The Shaw Foundation Limited

Treetops

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

Following concerns raised about the service we undertook an unannounced inspection on 16 and 17 January 2017. The last comprehensive inspection took place in April 2016 and, at that time, there were three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. The breaches found were in relation to consent, good governance, safeguarding service users from abuse and improper treatment and not submitting statutory notifications regarding significant events affecting the service. These breaches were followed up as part of our inspection. You can read the report from our last comprehensive inspection, by selecting the 'All reports' link for Treetops, on our website at www.cqc.org.uk

Treetops is a care home with nursing for up to 24 people. The service provides support for older people who are living with dementia. At the time of our inspection there were 22 people living at the service.

The service had been without a registered manager since March 2016. A newly appointed manager had recently commenced in post, they were not yet registered with the Commission. 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 was still reliant on the use of agency staff. Whilst permanent staffing levels had improved it meant that non permanent staff did not always know people or the systems of the service well. Staff did not always feel valued in their role and were not always supported effectively through regular supervisions.

Applications were made when appropriate in relation to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the capacity to consent to treatment or care or need protecting from harm. However, we found that the conditions set out in people's DoLS authorisations were not always being met. Capacity assessments and best interest decisions, when needed, were not always made in accordance with the MCA. Documentation to support this was not always completed or accurate to ensure compliance with the MCA.

Care plans were not person centred. They were not always fully completed, accurate, or consistent. This also applied to the recording of incident and accidents, healthcare needs and induction records. Risks and support needs were identified but there was not always sufficient guidance on how to support people safely and effectively.

Since our previous inspection the structure and facilitation of activities had improved, although there was feedback that some people were not always stimulated enough.

People and relatives had access to the complaints procedures and said they felt comfortable in raising

concerns. However, we found that changes necessary in response to issues raised were not always maintained or completed.

The home was not adequately managed. Changes the provider had outlined in their action plans in response to our previous inspections had not been sufficiently monitored or completed. This meant that improvements required throughout the service had not been achieved. Systems in place to monitor the quality of the service were not always effective as whilst areas had been identified as requiring improvements, necessary changes had not been implemented.

The service was caring and people were supported by staff that were kind and respectful. We observed positive interactions and relationships between staff and people living at the service. We received positive feedback from people and relatives about staff members. People's visitors were welcomed at the service at any time.

Notifications were now being submitted to the Commission and other agencies, such as the local authority safeguarding team when necessary.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have made a recommendation in regards to people's fluid and nutrition and also in regards to providing effective supervision to staff members. 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?

Requires Improvement

The service was not always safe.

Risk management plans were not always in place to ensure people were supported safely.

Incidents and accidents were not always recorded consistently.

Improvements had been made in reducing the use of agency staff. However, staffing was not always responsive to people's needs.

Recruitment procedures were safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Decisions about care and treatment in line with the Mental Capacity Act 2005 were not always followed.

The service was not meeting the Deprivation of Liberty Safeguards as people's conditions as part of their authorisations were not always being met.

Staff were not consistently supported by regular supervision.

People were not always supported effectively in regards to their nutrition and hydration.

People had good access to healthcare however, recording in regards to people's healthcare was not always accurate.

Is the service caring?

Good

The service was caring.

Staff had positive relationships with people.

Staff treated people with kindness and respect.

People's visitors were welcomed at the home.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care plans were not person centred, complete or accurate.

A complaint system was in place. Changes required from concerns raised were not always completed or sustained.

Activities were provided. People were involved and gave feedback into the activities on offer.

Feedback was sought from people and relatives.

Is the service well-led?

Inadequate

The service was not well managed.

The provider had not ensured the actions required to improve the service had been completed or effective.

Quality assurance systems were not effective in ensuring necessary changes were made.

Information was not always communicated effectively to staff.

Treetops

Detailed findings

Background to this inspection

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

The inspection was carried out by two inspectors and an expert by experience. 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 we reviewed previous inspection reports and all other information we had about the service including statutory notifications. Notifications are information that the service is legally required to send us.

Some people at the service were living with dementia. This meant they were not always able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the home. As part of our observations we used the Short Observational Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us

During the inspection we spoke with four people living at the home, seven relatives and ten staff members. This included the deputy manager, manager and operations manager. We looked at eight people's care and support records and four staff files. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies, audits and complaints.

Requires Improvement

Is the service safe?

Our findings

Relatives commented that people were safe at Treetops. One relative said, "She is safe overall." However, we found that not all aspects of the service were always safe.

Medicines were stored securely, and when no longer required, were disposed of safely and in line with the provider's procedure. The provider used an electronic medicines administration recording system (eMAR). This system contained photographs of people and details of any allergies. The nurse administering the medicines ensured people took their medicines as detailed in their care record. Medicines that were given, 'as required' had protocols in place which detailed why people might require additional medicines, such as pain relief.

Medicines that required storage in a medicines fridge were done so. However, the temperature monitoring log did not show that the temperature was monitored consistently. For example, during December 2016, there were gaps on 14 occasions and during January 2017 there were three gaps. This may mean that medicines were not stored according to the manufacturer's instructions and may not be safe or effective. This had been noted in the medicines audit in November and December 2016 and added on the relevant actions list but had yet to be addressed.

We observed that the morning medicines round was still ongoing at midday and then led almost straight into the lunchtime medicine round. This meant that a high proportion of the nurse on duty's time was engaged in completing the medicines round. The nurse administering the medicines said, "We used to get help for medicine rounds, but that stopped. It takes so long because people need support and sometimes people are still asleep." This meant that people were at risk of not receiving their medicines at a regular time or with enough of an interval between doses. However, we saw that time specific medicines were administered as prescribed.

We reviewed five forms which directed medicines to be given covertly (disguised in food or drink). Included in all of these forms were instructions for staff to crush tablets. It was not specified if all or some of people's tablets should be crushed. Crushing medicines can alter their mode of action and may mean they are being administered 'off licence.' This can affect their safety and effectiveness. The provider's policy stated, 'Please note that medication should only be crushed with permission and written directions from the GP and pharmacist as changing the form of a drug renders it unlicensed.' When we discussed this with the nurse on duty and the deputy manager, neither were aware that pharmacist input was required prior to crushing medicines. This meant that nursing staff were not following the provider's own policy and people may not be receiving their medicines safely or in a way that ensures their effectiveness.

The provider's policy also made reference to an annual medicine competency check. The competency status form that we saw showed that two out of the three nursing staff employed by the service had been reassessed in the last 12 months. It was however unclear how the provider could be assured that all of the staff were competent to administer medicines.

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

Care plans contained risk assessments that had been reviewed regularly. However, when risks to people's safety had been assessed, the care plans did not always contain enough information for care staff on how to reduce the risks. For example, one person had been assessed as having a high risk of falling. Although there was a falls support plan in place it was not detailed. It had been documented that the person could not maintain their balance and needed to call for help, but there was no other detail on how staff should support the person. In addition, when we checked on the person, the call bell was out of reach and so they would not be able to call for help if needed. However, for another person who was also at high risk of falls their care plan detailed how the person's bed should be set at the lowest height setting and that a crash mat should be positioned next to the bed. The same plan detailed how staff should move the person safely, including details of which hoist and sling should be used.

Incidents and accidents were recorded. Staff we spoke with were fully aware of the procedure to follow when an incident or accident occurred. However, we found inconsistencies in how incidents and accidents were recorded. Some reports gave a detailed account of what had happened and the immediate action taken to make the person safe. Others did not provide a clear overview of what had happened or had left sections of the form blank with no information recorded. In one report it was not indicated if any first aid treatment was given in the appropriate section, despite the report stating to put, 'None' if none given. The actions taken as a result of incidents and accidents were not always made clear to the staff team. One staff member said, "There is no follow through on what has been done after we hand in the accident form."

A checklist had been introduced which attached to the incident and accident report to ensure that all necessary actions were taken following an event. We found that these were not always completed fully or accurately. This meant that systems that had been put in place for example, to ensure people's families were notified were not always effective.

A monthly analysis was completed to give an overview of incidents and accidents that had occurred. The purpose of this was to identify any trends or patterns and to minimise future risk. However, we viewed one person's records who was sustaining continual falls in subsequent months. Whilst a support plan was in place it did not effectively explain the actions taken as a result of these falls.

A 'Service user adverse incident log' was kept in the person's care record detailing all incidents and accidents that had occurred. We found that these were not always accurately completed. For example for one person's log, the summary of the incidents were not always described and signatures of the person completing the log were omitted. Specific boxes that were meant to be ticked yes or no to indicate if a GP or relative had been informed had not always been completed. Out of six falls recorded the 'review of support plan' box had neither been ticked yes or no on any occasion, despite the number of recorded falls which should have led to the support plan being reviewed. For another person their last recorded incident and accident on their log sheet was in April 2015. However from reviewing the incident and accident reports we saw that they had sustained an accident in August 2016 and November 2016.

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

The staffing rotas demonstrated that staffing levels were kept at the required number set by the provider. At our previous inspection in April 2016 there was a high use of agency staff both within the care and nurse teams. At this inspection in January 2017 we were told that agency use had decreased within the care team,

which was evident from the rotas we reviewed. However, there was still a high use of agency nurses. Nurse's night shifts were all being covered by agency staff.

The feedback we received about staffing was not always positive. One staff member said, "Agency staff are used less." Another staff member said, "There is still a high use of agency staff at the weekend. Sometime it means there is not always three permanent staff on." Two care staff were assigned to each unit and many people required support by two members of staff for particular areas of care. This could leave people unattended in the communal areas of the home, which we observed. One staff member said, "Sometime two staff are needed for support care, there is not enough staff then as there is no-one in the lounge." Another staff member said, "Floating staff would be useful as it can be unsafe as people are left."

The provider had policies in place for safeguarding vulnerable adults. This contained guidance on the action that would be taken in response to any concerns found. Staff we spoke with were knowledgeable about how to identify safeguarding concerns and the procedure to follow. One staff member said, "I would report to a team leader, fill out the incident report and daily notes." Staff received training in this area within their induction programme and as ongoing training. At our previous inspection in April 2016 we found that incidents were not being reported to the local safeguarding authority or the Commission as required. This was now being completed. A tracker system was in place to record the actions taken and the reporting completed following concerns being raised. There were signs displayed around the service which also described whistleblowing, explaining what this was and the procedures to follow.

The home followed an appropriate recruitment process before new staff began working at the home. Staff files showed photographic identification, a minimum of two references, full employment history and a Disclosure and Barring Service check (DBS). A DBS check helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with certain groups of people.

We reviewed records which showed that appropriate checking and testing of equipment had been conducted. This ensured equipment was maintained and safe for the intended purpose. This included safety testing of mobility aids and electrical equipment. There were also certificates to show testing of fire safety equipment, electrical equipment and gas servicing had been completed. Systems were in place to regularly test fire safety equipment such as emergency lighting, alarms and extinguishers. Regular practice fire drills had been undertaken. We observed that the call bell system was being serviced on the day of our inspection.

People had an individual evacuation plan detailing the support they would need in an emergency situation. This was located in a 'grab and go' file at the entrance to the service. A business continuity plan was also in place which gave procedures to follow in emergency circumstances such as adverse weather conditions, flooding or electrical failure. We saw that regular maintenance checks were conducted of the home and grounds. We did note that a daily manager's check that had implemented previously to address safety concerns in the external environment had lapsed.

Requires Improvement

Is the service effective?

Our findings

Care and support was not always effective in meeting people's needs. At our last two comprehensive inspections we found records relating to assessments of people's decisions about their care and treatment were insufficient. We found the actions the provider had told us they were going to take had not been achieved. Limited improvements had been made in this area.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We found that consent to care and treatment was not always sought in line with legislation and guidance. In all of the care records we reviewed we found that documentation relating to mental capacity assessments had not been fully completed. Staff failed to complete specific boxes within the care record which asked if people's mental capacity in a particular area of care needed assessing. Where a person's capacity was identified as needing an assessment the provider's 'Two stage test document' was not always completed. We also saw examples of these documents being half completed with the second page missing.

When a best interest decision was needed. We found that these were not always completed. For example, we saw that one person had a sensor mat in place. With this type of equipment, there is an impact on the person's privacy and also a risk that it can be used as a form of restraint. It is therefore important that their use is considered carefully. We were informed by a senior staff member that the person did not have capacity around this decision. There was no best interest decision recorded to show how it had been decided this was in the person's best interest and the least restrictive option. For another person we saw that they had bed rails in place. There was no record to show they had consented to this. The assessment in regards to this area of care indicated they had capacity. However, a senior staff member said they did not have capacity to be able to make this decision. We saw for another person they had been assessed as having capacity in regards to a lifestyle choice. However, then a best interest decision was recorded. We found that there was a lack of understanding on the purpose of a best interest meeting. We saw many examples where the relevant document described the characteristics of the person rather than the decision that was to be considered.

Some people were receiving their medicines covertly. This is when medicines are disguised, usually in food or drink. The staff had not followed the provider's policy which stated, 'Where a service user is considered to lack the mental capacity to consent and it is felt that any refusal to receive medication is not in their 'best interests' a formal assessment of capacity should be completed and a 'best interests' decision meeting convened to agree and document the action to be taken. A DoLS referral will need to be undertaken before any agreed action can be taken. The issue should be fully discussed with other members of the care team, including the GP and pharmacy. Relatives of the service user should also be involved, where possible.'

Although we saw documentation to show how the decision to administer medicines covertly in two people's care plan had been reached, neither had been dated, no review date had been set, and there had been no next of kin, advocate or pharmacist involvement. We looked at a form in place called, 'Agreement for covert medication administration' for five people. The document stated that three monthly reviews should take place, these had not been completed. Although all of the forms had been signed by the GP, only two had been signed by the named nurse and dated. None of the forms had been signed by the pharmacist.

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

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 application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). At our last inspection of Treetops in April 2016 we found that people were not being lawfully deprived of their liberty in accordance with the DoLS. This was due to the service not having a robust system in place to monitor the status of people's applications, to review when they expired and to meet any conditions attached to the authorisation, which the service is legally obliged to do.

We found that improvements had been made and that a tracker system was now in place. This monitored when authorisations had been applied for, granted, their expiry and when the Commission had been notified. Staff had received DoLS training in a team meeting. Staff we spoke with were now aware of who had an authorised DoLS in place. However, we found for the one person who had conditions attached to their DoLS authorisation, these were not all being met. For example, a purchase of new equipment had been fulfilled but the ongoing monitoring of specific behaviour had not been consistently completed. Their care plan recorded a review in November 2016 of how the conditions were being met but had not been completed since.

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

A dietary assessment was in place as part of the care records. This detailed information such as where people would like to take their meals, the type of diet required, portion size, food allergies and any issues with swallowing. We saw that copies had been given to the chef and kitchen staff so that they were aware of people's needs. However, out of three dietary assessments that we reviewed, two were not fully completed. For example, the food people liked and disliked, whether they required a food diary and details of their weight were absent.

People told us they enjoyed the food provided. One person said, "I like the food, I get a choice of what I like." A relative said, "The food is nice and staff will arrange food just for him if it helps."
We observed that mealtimes were relaxed. We did note, that the medicine round continued through the mealtime and this distracted or interrupted people from their meal. A system was in place where other members of staff in addition to the care team staff were allocated to provide support at mealtimes. However, despite the system in place staff were not always able to provide assistance to everyone who needed it. This meant that while a member of staff was helping one person with their lunch, another person had to wait for the member of staff to become free before they could eat. We observed several people who needed prompting throughout their meal. This was highlighted to the manager who said mealtimes would be reviewed.

Care plans showed that people had their weight monitored regularly and that when necessary additional

support and guidance was sought. Food and fluid charts for people who were having their intake monitored were completed in full. However, how quickly staff were identifying concerns and the process for escalating any concerns in relation to intake was unclear. For example, we looked at the fluid charts for one person. There was no target intake recorded on the fluid chart and there was no target documented within the care plan either. Instead the care plan instructed staff to, "Encourage" the person to drink and, "For [person's name] to drink a lot." The fluid charts for this person did not demonstrate that they had drunk an acceptable fluid intake over the course of the five days prior to our inspection. For example, the charts showed the person drank 150 millilitres on 12 January 2017 and 210mls on 13 January 2017. On each of the five days we reviewed the total fluid intake was less than 600mls. On the day of our inspection, the nurse said they had contacted the GP for advice, but no concerns had been raised to the GP on any of the previous days. This meant that concerns were not identified and addressed in a timely manner. In addition, food charts for the same person showed that their dietary intake was poor and yet action had not been taken and there was nothing documented to show that staff had either identified this or raised any concerns.

We recommend that the service seeks support and guidance to ensure it has systems in place to identify and escalate concerns about people's fluid and nutrition promptly.

Relatives and staff told us people had good access and support to healthcare. One relative said, "The doctor is called when necessary. She had sore eyes, staff called the GP who prescribed medication and they are better now." A member of staff said, "Regular observations of people are completed and the doctor is called and comes out the same day." There was a document in place to accompany people should a hospital admittance be required, which gave an overview of their healthcare needs. The document contained details of allergies, current medicines and essential contact details.

Records were kept about people's healthcare. We saw that records were kept about appointments and contact with healthcare professionals such as the GP, chiropodist and optician. However, we found that records were not always clear or accurate. For example, we tried to locate information in regards to one person's appointments with their GP which we were told had taken place. The details of the appointment were not recorded in their file. For another person we were aware that they had input from additional healthcare professionals. This was not recorded in their care record. A lack of accurate records could lead to health needs not fully being met. This had also been highlighted to the provider at the last inspection.

New staff completed an induction programme which was aligned with the Care Certificate. All staff we spoke with confirmed they had received an induction when they started work. One member of staff described how they shadowed a more experienced member of staff for several weeks. They said, "I was always with a permanent member of staff." Another member of staff said, "The induction was comprehensive, it was very good." However, we reviewed the induction records of two recent new starters. We saw that induction records had not been fully completed. Therefore it did not give an accurate record of the areas covered.

Staff spoke positively about the training they received. We reviewed the training records and saw that staff received training in fire safety, infection control and the manual handling. One member of staff said, "Training is good here." Another member of staff said, "The training we receive is good overall. I have completed manual handling training three times since I have been here." Staff received dementia training as part of their induction and then refresher training. One staff member told us about the training they had received in dementia care and said, "This was really helpful. It helped put things into perspective." However, training in some key areas such as the mental capacity act was not always up to date for all staff members.

The provider's policy stated, 'All employees are to receive a minimum of formal supervision sessions a year. Of these no more than two can be group supervisions.' Supervisions are where staff members meet with

their line manager or a senior staff member to discuss their performance and development. The provider's policy described the different types of supervision sessions that could be facilitated in addition to one to one meetings. We reviewed the supervision records and found that staff had not been receiving supervision in line with the provider's policy. One member of staff said, "I've only had one supervision in the time that I have been here." Another staff member said, "I've had one supervision since April 2016. I haven't had a named supervisor." The manager showed us a plan to address this issue, with all staff members having an allocated supervisor and a schedule of their sessions.

We recommend that the service follows published professional guidelines in regards to providing staff members with effective supervision.

Good

Is the service caring?

Our findings

People were supported by staff who were kind and caring. People and relatives spoke positively about the staff. One relative said, "The family are very satisfied. Staff are friendly and very pleasant and residents are treated with kindness, dignity and respect." Another family member said, "He [Relative] is well looked after and the staff are so caring. They always treat everyone so well and with such patience."

People had good relationships with staff. One person said, "She is the top. She is a perfect carer. She has done my hair this morning." One relative said, "I can go away and relax, in fact I had a holiday and I didn't worry at all. They treat them as if they really care". Another relative said, "
Relatives told us there was a positive atmosphere in the home. One relative said, "Everything seems to go well and the carers work very hard." One relative told us how staff had made a suggestion to enhance a person's well-being. They said, ""Staff suggested a bird table outside her window so that she has something to watch and it works well."

A member of staff supported someone to maintain their dignity as they were starting to take off their clothing in a communal area of the home. The staff member spoke to them in a kind and caring way suggesting they helped do up their buttons. The member of staff engaged the person into doing something else suggesting, "Would you like to help me make a coffee."

We observed one member of staff making a dignity tree with a person. The member of staff told us this would be displayed in the home so people and visitors could express what dignity meant to them. Posters were displayed around the home that explained what type of care a service that respected people's dignity provided. One relative said, "The carers treat everyone with dignity and respect and it's not just some it's everyone."

A member of staff engaged a person in a conversation about their past employment. The person enjoyed talking with them about this. The member of staff offered the person a hot drink and whether they would like milk or sugar. The person replied, "I don't mind." The member of staff said, "What would you like today?" The waited until the person responded about how they would like their hot drink made. Another person said they felt cold;, a staff member immediately went to get them a cardigan. They then checked back a short while later to see if the person was now warm enough. When they said they still felt cold the member of staff went and got them a blanket.

The home had received eight compliments since January 2016. One compliment said, "I would like to thank all the staff at Treetops for the kindness and consideration that [Name of person] received over many years from you all." Another comment said, "I would like to commend [Name's of staff members] for the many years of outstanding devotion to duty and care, consideration and un-devoted care and consideration to the residents in their care, but also to enable the relatives to have help and support and to face the future."

Staff and relatives told us that family and friends could visit the home at any time. We observed and spoke with family members who visited on the day of our inspection. One staff member said, "There are no

restrictions on visitors, they can come whenever they want."

Staff were aware about maintaining confidentiality within their role. One member of staff described this as, "Don't talk about the residents in front of other residents, not to be overheard by others, not to discuss things out of work, not to talk in front of visitors." A staff member ensured confidentiality by checking our identification before giving us access to people's care records which were stored securely. However, we did overhear staff discussing working arrangements in front of people living at the home.

Requires Improvement

Is the service responsive?

Our findings

At the last two comprehensive inspections of Treetops in January 2015 and April 2016 we found that people did not receive care that was person centred and responsive to their needs. Care records were not always fully completed and did not contain sufficient guidance for staff on how people preferred their care and support to be provided. We found the actions the provider had told us they were going to take had not been achieved. No improvements had been made to the accuracy and completeness of care records.

Care records contained a pre-admission assessment to ensure the home could meet people's needs. However, these were not always fully completed. For example, in one pre-admission assessment despite the person having a diagnosis of dementia the section in relation to how this impacted on their communication was blank.

Following people joining the service an ongoing care assessment was completed. However, all of the care records we reviewed did not have the ongoing care assessment fully completed. For one person who had joined the service in December 2014 their care assessment was blank. This meant there was a lack of information about people's care support needs and preferences.

Care plans did not consistently contain detailed information about people's personal histories and care preferences. For example one record detailed the person's past employment and religious needs. However, another care plan had a blank personal profile in place and daily living preferences that not been consistently completed. This meant it was difficult for staff to know people's preferences and therefore would be difficult to provide person centred care, particularly for people living with dementia who may have difficulty expressing their views. For example, one care record documented a person's gender preference of carers whilst another care plan had not answered this question.

One agency staff member told us, "I had an induction when I first started and the permanent staff always take the lead." At the last inspection it had been highlighted that key information easily accessible to non permanent staff members unfamiliar to the service was not available. This had not been addressed as we only saw one daily file, which contained a profile overview of the person and their care and support needs.

When care plans had identified specific needs of people, the information within the plans was sometimes limited. For example, one person had pressure ulcers, but the care plan in relation to their skin integrity did not make reference to this. The wound care file that we looked at did not contain any photographs of the wound. These pictures were later shown to us. However, it was difficult to see how staff would be able to assess whether the wound was improving or deteriorating when the photographs were not filed in the wound care folder. The same person was being cared for on an air mattress, but this was not detailed in the care plan. Air mattresses that were in use by the service were weight specific. This meant the mattress needed to be set in accordance with the person's weight. The mattress for this person was set at 140 kilograms, but their actual weight was 68.4 kilograms. We looked at six other air mattresses. Of these, only two were set correctly. The other four had all been set incorrectly. This meant the pressure of the mattress might be uncomfortable for people and the risk of people developing skin damage would be increased. We

showed the mattress settings to the nurse on duty, who immediately informed staff they were set incorrectly and changed them accordingly. There was no documentation to show that mattress checks were routinely undertaken by the nurse in charge or anyone else.

We viewed a person's care record which made reference to night checks and repositioning. On the same page in their care plan it said, '[Name of person] is checked hourly in the night,' and '[Name of person] has two hourly night checks and turns.' We reviewed the records that documented their repositioning for the previous 16 days. The person had not been repositioned two hourly as directed in the support plan. On this document there was a box referring to, 'Frequency of repositioning and turning.' This was not completed for any days that we looked at. None of the records we viewed had a signature of a team leader as directed.

In another person's care plan it had been documented that they, "May present with challenging behaviour." However, the guidance for staff on how to meet the person's needs was, "To leave safely for ten minutes, then go back" and "Encourage and offer reassurance." There was nothing documented to indicate what triggers might cause the person to display such behaviour, how staff could minimise the triggers or how the person should be supported. In another person's care record it directed staff to complete a record of any challenging behaviour incidents in their daily file. However, there were no records being kept in the daily file. In contrast, in another person's care plan, there was clear guidance and detail for staff on how to provider catheter care and prevent complications.

Care records were in a format that meant they would not always be easy for people and staff to follow and find necessary information. One staff member said, "Care records are not helpful. I don't know where to find things for example, someone's hoist size."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

A keyworker system was in place. People had an allocated key worker who had responsibilities to ensure certain needs were met. For example, ensuring people's clothing was labelled and that people had enough toiletries. Staff spoke positively about this system.

There was a designated activity co-ordinator. A noticeboard in the hallway displayed information about forthcoming events. This included singers, musical entertainment religious services and parties. We observed people enjoying a musical performance on the day of our inspection. A monthly list showed what was planned for each day which included films, bingo and craft activities. This also showed times where people received one to one time with the co-ordinator to do an activity of their choice which included shopping, nail care or having time together to talk. We observed a person going to the local high street supported by the activities co-ordinator to purchase food items of their choice. A pantomime had been arranged before Christmas that people had enjoyed. This had raised money for future activities.

Despite the activities in place we received mixed feedback about the provision of activities. Several staff members commented that people did not have enough to keep them stimulated. One member of staff said, "There is not enough for people to do." We saw one person engaged in doing the washing up. A member of staff said, "A resident likes to wash up, let them wash up, it keeps them happy and occupied." A record was kept of the activities people were offered and participated in to monitor what activities were meaningful to each individual.

Relatives said they would feel comfortable to raise any concerns if needed. We saw that the complaints policy and procedures was displayed and accessible to people and visitors in the entrance to the service.

One relative said, "I don't have any complaints, but the deputy manager is always about and I would be happy to raise a concern. I know she would listen and act."

We saw that regular meetings for people were now in place. These meetings asked people for their opinion and feedback in areas such as the environment, meals and activities. We saw suggestions raised were taken forward. For example, bingo sessions had been introduced and photographs of an activity was displayed in the hallway. Meetings for relatives had also started on a regular basis and this had been positively received. One relative said, "I came to the relatives meeting last week. The manager took notice of the concerns raised."

We observed that staff responded to people's needs. For example, we saw that call bells were answered promptly and when people asked for drinks these were made. One person said, "Can we have a film on." We observed that staff put a film of the person's choice in the location they wished to watch it. A relative said, "As soon as he needs help, they're [staff] there."

Inadequate

Is the service well-led?

Our findings

The service was not well-led. The service had been without a registered manager since March 2016. A new manager had started in December 2016 and was in the process of their induction. During the interim period senior staff had been supported by regional and other managers. At our last inspection in April 2016 four breaches of regulation had been identified. The provider had sent us an action plan detailing how they were going to make improvements but the majority of these actions had not been taken.

We found that in other areas some steps had been taken to make improvements. For example, training had been provided for staff in the Mental Capacity Act 2005 (MCA) and a tracker system of people's DoLS had been introduced. However, these steps were not sufficient to ensure compliance with the regulation or the Mental Capacity Act 2005 to ensure people's rights were protected.

People's care records were still inaccurate or incomplete which could lead to unsafe or inappropriate care and treatment. We saw from meeting minutes that senior staff had met in July 2016 to review the action plan. However, no other meetings were held and no further review or monitoring of the action plan had taken place.

A detailed audit system was in place but this was not effective in improving the quality and safety of the service. There was a monthly assessment completed by the manager which monitored care records and medicines. In addition, other areas were checked on a rotating basis such as health and safety, the environment and catering. A provider audit was completed by a regional manager on a bi-monthly basis focusing on areas such as safeguarding adults, record keeping, care records and infection control. These audits did identify areas that required further actions and listed them on an action plan document. For example, we saw actions to be taken around induction, medicine storage temperatures and the testing of equipment. These were then signed off when completed. However, there were numerous outstanding actions which had not yet been addressed, including capacity assessments, best interest meetings, updating of care records, and agency inductions. There also continued to be breaches of regulations identified at previous inspections.

The nature and extent of incomplete, inaccurate or undetailed documentation found during this inspection meant that these audits were not effective in ensuring that the necessary improvements were made. For example, when gaps in people's care records had been identified there was no follow up to show that all areas had been sufficiently completed by the following audit.

The service had received four complaints since April 2016. We found that information regarding complaints were not always held in one place. We saw three of the four complaints had been investigated and responded to fully. However, in regards to one of these complaints the preventative action that had been detailed in the response to prevent future re-occurrence had not been maintained by the service. In addition, records relating to communication with the person's family member had not been accurately kept so it was unclear if they had received notification of other incidents. In regards to the fourth complaint made in September 2016 the points raised had not yet been addressed or completed.

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

The new manager had just started in post. Staff said they appreciated the hands on approach they demonstrated and felt having a permanent management team now in place for the service would be beneficial. One staff member commented, "It will be good to have stability." Staff commented that they felt well supported by other senior staff members. One staff member said, "[Name of senior staff member] is very approachable." Senior staff members recognised that improving the staff culture and how staff felt valued was necessary.

Information was not always communicated effectively through the staff team. For example, one person's hearing equipment was unavailable to them. Staff did not know if these had been lost, broken or the person was choosing not to use them. We established that they had been lost, possibly for several weeks. We could not find any records of this being reported as lost or broken. Following the inspection the provider notified us that this had been addressed. Staff told us they were not confident that information they needed would be communicated effectively. One staff member said, "Communication is not good. If I was not on duty for a few days I wouldn't know things. It takes ages for care records to be updated." A new handover document had been introduced in January 2017 aiming to improve how information was communicated.

People and relatives had been invited to complete a questionnaire in June 2016. The results overall were positive. These results were displayed in the hallway. However, this showed several comments that would have required further action or follow up which had not been completed. For example, that laundry was not being returned to the correct person. The information gathered through this survey had not been effectively used to make changes, nor had this been communicated to interested parties.

Bi-annual team meetings were now in place for the care staff. Separate meetings were held for team leaders. From the meeting minutes we reviewed we saw that areas such as handovers, training, teamwork and meals had been discussed. Staff said they felt able to make suggestions. One staff member said, "We can raise anything." However, one staff member explained that as the service needed to continue running they had not been able to attend any staff meetings as yet.

Relatives told us that they were kept well informed. One family member said, "They will always call if there's a problem, the communication is good between the home and the family." We observed that senior staff members always made time to speak with relatives who visited the home. Explaining any changes or concerns around their relative.

The service was now submitting statutory notifications regarding significant events affecting the service as legally required.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 (1) 3 (a) (b) The provider had not ensured that care records contained sufficient information to meet people's needs or preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (2) (b) The provider had not ensured that all reasonable steps had been taken to mitigate risks. People could not be assured that they would receive their medicines on time or in the prescribed format.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13(4)(d), 13(5) People were not being lawfully deprived of their liberty in accordance with the Deprivation of Liberty Safeguards.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 (1) People's rights were not fully protected because the requirements of the Mental Capacity Act 2005 were not being followed.

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (2) (a) (c) (f) People were not protected from the risk of unsafe or inappropriate care and treatment arising from the lack of accurate and complete records. Risk assessments did not always include risk management guidance and the recording and management of incidents and accidents was not effective. The provider had had not sufficiently monitored and implemented their action plan. The provider had not ensured appropriate actions had been taken to improve areas identified in their audits.

The enforcement action we took:

We issued a warning notice