DFA Care Limited

Darenth Grange Residential Home

Inspection report

Darenth Hill
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Darenth Grange on the 5 and 10 July 2017. The first day of the inspection was unannounced. Darenth Grange is a care home providing accommodation, personal care and support for up to 29 older people and older people living with dementia. There were 28 people using the service at the time of our inspection. Not all were able to communicate verbally with us. The registered provider had 25 single bedrooms and two bedrooms that could either be used as a single bedroom or shared by a couple. One bedroom was being used as a shared bedroom at the time of the inspection.

There was a manager in post who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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.

At our last inspection, in November 2016, we found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to the management of risk to individuals' safety, person centred care, consent, staff support, governance systems, displaying their rating notifications of significant events. We issued a warning notice to the registered provider for the breach of regulation relating to governance. The registered provider sent us an action plan telling us they would become compliant with the regulations by 31 March 2017. This inspection took place to check that the registered provider had made improvements in these areas. We found that some improvements had been made, but the registered provider continued to breach four regulations and was also in breach of a further four regulations.

People were not always safeguarded from abuse because the registered manager had not recognised and responded appropriately to allegations of abuse. People told us they felt safe using the service however we found that the service was not always managed in a way that ensured their safety. Risks to people's safety and welfare had not always been managed appropriately to ensure they were minimised. Where people had been assessed as being at risk of dehydration there was not an effective plan in place to monitor their fluid intake and take action when they were not drinking enough. People's medicines were not always managed safely. The registered manager did not make checks to ensure that staff were competent in administering medicines safely. The registered provider had not ensured there were effective systems to reduce the risk of infection spreading in the service.

Staff were encouraged to gain qualifications relevant to their roles and they received essential training to enable to carry out their roles. Staff received regular supervision and an annual appraisal in line with the registered provider's policy. However, the registered manager did not always provide staff with appropriate feedback about their performance and did not follow the registered provider's disciplinary procedure to respond to concerns about staff performance. The registered provider had systems in place to check the suitability of staff before they began working in the service. There were sufficient numbers of staff on duty to meet people's needs in a safe way.

The registered manager and staff had not always met the requirements of the Mental Capacity Act 2005 (MCA). People are not supported to have maximum choice and control of their lives and staff do not support them in the least restrictive way possible; the policies and systems in the service do not support this practice. There was a lack of understanding by the registered manager about the principles of the MCA. However, on a day to day basis staff sought people's consent before they provided care.

The registered provider had not ensured that the premises were properly maintained, clean, safe, comfortable and pleasant for people to use.

People's care was not planned in a personalised way. People's care plans were limited in the information they provided and did not reflect their individual preferences. Staff were not provided with information about people's dementia to ensure they could meet their specific needs in a personalised way. People were at risk of an inconsistent approach to their care, especially where agency staff were used, because there was a lack of clear instructions for staff to follow to meet all areas of their needs. Whilst some staff were caring and kind, not all staff treated people in a way that demonstrated respect.

The service was not well led. The registered manager did not provide clear and directive leadership for the service and had not established an effective improvement plan to ensure the regulations were met. Shortfalls in the quality and safety of the service were not identified because governance systems were not adequate or effective. The registered provider had not ensured that the required improvements were made to meet the regulations following our inspections in November 2015 and November 2016.

People knew how to make a complaint if they needed to and felt they would be listened to. It was not clear from the documentation that people were involved in reviewing their plans. Ways to seek the views of the people that used the service had not been properly explored to enable their voice to be heard.

The registered provider had not ensured that accurate and complete records were maintained to allow effective monitoring of care delivery. There was a lack of effective systems for analysing recorded information to identify patterns in risk and to take action to keep people safe.

Staff identified and met people's health needs. Where people's needs changed they sought advice from healthcare professionals. People had enough to eat and were supported to make choices about their meals. Staff knew about and provided for people's dietary preferences and restrictions.

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

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's safety and welfare had not been managed effectively. People at risk of dehydration did not have their fluid intake monitored. Where there were changes to people's mobility their care plans and risk assessments had not been reviewed.

People had not been supported to manage their medicines in a safe way.

Staff knew how to recognise the signs of abuse and report any concerns, but the registered manager had not taken appropriate action to report allegations of abuse following the safeguarding policy.

Sufficient numbers of staff were deployed to meet people's needs and keep them safe. Safe recruitment procedures were followed in practice, but action was not taken to address concerns about the fitness of staff once in post.

The registered provider had not taken sufficient steps to reduce the risk of the spread of infection in the service.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The premises had not been properly maintained. Areas of the home were worn or damaged and the registered provider had failed to take action despite concerns being raised in 2015. This did not provide people with a safe or comfortable environment to live in.

Staff had received the training they needed to meet people's needs. Staff were provided with supervision and appraisal of their performance in line with the registered provider's policy.

Staff and the registered manager did not fully understand the principles of the Mental Capacity Act 2005 (MCA) and had not consistently followed these.

People were supported to eat sufficient amounts to meet their needs and were provided with a choice of suitable meals. People were supported to access healthcare professionals as required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Most staff treated people with kindness, compassion and respect, but some staff did not engage with people in a way that demonstrated respect for them.

People's dignity was not consistently promoted by staff. Staff promoted people's independence in some areas of their lives, but this was inconsistent and people did not have care plans to enable them to maintain and develop skills. People were not always involved in developing their care plan.

People did not have care plans in place to ensure they were cared for in the way they wished at the end of their life.

Staff knew people well and knew what was important to them. However, this had not been used in planning their care.

Is the service responsive?

Inadequate

The service was not consistently responsive.

People did not have personalised plans that met their specific individual needs, including their social needs. People's care plans lacked information about how to meet their needs relating to their dementia.

The registered provider had not explored ways to enable people to give feedback about the care their received, despite their communication needs.

Is the service well-led?

Inadequate

The service was not well-led.

The registered provider had not ensured that the required improvements from the previous two inspections had been made and maintained. There was a lack of clear and directive leadership in the service to ensure people's needs were met and the service provided high quality care.

There was a lack of effective systems in operation for checking the quality and safety of the service at regular intervals. Where

there were shortfalls in service delivery the registered provider had not identified these or taken relevant action.

Accurate records were not maintained about people's needs or the care provided to them. This meant that the registered manager could not effectively monitor care delivery or identify any changes to people's needs.

Darenth Grange Residential 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. At our last inspection on 04 November 2016 we found seven breaches of regulation. This inspection was carried out to check whether the provider is now 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 carried out on 5 and 10 July 2017. The first day of the inspection was unannounced. The inspection team consisted of 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 the action plan the registered provider had sent us detailing the improvements they intended to make to ensure the requirements of the regulations were met. They had told us they would be compliant with the regulations by 31 March 2017. We also looked at records that were sent to us by the registered provider and the local authority to inform us of significant changes and events. We spoke with the local safeguarding team and commissioning team to obtain their feedback about the service.

We looked at twelve people's care plans, risk assessments and associated records. We reviewed documentation that related to staff management and five staff recruitment files. We looked at records of the systems used to monitor the safety and quality of the service, menu records and the activities programme. We also sampled the services' policies and procedures including those relating to fire safety and staff management.

We spoke with 10 people who lived in the service and three people's relatives to gather their feedback about the care provided. We spoke with one director, the registered manager, assistant deputy manager, two senior care workers and three members of the care team. We used the Short Observational Framework for

Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We last inspected the service in November 2016 when we rated the service 'Requires Improvement' overall, with the key question 'Is the service well-led?' rated as inadequate. The service was placed into special measures.

Inadequate

Is the service safe?

Our findings

People and their relatives told us they felt safe living at the service. One person told us, "I feel safe here, I would ask staff yes if I was worried. I do worry about going to the "men's" on my own and also I worry that I will lose my chair, someone else will sit here. No problems with the staff though they are as good as gold, they do care, they listen." Another person told us, "Nothing to complain about, the staff are around they do ask if you are ok. If you are worried about the shower and washing they help, you just ask them if you don't feel safe, they are good."

However, we found that despite positive feedback from people using the service the registered provider continued to fail to ensure that the service was managed in a way that ensured people's safety. At our inspection on 18 November 2015 and again on 4 November 2016 we found that the registered provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. They had not ensured that appropriate action was taken to identify and reduce risks to individual's safety and welfare. This included not ensuring that risks relating to fire and individual risks were reduced. They had not ensured that staff had access to clear plans for safely moving people and that risks relating to dehydration were appropriately managed. The registered provider sent us an action plan telling us they would be compliant with this regulation by 31 December 2016. At this inspection we found that whilst some improvements had been made, the registered provider continued to breach this regulation.

At our last inspection we found that individuals care plans did not provide sufficient information to enable staff to safely move people who required assistance. At this inspection we found that this continued to be the case. Care plans had not been updated when there had been a change in need. For example, staff told us that a person had begun to use a wheelchair 2-3 weeks earlier due to a change in their mobility. The falls risk assessment had not been reviewed and their care plan for their mobility had not been updated to include this information. Another person had been reviewed by the specialist falls team and provided with a walking frame. The care plan and risk assessments had not been updated to reflect this advice from the falls team or to include guidance for staff about how to encourage the person to use the frame. Risk assessments relating to people's mobility and to the risk of falling did not take into account appropriate footwear as a measure to reduce the risk. When people had fallen their risk assessment had not been reviewed. One person had fallen on three consecutive dates in June 2017. Senior staff told us that they had contacted the falls team for advice, but this had not been recorded.

At our last inspection we found the risk of dehydration had not been managed appropriately for people who had a low fluid intake. At this inspection we found that this breach remained. Two people's records we viewed showed frequent daily totals of extremely low fluid intake. The British dietetic association recommends that the fluid intake for adults, including the elderly, should be 1600-2000mls per day. The records we saw showed the fluid intake for two people was 30 – 60mls for some days. There was no analysis of this low fluid intake to review the risk and agree if any action needed to be taken. Staff told us that it was common for these people not to drink much. One person's care plan noted this risk and instructed staff to offer and record drinks regularly. The other person's care plan noted the person 'eats and drinks well.' There was no evidence to show that staff had offered regular drinks and the registered manager was unable to

confirm if the records were accurate or what action had been taken. This meant that the registered manager could not be assured that the risk of dehydration was being effectively reduced.

People did not always have effective care plans to manage risks relating to malnutrition. One person's care plan stated that they were not eating well and required their food intake monitoring. The food records for this person had not been completed consistently and there were dates that had no entry for one or more meals. There had been no analysis of the person's food intake or record of the action taken when it was low. Another person had been assessed by the speech and language team and required a soft diet. The person's nutrition assessment recorded that they had no needs in relation to eating and drinking and had not been updated to include the advice provided by the speech and language team.

During the inspection we found other areas of risk that had not been appropriately identified, assessed and reduced. There was a metal hot plate in the servery area which staff told us was turned on to heat up an hour before meal service. We saw that this hot plate, which was heated by water, was steaming hot for the majority of the day. There had been no assessment of the risk of scalding to people. Staff and people used the servery area as a cut through from the lounge to the dining room. This meant that people were regularly walking through the food service area which is unhygienic.
Two people had an air flow mattress on their bed which was set for a person weighing 120kg. Staff were unsure what the mattresses should be set at. When they checked the weight of the individuals they both weighed near to 40kg. The registered manager did not know how to establish what the mattresses should be set to for each person. There was no system in place for checking that the mattresses were operating correctly and set at the correct level.

People were at risk of harm because staff did not ensure that they were appropriately supervised during the first day of our inspection. One person's care plan said they required monitoring and assistance with their mobility. We observed that there was no member of staff present in the lounge for a 35 minute period after lunch. During this period of time staff were alerted by another person using the service that the person was on the floor in the lounge having slipped from the chair.

The registered provider had failed to ensure that care and treatment was provided in a safe way. Risks to people's safety and welfare were not appropriately managed to ensure the risks were reduced. This is a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 from November 2015 and November 2016 inspections.

People were not always protected from the risk of harm and abuse. Staff knew how to access information about safeguarding and where the policy related to the safeguarding of adults was located. Staff understood their responsibilities to report any concerns about abuse and told us they were confident to do so. However, we found records that showed three separate allegations of abuse had been reported to the registered manager, but they had not recognised these as potential abuse and had not reported it using the local multi-agency safeguarding procedure. In response to one of the allegations made the registered manager had arranged a meeting between herself, the staff concerned and the person who had made the allegation. When we asked the registered manager why they had not reported one of the allegations they told us, "I didn't even think of it." When we asked why a second allegation had not been reported, they told us, "X [the person] only mentioned it once and it was not mentioned again."

One person was at risk of emotional abuse from another person using the service. Staff told us that this occurred frequently and had been reported to the safeguarding team in the past, but recently incidents had not been reported. Staff told us that they reported any physical abuse by the person and we saw that this had been done in respect of this individual. The person at risk of the abuse had this noted in their care plan,

but the plan did not instruct staff to report this using the safeguarding procedure. The care plan advised staff to move the person if they were experiencing abuse, but it did not present any long term strategies to reduce the risk of this reoccurring.
The registered provider had failed to establish effective systems to prevent abuse or to investigate allegations of abuse. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

At our inspection on 18 November 2015 and 4 November 2016 we found that the registered provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 in relation to managing people's medicines safely. The registered provider sent us an action plan telling us they would be compliant with this regulation by 31 December 2016. At this inspection we found that whilst some improvements had been made, the registered provider continued to breach this regulation.
Staff had completed training in administering medicines, but there had been no check by the registered manager that staff continued to be competent to do so. The senior staff who was administering medicines during our inspection confirmed they had recently completed medicines training, but they could not recall having their competence in medicine management checked. The medicine trolley was left unattended and unlocked whilst medicines were administered to individuals in the dining area. This meant that people living with dementia were at risk of accessing medicines that were not prescribed for them. Some staff administered insulin to people with diabetes. We were informed by the registered manager that staff had been trained by the district nurse to give insulin, however there was no record of this training to confirm they were competent to undertake this task. There had been no audits of medicines practice in the service to ensure that it was safe.

The registered provider had failed to establish an effective system to ensure safe management of medicines in the service. This is a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Guidance for staff on when to offer as required (PRN) medicines had been developed since our last inspection. Staff gave people time to take their medicines and explained what they were and why they needed them. Staff checked and recorded the temperature of medicines storage areas on a daily basis. The service had an effective system for the disposal of medicines. Since our last inspection the registered manager had changed the way controlled medicines were recorded to ensure an accurate balance could be recorded. However, there were no checks of the balance of these medicines outside of the times they were administered. The registered manager had introduced a daily check of the balance of controlled medicines when we returned for the second day.

The risk of infection spreading in the service had not been assessed and appropriately managed. The bathrooms were not kept clean and hygienic. This was partly due to poor maintenance of these areas which made it difficult for staff to clean. For example, flooring was not sealed around the edges of bathrooms and around toilets. This meant that dirt and fluids could leak under the vinyl flooring, where staff could not access for effective cleaning. The upstairs sluice room had dirty floor, cracked walls and unsealed chipboard sides. In shared bathrooms we saw that unused incontinence aids were stored in open packets next to urine bottles. There were no clinical waste disposal bins in some bathrooms and we saw clinical waste had been disposed of in a general waste bin that had a sign on that said 'no pads.' This increased the risk of infection spreading in the service.

The service did not have a lead person for infection control as referred to in the code of practice on the prevention and control of infections published by the Department of Health. An audit of infection control practice had been introduced since the last inspection, but this was not appropriate to the setting, referring

to surgery units and custody suites as areas of the service to be checked. The audit had not been effective in identifying the risks we found on our inspection.

The registered provider had not ensured that the risk of infection spreading in the service was minimised. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.
The registered provider followed robust procedures for the recruitment of new staff. Where agency staff were employed, appropriate checks had been made of their suitability and fitness to work in the service. All staff received an induction and shadowed more experienced staff until they could demonstrate a satisfactory level of competence to work on their own. However, where concerns about staff performance were raised, once the person was in post, the registered manager had not followed the registered provider's disciplinary procedure to respond to the concerns. In respect of one concern about failure to provider care the registered manager told us that they had met with the staff member to discuss the concerns, but they were unable to provide any records to confirm this or to describe what action had been taken. The supervision records for the member of staff, dated after the event, stated that they continued to work to a high standard. In another instance meeting minutes reported a concern about staff performance. The registered manager told us this related to the performance of one member of staff and had been ongoing for some time. The registered manager had not addressed the concerns with the staff member as they told us "I didn't want to victimise them." The supervision notes for the staff member recorded that their 'performance and knowledge continues to be of a high level.'

The registered manager had failed to respond appropriately to concerns about staff fitness and ability to carry out their role. This is a breach of Regulation 19 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Improvements had been made to fire safety practices. Regular checks were made of the fire safety systems and remedial action had been taken where faults were found. Servicing of fire safety equipment by an external contractor had been completed following our last inspection and action had been taken to address the required actions in the report. People had personal emergency evacuation plans (PEEPs) to inform staff what support they needed to evacuate the building in the event of an emergency. The fire evacuation procedure had been reviewed and updated in December 2016. It included an instruction for staff to use the evacuation chairs, located at the top of the stairwell, to evacuate people from the first floor. However, the registered manager and two members of care staff we spoke with told us that they were not confident in the correct way to use the evacuation chairs. The registered provider informed us after the inspection that the evacuation procedure was incorrect and should advise these chairs are for use by the fire rescue service only. There were several wheel chairs stored under the main stairwell which may present a fire safety risk. A disaster plan for the service had been developed to ensure that the service could continue to operate in the event of an emergency. This included information about action to take in the event of a fire and other events such as flood and loss of power. The plan included information about alternative accommodation that could be used in an emergency situation. We recommend that the registered provider take advice about the evacuation procedure and storage of wheelchairs.

The registered manager told us they had an agreed number of staff that worked each day and the staff rotas showed that this number of staff were deployed during the day, at night time and at weekends. Where it was not possible to fill shifts with regular staff, the provider used agency workers to cover vacancies. There was a number of auxiliary staff employed at the service who provided support with housekeeping and laundry. Staff were also employed to work in the kitchen.

Requires Improvement

Is the service effective?

Our findings

People's relatives told us that the service was effective in meeting their relative's needs. One person's relative told us, "Staff are absolutely brilliant, we cannot be happier, we cannot believe how good they are, explained everything, they are knowledgeable and tell you what is going on, they phone us if mum is ill or needs to see the doctor and they give good advice." Another person's relative told us, "You cannot fault the care. I do think the place could do with a lick of paint and I would love to sort those windows, but the care is more important to me. We don't want a place that is all shiny and new, but the care is dreadful. No, mum is happy here they do care for her well." A further person's relative commented, "We feel happy leaving her, she seems much better here and if there are any problems they call us, they are very good."

Despite positive feedback about the care of their relatives we found that the service was not always effective. At our inspection on 18 November 2015 we found that the registered provider was in breach of Regulation 15 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. They had not ensured that the premises were suitably maintained and safe for people to use. The registered provider sent us an action plan telling us they would be compliant with this regulation by 2017. At our inspection on 4 November 2016 we found that some improvements had been made. There were still areas of work remaining, but these had been included in a full refurbishment plan. As the registered provider had developed a clear plan to make the remaining improvements we did not report a breach of Regulation 15 at our November 2016 inspection. However, at this inspection we found that little progress had been made to the maintenance of the building and areas of the building were worn and in some cases unsafe. Areas of the premises did not provide a comfortable environment for people to live in and in some cases the condition of the building made it difficult for staff to ensure the required standards of cleanliness.

New vinyl flooring had been laid to a downstairs bathroom and one of the downstairs toilets since our last inspection, but this had been completed to a poor standard and had ripped in areas. It was not sealed around the edges to ensure that it was easy to keep clean and hygienic. An upstairs shower room had split areas of flooring at the edges and was very dirty and scaled. The shower screen was split and there was an exposed water pump for the shower. Some tiles were damaged and grouting was dirty. The shower chair was dirty on the back and underneath. The door lock had broken. The registered provider told us that they had covered the pump and repaired some tiles following our inspection. In an upstairs ensuite toilet the flooring unsealed where it met the skirting. The cupboard and sink unit sides had significant damage to the laminate, exposing the chipboard underneath. An upstairs toilet had cracked walls and boxing which covered areas of pipework had broken. Toilet rolls were sitting on a dirty window sill. There was no hand wash, basin or soap, only a hand sanitiser. Bathrooms required a deep clean as they had dirty flooring, windows and sides. There was an odour of urine in an upstairs bedroom.

Pictures had been added to the hallway walls since our last inspection to provide pieces of interest as people moved about the home. However, the walls in hallways were dirty and worn and paint was peeling from the skirting boards. The carpet in an upstairs hallway was threadbare and two bedroom carpets had damaged areas. The medicines room was in a state of disrepair. The ceiling had fallen down and the registered provider had started to put up a temporary ceiling. Staff told us the ceiling had been like this for

some time and repairs were started, but never finished. The outside of the building had not been maintained; the windows were rotting and requiring repair and painting. The upstairs fire escape route had cracked concrete and not been well maintained.

There was a large conservatory which was a lovely facility for people to use, but staff told us it was too hot as there were no blinds. At the rear of the premises there was a beautiful garden with some areas of seating. Staff told us that people could not access this without staff support as the grounds were not secure. This meant the garden was not freely accessible for people who were not independently mobile or were living with dementia. Some improvements had been made to the premises to meet the needs of people living with dementia. For example, way finding signs had been fitted and contrasting colours used to help people see their meal plates clearly. There had not been consideration given to the decoration and lighting throughout the service to ensure that people with dementia, which often affects people's vision and perception, could find their way around. The service was decorated in neutral colours, which can make it hard for people to define doorways and areas of the home.

The registered provider had not ensured the premises were clean and properly maintained. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

At our inspection on 4 November 2016 we found that the registered provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. They had not ensured that they had complied with the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. The registered provider sent us an action plan telling us they would be compliant with this regulation by 31 January 2017. At this inspection we found that whilst some improvements had been made, the registered provider continued to breach this regulation.

Staff had been provided with training in the principles of the Mental Capacity Act 2005 (MCA), but this training had not been effective in ensuring their understanding of the Act. 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 their best interests and as least restrictive as possible. We saw that staff gained people's consent before providing care, however staff and the registered manager had not ensured the principles were consistently followed. The registered manager demonstrated that they had not fully understood the requirements of the Mental Capacity Act 2005. When we asked them to describe the principles they told us, "If a person has capacity we respect their decision unless it is an unwise decision." This is incorrect as the Mental Capacity Act acknowledges people's right to make unwise decisions. Mental capacity assessments had been completed for people before an application for a deprivation of liberty authorisation had been made, but these did not always state the decision that they were assessing the person's capacity to make. The principles of the MCA require all assessments to be specific to a decision. One person's assessment stated that they had the capacity to make a decision about being in a care home, but a deprivation of liberty authorisation had been applied for. The registered manager told us they did not believe the person had capacity to make the decision and that the assessment had been completed incorrectly. Another person had a best interest decision recorded which had been made to apply for the deprivation of liberty authorisation, but a mental capacity assessment about whether they could consent to being in the care home could not be produced when we asked for it.

The registered provider had not ensured that the requirements of the Mental Capacity Act 2005 had been understood by the registered manager and staff and complied with. This was a continuing 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 Mental Capacity Act 2005 (MCA). The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether any conditions on authorisations to deprive a person of their liberty were being met. Nine people using the service required an authorisation to deprive them of their liberty in order to ensure their safety. The registered manager had made applications for these nine people and authorisations had been received for three people at the time of our inspection. These were in date and the registered manager was aware of the conditions attached to keep the restriction under review.

At our inspection on 18 November 2015 and 4 November 2016 we found that the registered provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. They had not ensured that staff were regularly supervised and had their performance reviewed at regular intervals to ensure they were competent in meeting the requirements of their role. The registered provider sent us an action plan telling us they would be compliant with this regulation by 31 March 2017. At this inspection we found that improvements had been made and the registered provider was meeting the requirements of the regulation. The registered provider had a system in operation to ensure that staff received a supervision meeting with their line manager every two months. We saw that staff supervisions were up to date for 2017 and records were maintained of all supervisions. All staff had an annual appraisal. A staff member told us, "I get frequent supervision and an appraisal."

Staff received essential training to enable them to carry out their roles. There was a programme of training for staff to complete that included safeguarding, first aid, food safety, infection control, safe moving and handling and dementia. Staff attended an induction and orientation to the service. Training needs that had been identified through the appraisal and supervision process were included in the training programme. Staff had recently completed a refresher course in fire safety. Staff were encouraged to gain qualifications relevant to their roles. New staff were required to complete the Care Certificate. The 'Care Certificate' was introduced in April 2015. It is designed for new and existing staff and sets out the learning outcomes, competencies and standard of care that care homes are expected to uphold. New staff had completed the care certificate standards and staff had access to qualifications relevant to their roles. The registered manager told us they had an ongoing programme of staff qualifications with a new group of senior staff starting the NVQ five in care leadership.

People's care records showed that health and social care professionals were involved in their care, including GPs, dentists and district nurses. A GP from the local surgery visited the service weekly and district nurses visited twice a week. A chiropodist was available in the service every eight weeks for people to use if they wished. Staff reported concerns about people's health to the person in charge of the shift and they reported these onto the health professional as needed. Records showed that there was effective communication with the GP and concerns were reported quickly.

People told us they enjoyed the meals and had sufficient choice. One person said "The food is good, you have hot drinks and cold drinks, yes lots of drinks." A person's relative told us, "The food is great mum eats everything and they ask her what she likes. Lots of drinks they are always coming out with drinks, choices orange or blackcurrant and a hot cup of tea when she wants." Another person's relative said, "She has put on weight and enjoys her meals, we don't have to worry that she is not getting enough to eat and she always likes the food, All cooked here on site very good." People's dietary needs and preferences were documented and known by the kitchen staff. People told us that if they did not want one of meals from the menu the cook would prepare an alternative.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us the staff were caring and treated them kindly. One person told us, "Very, very kind and very caring." A friend of a person who had used the service told us, "The care is exemplary. The building is shabby and on first impressions I wouldn't place a relative here, but the people, care and communication has been marvellous." A person's relative told us, "She is very well looked after, they call us whenever her needs change." Another person's relative said, "They treat my mum with real care, we couldn't ask for more, yes with dignity and respect."

Despite the positive feedback from people using the service we found that the service was not consistently caring. Most staff treated people kindly and with respect. However there was a culture of language that was used to describe people by their needs rather than recognising them as individuals. For example, we frequently heard the registered manager, senior staff and care staff using terms such as 'feeders', 'walkers' and 'wanderers' to describe people. These terms were also used in people's care plans and on the staff office noticeboard. Whilst staff were mostly kind in their interactions some staff referred to people as 'darling' and 'babe'. People's care plans did not record their preferences about how they wished to be addressed and staff we spoke with told us they had not checked with people that they did not mind being spoken to in this way. We heard one staff member walk into the lounge where people were seated and say "I feel like I have just done 10 rounds with Mike Tyson." We also heard them say to two people using the service, "You would think that she was posh the way she talks but she ain't, she's one of us" when talking about another person that uses the service. However, other staff interacted with people in a kind and respectful way. They did not rush people and were gentle in their approach.

Staff did not always take action where a person's dignity was compromised. We saw that a person was asleep in a chair in the busy lounge and had their skirt hitched up which exposed their underwear. Staff in the room did not notice this, despite delivering the person a cup of tea, and did not take action to rectify this. During an incident where a person was found on the floor in the lounge staff did not act to ensure the dignity of the person was not compromised as their clothing had ridden up. The registered manager took action to rectify this. People were provided with plastic aprons to wear whilst eating their meals to protect their clothes. This was undignified and did not protect the clothes well as the lack of absorbency meant that spilled fluids poured onto their clothing. We saw that two staff members took their lunch break in the garden whilst people were still waiting for support to eat their dessert.

The registered provider had not ensured that people were treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

We saw staff encouraging some people to do things for themselves. They asked if people wanted help with their meals before providing it. People were provided with equipment, where needed, to enable them to move around independently, for example walking frames. One person was helping with a number of household tasks such as washing up. They told us, "I help to fold all the towels up and help to keep the place running." However, people's care plans did not include information about how staff should encourage them to be independent. For example, one person's care plan for dressing stated "staff to choose appropriate

clothing" and there had been no exploration of different ways they could help the person make their own decision around this. At our last inspection in November 2016 we made a recommendation for improvements to the way in which people were involved in their care planning. At this inspection, we found that people had not been involved in writing or reviewing their care plans. Care plans were basic and did not reflect that people had shared their views. We asked staff how they involved people in developing and agreeing their care plans. Staff told us that most people using the service were unable to be involved due to their dementia. The registered manager had not explored alternative communication methods to enable people to make their own decisions about their care and treatment.

There were four people using the service who were receiving specific care at the end of their life. The service was working effectively with the hospice team to ensure that each person received the pain relief and care they required. However, we found that people did not have care plans written detailing this support. When caring for a person at the end of their life we would expect to see a written care plan that reflected their wishes around dying and which gives guidance for staff in how to meet their needs during this time. This should include how to ensure they remain pain free and comfortable and how to reduce other risks to their wellbeing such as developing pressure wounds or malnutrition.

The registered provider had not ensured that people were provided with appropriate opportunities to make decisions about their care. The registered provider had not ensured that people had care plans that reflected their preferences and wishes for their care at the end stages of their life. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Staff knew people well and understood what was important to each person. Care and support was provided at an appropriate pace for each person so that they did not feel rushed. Staff were sensitive to people's needs and ensured they were comfortable, for example by positioning fans near people as the weather was very hot. Staff had supported people to dress appropriately for the weather and their preferred tastes. There was a hairdressing salon in the service which we saw was in use on the second day of our inspection. A person's relative told us, "Mum always has her hair done every week." Another person told us, "X [a staff member] does my nails. He does them so carefully and then if I don't like them he does them again, most weeks he does them I love that."

People's spiritual and cultural needs were met. They were supported to attend any church services as they wished and their right to pray and practice their religion was respected. Significant events, such as Christmas and birthdays were celebrated in the service. Information about people's specific cultural needs had been recorded in their care plan and were known by staff.

Inadequate

Is the service responsive?

Our findings

Some people and their relatives told us that the staff were responsive to their needs and requests. One person told us, "The staff are always walking past my room you can call out or they come in and chat and listen to you." However, one person using the service told us, "No I don't like it here particularly, you have to wait all the time for them to come and now I hear there is something up with the lift so everything has to be brought up and down the stairs, we have to wait for stuff to be brought to us, but the staff are pretty good." A person's relative told us, "Yes they did listen, because we insisted that mum did not stay in her room; we wanted her to go into the dining room and have her meals in there."

At our inspection on 18 November 2015 and 4 November 2016 we found that the registered provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. People's needs care had not been planned and delivered in a way that reflected and met their individual needs, preferences, and social history. People did not have care plans to support them to manage the symptoms of their dementia and there were no plans to promote individuals continence. People were not supported to have a bath or shower at the times they said they wished to. The registered provider sent us an action plan telling us they would be compliant with this regulation by 31 January 2017. At this inspection we found that the registered provider continued to breach this regulation.

Each person had a computer based care plan that addressed some of their care needs such as their personal care needs and health needs. However, this was not written in a way that ensured their care was provided in a personalised way. For example, people had been asked when they would like a bath and this was recorded in their care plan, but there continued to be a bath rota in operation which did not reflect these requests. A bath rota is considered to be institutional practice and not in line with providing personalised care. The records showed that staff were following the bath rota rather than the preferences detailed in individuals care plans. In some cases the bath rota had not been followed and records showed that people had not had a bath for long periods of time. For example, two people's care plans said they would like a shower twice a week. Their care records only showed one recorded in the last 30 days. Another person had also requested two showers a week. It had been recorded that one had been offered and declined and had one received within last 30 days. We asked the deputy manager if they could confirm that the service users had been supported to have a bath or shower on any dates other than those recorded, but they told us that the personal care records and the bath book would be the only record of this.

People's care plans for their continence continued to lack detail and personalised information about the support they required to remain continent. The care plans stated that the person should be offered the use of the toilet regularly, but there was little information about what regularly meant to ensure that staff were consistent in their approach. Each person is different and will have different requirements regarding how often they need to visit the toilet. Where people required the use of continence aids it was not recorded in their care plan what type and size they were prescribed.

The majority of people using the service were living with dementia, but we found that their care plans continued to lack information about their needs in this area. Information about hallucinations as a

symptom of a specific type of dementia had been added to a person's care plan following the inspector raising this at the last inspection. However there was no guidance to direct staff how to respond when the person was hallucinating. There were no care plans for people living with dementia to outline how their dementia affected them and what staff must do to help them manage the symptoms and live well with dementia. This could include agreeing responses that staff would or would not give to a person when they are confused or experiencing memory loss. One person's care plan stated that they often had disturbed nights and will 'wander'. The care plan instructed staff to encourage the person back to bed, but there was no exploration of the reasons for the disturbed nights and no guidance about how to comfort the person, for example offering a cup of tea, watching TV or having a chat for half an hour until tired again. Another person's care plan for their communication stated that their dementia was affecting their communication and they were becoming more confused. The care plan did not include any guidance for staff about how to support this person to overcome this difficulty, such as considering their hearing, vision, communication aids, risk of infections or the impact of the time of day on their levels of confusion. A further person's care plan for their mental health stated that they could become emotional and agitated if they could not remember things. There was not a clear plan in place to help them with their memory loss to avoid this agitation.

People did not have effective care plans that met their social needs. People's care plans continued to lack guidance for staff about how to ensure they receive the support they need to continue with hobbies and interests. For example, one person's care plan noted that they liked to feed the birds. There was no plan in place to ensure they received support to do this and there were no records to show this had happened. People told us that recently the range of opportunities for social activities had reduced in the service. One person said, "A few months ago the bus broke down and we can't seem to get another bus, I really miss it, it's so important to go out. The lucky ones here go out if they have relatives who come and take them out, but now not much goes on. We used to go to a big shopping centre, garden places and churches. A lot more used to go on, much more lively, now everyone sleeps. We all liked the bus going out once a week; we really liked it." Another person said, "I do say to the staff there should be more to do, but I don't think they listen much to that. If you look around here everyone is asleep that's no good, it would be good if they did more to keep everyone awake." The registered manager confirmed that there had been no outings in the last two weeks due to a lack of transport and that some activities had needed to be cancelled. Some entertainers were still arranged and on the second day of our inspection a singer was visiting. People had access to some craft activities and those that could use these independently enjoyed doing so. One person told us, "They have sorted some of my watercolour paintings here you can see them on the wall, I would like to paint some more here, but I don't think they can manage the paints so I have this colouring book, this keeps my brain going. I like anything that keeps me thinking." There was an activities worker employed at the service, who worked in this role two days a week. A further activities worker provided seven hours a week of activities. A music therapy group was held once a week and a music for health session monthly. There was also an exercise session once a week.

The registered provider had not ensured that people had personalised care plans that ensured their care was provided in a way that met their individual needs. Staff were not provided with the information they needed to provide people's care in a consistent way. People did not have their social needs met. This was a continuing breach of Regulation 9 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 from our November 2015 and November 2016 inspections.

People and their relatives were aware of how to make a complaint. Information about how to complain was provided for people in the brochure and in the reception area of the service. There had been no complaints recorded.

Inadequate

Is the service well-led?

Our findings

People and their relatives told us that they were satisfied with the service provided. Despite this positive feedback, we found that the service was not well led.

At our inspection on 18 November 2015 and 4 November 2016 we found that the registered provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. The registered provider did not have effective systems in operation for checking and improving the quality and safety of the service people received. Systems for ensuring people's care met their changing needs were not always effective. The registered provider had not ensured accurate and complete records were maintained in relation to people's needs, the care provided and the running of the service. We issued a warning notice in respect of this breach and required the registered provider to meet the Regulation by 31 January 2017. At this inspection we found that this regulation continued to be breached.

There continued to be a lack of effective systems for monitoring and improving the quality and safety of the service. The registered provider had not identified the breaches of regulation we found in our inspection. Audits were in place to make checks of the safety of the service, including the safety of equipment and fire safety. However, action had not always been taken to address shortfalls. A water safety report had been completed by an external contractor in May 2017. The report had been filed away, but the required actions had not been completed. This included introducing a system to regularly 'flush' through standing water in an unused bathroom to reduce the risk of legionella. The director of the company, present at the time of the inspection, arranged for a contractor to quote for the work. The delay in action placed people at harm from potentially unsafe water supply. There were no systems in operation to check the people were receiving the care they needed and wanted. The registered manager was unaware that people were not being supported to have a bath when they wished and that those that required it were not having their fluid intake monitored effectively. The registered manager told us that they intended to introduce a medicines audit and a new infection control audit, but had not yet been able to do so. Monthly management meetings had been held between the registered provider and the registered manager, but these did not identify or discuss the breaches of regulation we found.

The registered manager described action they had taken to reduce the risk to individuals when they had fallen, such as moving furniture in their bedroom. However there was no overall analysis of falls in the home to allow the registered manager to identify any trends and further reduce risk. Accidents were recorded, but these were not appropriately analysed and the action taken to prevent an accident reoccurring had not been recorded. An incident report had been completed by a staff member about a person who had been found on the floor on the first day of our inspection. The staff member had stated that the person had slipped from their chair, but at the time of the incident there were no staff members present to witness it so this record was based on a verbal report from another person using the service rather than known facts.

During our inspection we identified that the hot plate in the servery presented a risk of injury and discussed with the registered manager the need to assess and manage the risks. The registered manager asked us what they should do to respond to the risk. Registered managers must be able to take decisions to ensure

the safety of people using the service. The registered manager did provide us with a completed risk assessment on the second day of our inspection.

Records about the care provided to people and their wellbeing were limited. Staff had reported on the personal care provided to people and people's physical health needs. Staff did not record and monitor people's mental health, for example there was no record of how people's dementia was affecting them or progressing in order to monitor patterns. Staff did not consistently record how people were occupied during the day to ensure that the registered manager could monitor that their social needs were being met. There was incomplete recording of the food and fluid intake of those identified as being at risk. There was a lack of records to show what action had been taken to respond to low food and fluid intake. A person's care plan said that they often became aggressive to staff and another person using the service. The plan stated that staff must record and monitor this risk. Staff were unable to produce the records to show this was monitored and there had been no review and analysis of the behaviour to identify any patterns that could help further reduce the risk. This meant that when people's care plans were reviewed there was no record of what was working well and what might need to be improved in these areas.

Care plans did not always provide sufficient information about people's needs to ensure these could be met consistently, particularly when agency staff were employed in the service. A person's care plan stated that they often refused personal care and could become aggressive towards staff. Staff we spoke with were able to describe a number of positive strategies that they used to help the person calm before offering the care again. This included offering a cup of tea and a banana or using a different staff member. However this information was not recorded in the care plan. This meant that not all staff had access to the information and consequently may not approach the refusal of care in a consistent way.

Where people were able to complete a questionnaire they had been given the opportunity to do so since our last inspection. One person told us, "I think I did fill in some sort of survey once some paper thing, they do ask about what you would like to do and what you think of the food." The registered manager was unable to demonstrate how people had been involved in reviewing their care plans. They had not explored alternative ways to help people communicate their views when their dementia made this challenging. People's relatives had been asked to complete a questionnaire and the registered manager was able to describe action taken to respond to suggested improvements and comments received.

The registered provider had failed to respond effectively to previous breaches of regulation. At our inspection on 18 November 2015 we found six breaches of regulation. At our inspection of 4 November 2016 we found that four of these regulations continued to be breached and the registered provider was in breach of a further three regulations. We met with the registered provider following our inspection in November 2016 to discuss our concerns and seek assurance that action would be taken. At this inspection we found that four of these regulations continued to be breached and the registered provider was in breach of a further four regulations. Following our last inspection the registered provider had appointed a new registered manager to address the breaches of regulation and make improvements to the quality and safety of care. We found that the registered manager had not developed a robust action plan to respond to the breaches and they had not carried out assessments of the service to establish areas for improvement. The registered manager told us it was taking longer than they had anticipated to get a clear plan for change in place. The registered manager told us that their initial remit had been to address the concerns in the inspection report and review the quality of staff performance. We found evidence in this inspection that these matters had not been resolved.

The registered provider had not ensured that the service was managed in a way that delivered consistent safe and effective care to people. They did not have effective governance systems in operation and had not

identified shortfalls in the quality and safety of the service. Accurate records were not kept for the purpose of running the service. This is a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 from our November 2015 and November 2016 inspections.

The registered provider did not have effective procedures in place for dealing with emergencies. When we arrived on the first day of our inspection the registered manager informed us that the shaft lift had broken the previous day and the top section of the stair lift was out of order. Three people had been required to sleep in the lounge on recliner chairs as they were unable to get up to their bedrooms. Three people were upstairs and unable to access the downstairs facilities as they could not use the stairs. Staff had arranged for their meals to be delivered to their bedrooms. There was one full body hoist that was required for people who could not weight bear. This was located on the first floor and could not be brought downstairs without the lift. This meant that three people who would usually use this equipment had to be supported to move with a 'stand aid' hoist which requires the person to be able to weight bear. The registered manager told us that the staff had assessed this and found it was safe to use this in an emergency situation. However, there was a note on the office whiteboard that stated one of these people must use the full body hoist at all times. When we asked staff how they had moved the person to support them with personal care they advised they had used the stand aid hoist. The stair lift was repaired during the first day of the inspection, but the shaft lift had not been repaired by the time we left on the first day. There was no contingency plan in place to manage people's care if the lift broke down. We discussed this with the registered manager who advised that they would put an extra member of staff on overnight. They then developed a plan and shared it with us on the second day of our inspection. This included ordering a second full body hoist and sourcing temporary accommodation if the lift is out of action for longer than 24 hours.

During the inspection a person using the service reported to staff that a person was on the floor in the lounge. Staff went in to attend to the person. As the hoist was upstairs and could not be brought down, due to the broken lift, staff were unclear what to do. The registered manager did not provide clear and authoritative direction about how to manage the emergency. A member of care staff carried the full body hoist downstairs, which the registered manager said they did not agree with, however there was no alternative strategy in place to respond.

The registered provider had not ensured they had taken all reasonable action to mitigate risks to people's welfare. They did not have in place arrangements to take appropriate action in the event of an emergency. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

At our inspection on 4 November 2016 we found that the registered provider was in breach of Regulation 20A of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. They had not displayed the rating issued under the Care Act 2014. The registered provider sent us an action plan telling us they would be compliant with this regulation by 31 December 2016. It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. At this inspection we found the provider had conspicuously displayed their rating in the reception.