us they had calculated the number of staff required to care for people based on individual levels of need. Staff rotas showed that most of the time staffing levels were maintained at the level set by the registered manager, however on some occasions the staff rotas showed these levels were not always achieved. In addition, we could not see how the registered manager had personalised the staffing dependency tools they sent us to show how the amount of staff required to meet people's needs was determined. For example, some tools were not filled in and some did not have dates of assessment or people's names added to the assessment tool. In addition, the registered manager told us nine people using the service required the assistance of two members of staff to help them get up and move around. On the assessment tool sent through by the registered manager we could not see how the time required for two members of staff had been reflected in their calculations

Inadequate

Is the service safe?

and therefore we were not assured that the staffing levels had been properly considered on an on-going basis. These were breaches of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff recruitment records showed the registered manager had completed the required recruitment checks to assure themselves people employed were suitable to work in the service. Most people told us they felt safe living at the service, one person told us, “Yes, I feel safe.” A relative told us, “I’ve no qualms about the place.” We could see staff had attended training in safeguarding vulnerable adults. This helped reduce risk to people using the service.

Inadequate

Is the service effective?

Our findings

At our previous inspection we asked the provider to take action as mental capacity assessments did not meet with the full requirements of the Mental Capacity Act 2005 (MCA). Where people lacked the capacity to consent to decisions, suitable arrangements were not in place to ensure all staff acted in accordance with authorised restrictions on people. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found sufficient improvements had not been made.

At this inspection, some people using the service had dementia and other health conditions that may have meant they lacked the capacity to make some decisions about their care and treatment. Where people lack capacity decisions should be made, in accordance with the principles of the Mental Capacity Act 2005 (MCA). The 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 the best interests and as least restrictive as possible.

One person did not have a capacity assessment in place as part of the process to decide if administering medicines covertly was in their best interests. In addition, people had recently received an annual influenza vaccination. We found that where people may have lacked the capacity to consent to this vaccine, their decision making had not been taken in line with the principles of the MCA. In addition, we found a relative had signed a person's agreement and consent form to their care at the service. There was nothing on file to indicate the person did not have capacity to sign this themselves and therefore this was not in line with the principles of the MCA. These were breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Some people using the service lacked the capacity to consent to live there. The registered manager told us they had identified six people who required an assessment for a Deprivation of Liberty Safeguard (DoLS) to ensure the restrictions on them were lawful. We saw these applications had been made to the local authority. However, we heard two additional people who used the service expressing their wish to leave. One person said, "Can you open the front door for me to get out, I want to go and see [my relatives]." We made the registered manager aware that these people clearly had restrictions placed on their freedom. Therefore they should consider whether the restrictions constituted a deprivation of their liberty and, if so, submit an application for these additional people.

At our last inspection in December 2014, we made a recommendation that the service finds out more about training for staff, based on current best practice, to ensure that staff have the skills to meet the needs of people using the service. At this inspection, although training for staff was mostly up to date, some new staff had not yet been trained in person centred care, care planning and nutrition. Some further training on dementia had also been planned at the time of our inspection. We were still concerned that some staff demonstrated unsafe practice and did not have the skills and knowledge to meet people's needs, based on current best practice.

People did not receive care that was based on best practice. At this inspection, one person told us, "I wouldn't recommend this place, staff are a bit rough with you." During our inspection, we observed a member of staff lift a person out of a chair by lifting them under their arms. The person cried out as the staff member lifted them, indicating they had been hurt by the lift. We also saw this member of staff, and other members of staff, assisting people to move in wheelchairs in ways that were not in line with best practice. When we spoke with staff about their practice they showed no insight into the risks people experienced when best practice principles were not applied to assisting people to move. Not all staff demonstrated the necessary skills, knowledge and competence, despite having received training, induction and supervision in areas relevant to their job role. This was because they had not embedded the principles of training into their day to day practice with people.

Not all staff demonstrated sufficient knowledge of people's dementia care needs. One person living with dementia displayed signs of wanting to use the toilet. After thirty minutes one member of staff prompted the person to visit

Inadequate

Is the service effective?

the toilet. The person's care plan stated they needed supervision and guidance to use the toilet. Staff did not provide this and this resulted in the person not being able to use the toilet appropriately. People did not receive the support required for their dementia needs as staff did not follow the guidance in care plans nor identify signs and triggers associated with people's dementia care needs. These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us the food was good. One person told us, "Food is fine and you get a choice." Other people told us they could request something different and the kitchen staff would supply it for them. One relative told us the food was, "Excellent." We saw fresh fruit and drinks were available for people who were able to help themselves to these refreshments. People had two different hot meal choices as well as sandwiches if this was their preference. We sat and chatted with people over lunch and found they had enjoyed their meal and that it was well cooked and hot. Where people required assistance to eat, we observed staff provided this support. Most, but not all, of the staff provided this support effectively. We saw some staff took their time and were gently encouraging with people to help them to eat. However, we observed another member of staff show signs of exasperation when a person would not eat straight away.

We were not assured that people always had their day to day needs met. This was because, for example, records did not demonstrate people had received enough fluids to prevent them from becoming dehydrated, or that mouth care was provided as required. Staff told us they found relationships with other professionals beneficial. We were aware of regular visits from health and social care professionals involved with people's care and we spoke with, and reviewed written feedback, from some of these other health and social care professionals. Other health and social care professionals considered people's day to day needs were met, although some expressed concern that communication was not always effective. Examples included concerns that information and instructions had not reached staff delivering care and that on occasion no staff had been able to, in the absence of the registered manager, provide information on people's health conditions.

Requires improvement

Is the service caring?

Our findings

At our previous inspection we asked the provider to take action as people were not always treated with dignity, consideration and respect. In addition, people's independence was not always supported. This was a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014. On this inspection we found sufficient improvements had not been made.

At this inspection we found staff had not always promoted people's dignity and respected their privacy. We observed a member of staff take a person from a bathroom to their own room in a wheelchair. The person's hair was still wet and they were not dressed. The member of staff had only wrapped them in towels, however these did not fully cover the person and their naked hip was exposed as they were transferred in their wheelchair to their bedroom. This demonstrated a lack of respect and did not offer the person sufficient privacy or promote their dignity.

We saw another person had their bedroom door open when they were still in bed. The person had no covers on them and their underwear was exposed. Staff were present in the corridor area outside their bedroom, however they did not recognise the need to take action to cover the person and promote their dignity.

On another occasion we observed a person using the communal areas of the service in their nightwear for an hour. As they walked around their nightwear was affected by different lighting levels and became transparent on occasion. When we spoke with the registered manager about this person they told us they had refused to get dressed. However, at no time during our observations of interactions between staff and the person concerned did any staff member recognise or respond to this situation. For example, by encouraging them to get dressed, or providing a garment that covered them more sufficiently. This person's dignity was not promoted.

We saw that one person required a hoist to help them move. We observed this person being assisted to move with the hoist, in a communal area, on two occasions. On both occasions, the person's thighs were exposed and staff did not attempt to cover their legs. This was undignified and demonstrated a lack of respect for the person.

Staff did not always consider people's comfort and well-being. For example, one person's dorguard on their bedroom door was continually beeping to indicate a low battery. Not only would this sound be constantly present for the person whose room it was, the person opposite their room was cared for in bed. Their bedroom door was open and so they also had a constant beeping noise to contend with. The person whose bedroom door was beeping told us, "I'd wondered what that noise was." Allowing a constant beeping sound to be present near people's bedrooms was not demonstrative of a caring or considerate attitude.

Although we saw people had been asked to sign consent to their care plans and relatives had been invited to review meetings, people's autonomy and independence was not always supported. One person told us they preferred to eat their meals without the presence of, or assistance of staff. This happened on one of our inspection days, however the person had not been provided with a plate guard to help them eat their meal independently. Staff told us there were not enough plate guards for everyone that needed them. This did not promote people's autonomy or independence.

On the second day of our inspection staff stayed with this person and assisted them with their lunch, even though the person had told us they preferred to eat in privacy, unassisted by staff. The person's care plan stated staff were to stay with them as there were risks associated with them eating their meals alone. The care plan did not reflect how the person's own views, preferences and their right to make decisions over risks had been taken into account. The person's own wishes for privacy had not been considered, nor had they been supported in their autonomy and independence. These are breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found communal toilets were not available for people to use without staff assistance because they were kept locked by bolts that were inaccessible to people using the service. In addition, some toilets could not be locked from the inside to ensure people's privacy and dignity. At this inspection, people could not always access toilets independently, despite some people being able to do so.

Communal toilet areas that the registered manager told us were definitely kept locked still had dementia signage on them to remind people living with dementia that the toilet was there. However, this signage was not used appropriately as it was used on toilet doors that people

Requires improvement

Is the service caring?

could not access independently. In addition, one of the toilets that we were told by the registered manager was used by people independently could not be locked from the inside to ensure people's privacy. Improvements from our last inspection had not been made. The service did not always support people in their independence and autonomy.

However, we saw other examples that showed some staff had developed positive and caring relationships with people using the service. One member of staff supported a person with their meal in a caring way. They asked what the person would like to start eating first and showed care and respect for the person while offering them assistance. Other staff were seen to use a hoist to move a person with care and respect, and other staff had conversations with people using the service while helping them. We also saw that staff knocked on people's bedroom doors before entering and closed doors when assisting people with their personal care. Some staff supported people with dignity and respect but this was not consistent throughout the service.

Requires improvement

Is the service responsive?

Our findings

At our previous inspection we asked the provider to take action as people were at risk of not receiving personalised care because not all staff knew how to appropriately meet the needs and reflect the preferences of service users when providing care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found there had been some improvements made for some people and their care had been reviewed. However, we also found other people were at risk of not having their needs met in a responsive or personalised way because care plans either did not accurately reflect people's needs, or staff did not consistently follow them.

People were at risk of not receiving personalised care, responsive to their needs because care plans were either not consistently followed, or were not in place to meet people's needs. For example, staff did not follow a care plan to ensure a person received sufficient fluids and not all staff followed the care plan to administer medicines to a person covertly. We also found no care plan in place for a person on when they needed to use specific equipment. In addition, we observed that people living with dementia, who expressed non-verbal behaviour did not receive a timely response to their expressed needs. People were at risk of not receiving personalised care that was responsive to their needs

The Registered Manager had not always considered people's individual needs and preferences in the way care was delivered. For example, one person's bedroom had a stair gate fitted across it to prevent another person from walking into their room at night. However, no consideration had been given to the impact of this, and there was no evidence to show how the other person's behaviour could be supported. People did not receive care that was responsive to their needs.

In addition, care plans did not show whether people had been asked their preferences for a male or female carer. A male carer was seen to assist a female with personal care, however there was nothing in their care records to indicate any consultation had taken place, to show whether or not this was acceptable.

During our inspection, we saw that some people chose to take part in chair based exercises organised by the activities coordinator. Other people we spoke with told us how they had been involved in using arts and craft to reminisce about the seaside. We could see some people were keen knitters and enjoyed knitting projects. Records showed that the activities coordinator offered a range of personalised activities and met and supported a range of people using the service. One person's activity file recorded, 'The activities coordinator sat with me and we filled in this record together.' However, one person told us they were not receiving personalised support to pursue their interests and hobbies. They showed us some art work they had done previously but told us they had not been offered the chance to do more drawing. They told us, "No activities, there isn't the staff." One relative we spoke with told us there was not enough mental stimulation provided for people. We also observed that some people spent most of the day in the same area of the building and did not change location, even for their meals.

We found that care staff mainly engaged with people when they were supporting them with care or treatment. We observed that when the activities coordinator was not present to engage people in activities or conversation, people experienced increased inactivity and less stimulation, and we saw people passively watching others and then falling asleep. This was the case even when other members of care staff were on duty in the main lounge area. We observed one member of staff just sitting quietly and making no attempt to converse with the people around them. People experienced a varied level of support to engage in activities that were meaningful to them. This was because although the activities coordinator tried to meet everyone's needs, not all staff took the opportunity to converse with people or provide them with stimulation or activity when the activities coordinator was not present.

One relative told us the service had responded positively when they requested a change to their relative's care. Information on how to make a complaint was displayed in the reception area of the service. The registered manager told us they had received a recent complaint about a person not receiving the care they required and they were in the process of investigating the complaint. The complaint was about a person not receiving appropriate mouth care. During our inspection we also found concerns over people not receiving appropriate mouth care and therefore no improvement had yet been made as a result of

Requires improvement

Is the service responsive?

the complaint. The registered manager showed us feedback, since our last inspection, from two visiting health professionals that praised the care and the staff at the service.

We saw meetings with people and their families were organised, and although not many families attended the meetings they did provide an opportunity for people and their families to contribute their views. Recent discussions had included a review of hobbies and interests available for people to try, and contributions from people regarding what events they would like to see organised in the coming months. People also shared their views on the food and had the chance to talk about other things of importance to them. People had opportunities to provide feedback on the service.

Inadequate

Is the service well-led?

Our findings

At our previous inspection we asked the provider to take action to ensure an effective system was in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others. We also asked the provider to take action as records of service user's care and treatment were not always completed contemporaneously. These were breaches of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found improvements had not been made.

We identified significant and ongoing shortfalls in the service provided and improvements had not been made despite a previous inspection drawing some of the issues to the attention of the Registered Manager and Provider. These included actions to improve the hot water supply and to mitigate risks from fire. This demonstrates the registered manager and provider did not take sufficient action to reduce risks to people nor used systems effectively to identify and mitigate risks.

We saw other systems designed to manage and monitor the quality and safety for services provided were also not used effectively by the registered manager. The monthly audits designed to assess the quality and safety of services provided had not identified any actions required for the previous five months. The last audit completed in September 2015 confirmed all wheelchairs were serviced. This audit had not identified the problem with the numerous broken and inadequately maintained wheelchairs that we identified during our inspection. We asked a member of staff who was using a wheelchair with a broken footplate whether the registered manager knew these wheelchairs were being used in a broken condition. They told us, "[The registered manager] knows." The audits had not identified inadequate fire safety practices, inadequate equipment and areas of poor staff practice and were therefore ineffective.

Where issues requiring action had been identified, no action had been taken. For example, an audit completed in April 2015 identified fire doors required accurate dorguards and the batteries should be replaced when needed. No further information had been recorded to show any action taken, and from our inspection it was clear that the action identified in this audit had not been taken.

At our last inspection in December 2014, we identified areas of the building had insufficient hot water and heating and we asked the provider to take action. An audit completed by the registered manager in April 2015 recorded water temperatures in the new wing took more than seven minutes to become hot. The audit identified the Directors would be responsible for taking action on this issue. No further records were completed to show that any further action had been taken. During our inspection, we checked the water temperatures of the showers and hand basin taps in this area of the building and found there was still insufficient hot water. This demonstrated that systems designed to manage and monitor the quality and safety of services were not effective, as no action was taken when issues were identified.

At this inspection we found records were still not made at the same time care and treatment was provided. Staff were unable to tell us what one person, who was at risk of malnutrition and dehydration, had eaten and drunk on the day of our inspection. This was because no entry had been made in their food and fluid chart for their breakfast. Later on in the day we found that a retrospective record had been entered into this person's food and fluid chart detailing their food and fluid intake at breakfast. We observed that other staff had not recorded drinks offered to other people because there were no record sheets available in people's care records for them to record people's fluid intakes on. The lack of maintaining accurate records may place people at risk of inappropriate or unsafe care because their well-being cannot be monitored effectively.

We found the registered manager had, at a staff meeting, discussed the fact that food and fluid charts were not being completed or organised properly in June and July 2015. However, although this issue had been identified, it had not been monitored by the registered manager or provider as we found food and fluid charts were still not completed or organised properly during our inspection. We could not see that the registered manager had taken any effective action to secure improvements and mitigate risks to people.

We found other examples of where care records were not always accurate. We observed fluids being refused by people being monitored for dehydration and at risk of developing pressure sores and staff did not enter these refusals onto people's fluid charts. Prescribed creams and lotions were recorded in files stored in people's own rooms

Inadequate

Is the service well-led?

however these records contained several gaps, so we were not assured people received their topical medicines as prescribed. People were at risk of not receiving appropriate care and treatment because the records to monitor their conditions were not accurately maintained.

We found some people required staff to assist them with their mouth care, however records did not accurately reflect if this had been done or not. Staff confirmed there were no separate records made of mouth care provided to people. We saw some staff had therefore made no record, and some staff made a note on the food and fluid charts. Therefore records of mouth care provided were inconsistent and we could not be assured people were receiving assistance with their mouth care as required.

People's personal care records were routinely left in corridors outside their bedrooms. We found people's care plans left on chairs in a communal lounge area. We also found people's personal emergency evacuation procedures had been left in the reception area. People's personal records were not kept securely and people's privacy was not respected.

The registered manager told us they carried out regular checks of the premises and environments, however, these were ineffective. This was because although the registered manager told us they had walked round the building on the morning of our inspection they did not identify the areas of non-standard practice that we found during our inspection. For example, the registered manager had not noticed yellow clinical waste bins were not being used in waste bins clearly marked for clinical waste. We asked the registered manager why there was a large area of damaged wallpaper in one person's bedroom. They told us this had been decorated and there was no damaged wallpaper. This was clearly not the case. In addition, they had not noticed broken wheelchairs and the poor standard of moving and handling practice demonstrated by some staff. In addition, we found the registered manager had signed the covert medicines policy for the service that stated the administration of covert medicines should be checked and agreed by a pharmacist; however they had not followed this in practice. We were concerned that the registered manager and provider had been ineffective in identifying issues and taking action to secure improvements. These issues were breaches of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The service is required to have, and did have a registered manager in place. Relatives had mixed views on the management of the service. One said, "The managers are quite good, [the registered manger] is alright." However another person told us the registered manager was, "Not visible." We spoke with the registered manager and the provider during our inspection. The provider told us they were, "Surprised," to hear that the improvements we had asked to be completed at our last inspection had not been met to our satisfaction. The registered manager told us they were disappointed that we had found ongoing failures with the safety and quality of services provided to people.

The registered manager had not always notified us of incidents they are required to by law. For example, we found an incident regarding an allegation of abuse made by a person using the service which we had not been informed about.

We could see from the minutes of meetings held with people using the service, their families and staff that people were able to contribute their ideas to the development of the service. We also saw that families and other professionals involved with people's care visited freely. However we also saw staff had raised concerns in meetings with the registered manager over two months ago and we found the same concerns still persisted during our inspection. The registered manager had not taken effective action to ensure the concerns were dealt with and improvements secured.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Where service users lacked the capacity to consent the registered person had not always acted in accordance with the Mental Capacity Act 2005 (MCA). 11(1)(2)(3)(4)(5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Service users were at risk as not all aspects of the premises were suitable for there purpose and being properly used and maintained. 15(1)(c)(d)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Service users' health, safety and welfare was not safeguarded as appropriate steps had not been taken to ensure that, at all times, there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed. Appropriate support was not provided to staff to ensure they embedded the principles of training into their day to day practice. 18 (1) (2) (a)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Service users were not always treated with dignity, consideration and respect and their independence and autonomy was not always supported. 10 (1) (2) (a) (b)

The enforcement action we took:
We cancelled the registered manager's registration with the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Service users were not protected against the risks of receiving care or treatment that was unsafe as risks to service users' health and safety were not always assessed and actions not taken to do all that is reasonably practicable to mitigate any such risks. Care plans and risk assessments were not always in place to ensure equipment supplied for use by service users is safe and used in a safe way. The arrangements for the proper and safe management of medicines were not always followed. 12 (1) (2) (a) (b) (e) (g)

The enforcement action we took:
We cancelled the registered manager's registration with the Care Quality Commission.

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems were not operated effectively to assess, monitor and improve the quality and safety of the services provided. Nor were systems operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.

This section is primarily information for the provider

Enforcement actions

Records of care and treatment provided, and decisions taken in relation to that care and treatment provided to service users were not always complete and contemporaneous. Nor were records always kept securely. 17 (1) (2) (a) (b) (c)

The enforcement action we took:
We cancelled the registered manager's registration with the Care Quality Commission.