Chestnut Care Limited

Savile House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 11 April 2017 and was unannounced. At the last inspection on 17 November 2016 we rated the service as 'Inadequate' and in 'Special Measures'. We found eight regulatory breaches which related to staffing, nutrition, safe care and treatment, dignity and respect, person-centred care, premises, recruitment and good governance. Following the inspection the provider sent us an action plan which showed how the breaches would be addressed. This inspection was to check improvements had been made and to review the ratings.

Savile House provides personal care for up to 24 older people, some of who may be living with dementia. There were 18 people using the service when we visited. Accommodation is provided on three floors, there are single and shared rooms and some have en-suite facilities. There are communal areas on the ground floor, including a lounge, dining room and conservatory.

The registered manager left in February 2017 and the deputy manager has been appointed as the manager of the home. The provider told us the manager would be applying for registration with the Care Quality 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 manager was not working on the day of this inspection; however the provider attended and received feedback from us at the end of the day. Overall we found limited progress had been made in improving the quality of service for people at Savile House.

Although the provider had increased the staffing levels, people told us there were not enough staff to meet their needs, particularly at night. Our observations confirmed this, as there often were no staff present in communal areas and on at least three occasions we had to go and find staff to assist people who needed help.

Staff recruitment checks were not always completed before new staff started work as we saw a reference for one new staff member was dated three days after they had started employment. Our review of records and discussions with new staff showed the induction process was not thorough. Staff competencies and skills to do the job had not been ascertained before they worked unsupervised, placing the people to whom they provided care at risk of unsafe and inappropriate care. Some staff training had taken place since the last inspection.

Medicines were stored safely and appropriately. However, we found a lack of consistency in the way medicines were managed which meant we could not be assured people were receiving their medicines as prescribed or when they needed them.

Individual and environmental risks were not well managed. For example, although incident reports showed one person's behaviour posed risks to other people there was no plan in place to show how these risks were being managed to protect people. Although there were some environmental risk assessments, not all areas of risk had been considered or managed. A gas fire in use in the dining room was unguarded posing the risk of burns or accidental contact with combustible materials. Adaptations had been made to the communal toilets on the ground floor however people who required a hoist to transfer were still not able to use these facilities in a way that maintained their privacy and dignity. Staff told us they struggled to use the hoist safely due to space restrictions and the layout of these rooms.

Staff had limited understanding of safeguarding and whistleblowing procedures. Although we saw some incidents had been referred to the local authority safeguarding team we found other incidents had not as they had not been recognised as potential abuse.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible.

People had access to healthcare services such as GPs, district nurses, dentist and chiropodist. A healthcare professional we met during the inspection said the staff were prompt in reporting matters and acted on advice they gave.

New care documentation had been put in place, however care plans were not always person-centred, up-to-date or accurate which meant people were at risk of receiving inconsistent and inappropriate care.

People told us they enjoyed the meals, although some felt the quality of food could be better. New food and fluid charts had been put in place to record people's dietary intake, however, we found these were not being checked by senior staff to ensure people had received sufficient to eat and drink.

People told us the staff were kind and caring, although they said some staff were better than others. Our observations and discussions with people and staff showed people's privacy, dignity and rights were not always respected or upheld. People told us there were limited activities and this was confirmed by staff.

People's care records were not person-centred and did not reflect people's needs or preferences. The complaints procedure was displayed and we saw the service had received one complaint since the last inspection. However, the details of the complaint and the subsequent investigation were not clear.

The rating from the last inspection was not displayed in the home. The provider told us they thought the report displaying the rating had been removed by a relative but could not tell us when this had happened.

We found there was a lack of consistent and effective management and leadership which coupled with ineffective quality assurance systems meant issues were not identified or resolved. This was evidenced by the continued breaches we found at this inspection. Following the inspection we made a number of safeguarding referrals to the local authority safeguarding team. We also contacted the planning department at the local authority to discuss the adaptations which had been made to the toilet facilities.

We found shortfalls in the care and service provided to people. We identified eight breaches in regulations – staffing, safe care and treatment, dignity and respect, person-centred care, consent, fit and proper persons, good governance and failure to display the rating. The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and

appeals have been concluded

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

Medicines management was not safe and effective, which meant we could not be assured people received their medicines as prescribed.

Staffing levels were insufficient to meet people's needs in a timely manner. Staff recruitment processes were not robust as checks were not always completed before new staff started work.

Risks to people's health, safety and welfare were not assessed and mitigated. Safeguarding incidents were not always recognised, dealt with and reported appropriately.

Is the service effective?

Inadequate

The service was not effective.

Staff had not always received the induction, training and support they required to fulfil their roles and meet people's needs

The service was not meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were not always met. People's healthcare needs were assessed.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us most of the staff were kind and caring. However our observations showed people's privacy, dignity and rights were not always respected and maintained by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were not person-centred and did not reflect

people's preferences.

People told us activities were limited. Although people's interests and hobbies were recorded this information was not used to support people in meeting their social care needs

Systems were in place to record, investigate and respond to complaints, although improvements were needed to ensure these procedures were fully implemented.

Is the service well-led?

Inadequate

The service was not well-led.

Leadership and management of the service was not consistent or effective. The registered manager had left and the deputy manager was now managing the service.

Quality assurance systems were not effective in assessing, monitoring and improving the quality of the service and we found regulatory breaches identified at the previous inspection had not been met.

Savile House

Detailed findings

Background to this inspection

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

This inspection took place on 11 April 2017 and was unannounced. The inspection was carried out by two adult social care inspectors and an expert by experience with experience of services for older people. 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 information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioning and safeguarding teams and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We did not ask the provider to complete a Provider Information Return (PIR) as they had completed one before our last inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We observed how care and support was provided to people. We spoke with eight people who were living at the home, three visitors, two senior care workers, four care workers, the chef and the registered provider. We also spoke with a visiting healthcare professional.

We looked at five people's care records, four staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms and communal areas.

Inadequate

Is the service safe?

Our findings

At our previous inspection we found systems and processes in place to manage medicines were not safe or effective. At this inspection although we found some improvements, concerns remained.

We looked at a sample of medicine administration records (MARs) and found discrepancies which indicated people had not always received their medicines as prescribed. For example, one person was prescribed a pain relieving medicine to be given twice a day, yet the MAR showed this medicine had not been given for two days as the stock had run out. This person was also prescribed a laxative to be given at night. The MAR showed this medicine had not been given over a 15 day period. There was no record to show this had been brought to the attention of any healthcare professionals.

We saw some people were prescribed 'as required' medicines. There were protocols in place for some of these medicines but not all. For example, one person was prescribed a medicine to ease anxiety. There was no protocol in place to guide staff as to when this medicine should be given. Another person prescribed a similar medicine had a protocol in place which advised staff to consult a behaviour chart to determine when this medicine should be given. This was not with the MAR and when we asked staff and the provider they acknowledged this information was not available. We saw this medicine had been administered several times yet there were no reasons recorded on the MAR to explain why staff had given the medicine.

Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These medicines are called controlled drugs (CD). The senior staff member told us one person was prescribed a CD. We checked the stock balance against the CD register and found this was correct. However, when we checked the MAR we found the last two administrations of the CD on 9 and 10 April 2017 had not been recorded.

Senior staff told us one person received their medicines covertly (hidden in food or drink). We saw staff had handwritten 'covert' on the MAR next to each medicine, yet there was no guidance to inform staff how the medicine should be given, for example, in specific food or drink. We saw only two of the medicines were tablets and all the others were in liquid form. The senior staff member told us they found the person took the liquid medicines normally and did not require them to be given covertly. They said they thought the tablets which were given early in the morning were put in the person's porridge but were not sure as these were administered by the night staff. We checked this person's care records and found conflicting information about covert administration.

Senior staff told us another person had their medicines crushed and there was a letter from the person's GP confirming this. However, there were no instructions on or with the MAR to show how these medicines should be administered. The senior staff member told us they crushed all the tablets together and then mixed them with water and gave them to the person on a spoon.

The provider's medicines policy was dated 23 February 2005 and had not been updated since the last inspection. This did not include any guidance about covert or crushed medicines. The provider told us they

had a copy of National Institute for Health and Care Excellence (NICE) document "Managing medicines in care homes guideline (March 2014), but were not able to produce this guidance when we asked to see it. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection we made a safeguarding referral to the local authority safeguarding team about the medicine concerns we had found.

People we spoke with told us staff administered their medicines although some people felt there was sometimes a delay in receiving them. One person said, "The staff do this [give out medicines]. It varies. Sometimes I get them sooner and sometimes I get them later." Another person said, "The time can vary when we get our medicines. It depends how busy they [staff] are." A further person said, "It is the senior staff that give out the medicines. I usually get my medicines on time."

We found medicines were stored safely and securely. Thickening agents had been removed from the kitchen and were now stored in the locked treatment room. Medicines requiring cold storage were kept in a medicine fridge where the temperature was monitored daily and recorded. The application of creams was delegated to care staff delivering direct care. We saw creams were stored in people's bedrooms and topical medicine administration records kept in people's rooms were completed correctly.

At our previous inspection we found there were not enough staff on duty to meet people's needs and we identified the same concerns at this inspection. At this inspection the provider showed us a staffing tool they used to calculate the staffing levels according to people's dependencies. Although the provider told us care staff hours had increased during the day, our observations and feedback from people who lived in the home, relatives and staff indicated the staffing levels remained insufficient.

Most people we spoke with told us they felt safe in the home. However, there were mixed responses when we asked people if there were enough staff to assist them. Two people told us they felt there were enough staff. Two other people made the following comments: "There is not enough staff – like last night there was only one on all night" and "There are two carers at night and three care staff during the day. I don't think there are enough staff. There was only one carer last night – a male carer – I don't like a male carer seeing to my personal care needs." We established there had been two care staff on duty overnight, however one of the staff members was unwell which may have led to the male staff member carrying out most of the care tasks.

Relatives made the following comments about staffing: "In the past it has been hit and miss – never having enough staff. It seems ok at the moment. Although the staff are pushed and kept busy all of the time" and "There have been some changes. Two staff have left and there are new staff. They are always busy. That's why I come every day at lunchtime. It does take the pressure off them."

Staff told us there were not enough staff to meet people's needs. Some staff said they occasionally felt pressured into doing additional hours at short notice. One staff member said, "Some shifts are too long, and we all feel we could do with extra staff. Putting people to bed can be a challenge. If there are just two of us and we are both needed to help someone there is no one to watch the floor." Another staff member said, "We have to do cooking in the evening and at weekends, we help with the laundry and cleaning as well. We often don't get breaks, you try but we have to protect people when they need us." A further staff member said, "It wouldn't be good enough here for my mum. I wouldn't like to think she was left on her own when staff are just too busy."

On the day of our inspection there were four care staff on duty from 8am, two of these staff were new and had worked at the home for only a couple of weeks. We observed communal areas were often left with no

staff present. On at least three occasions we had to go and find staff to help people who required assistance as there were no staff in the communal areas. We saw the call bells were fixed to the wall, meaning people may not have been able to use them if they needed assistance. We found care staff were still carrying out additional tasks related to laundry, cleaning, cooking and activities as well as providing care to people.

At night there were two care staff on duty from 10pm until 8am to meet the needs of people accommodated in rooms on three separate floors. Staff told us four people, who were all on different floors, required a hoist and two staff to assist them. Due to the limited space in some bedrooms a mini hoist was used at night which meant staff had to transfer the hoist between floors. In addition staff told us four people often were awake and walking around at night. This placed people at risk of harm as when both staff were attending to a person there were no staff available to respond to other people's needs. This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found robust recruitment procedures were not being followed. At this inspection we looked at the recruitment records of three staff. These included an application form, interview notes, employment and character references, and checks made with the Disclosure and Barring Service (DBS). The DBS holds information about people who may be barred from working with vulnerable people. We found a reference for one staff member was dated three days after they had started work in the home. We concluded the provider's recruitment practices were not always safe. This was a breach of the Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always have robust knowledge of procedures to follow if they suspected someone using the service was at risk of abuse. Some staff did not recognise the term 'safeguarding', believing this referred to risk minimisation measures such as removing trip hazards and safe usage of hoisting equipment. Staff told us they would report any concerns about people to the manager, but there was a lack of awareness of the provider's whistleblowing policy or which external bodies to refer concerns to, such as the CQC. Whistleblowing is the process by which staff can raise concerns about wrongdoing or poor practice within social care settings. We saw some safeguarding incidents had been referred to the local authority safeguarding team and notified to the CQC. However, we found one incident which related to a suspected theft where safeguarding procedures had not been followed.

Care plans we looked at contained risk assessments related to people's care and support needs. These included risks associated with falls, nutrition and hydration, oral care, moving and handling and skin integrity. We saw the risk assessments contained guidance which showed staff how care and support should be provided in ways which minimised these risks, however we found this did not always contain full up to date information. For example, we saw information in one person's care plan about anxiety the person experienced when being transferred using a hoist. There was information in the daily notes which showed how a staff member had found an effective method of reducing this anxiety, but this had not been included in the guidance for staff.

Some risks associated with people's care and support had not been assessed. We saw one person had exhibited behaviours which challenged the service and may have put other people at risk. Although we saw staff had responded to the incidents, there was nothing in the person's care plan to show the risk of repeated incidents had been documented with guidance for staff to follow.

The provider had undertaken some environmental risk assessments, including those for fire, legionella, use of ladders and use of external areas of the home. We also saw there was a plan in place to ensure people's continued safety in the event of a serious incident such as sustained loss of mains power or significant damage to the building. However, some environmental risks had not been considered. We saw there was a

large staircase rising from the ground floor to second floor. Risks associated with people prone to falls or with poor mobility choosing to use this staircase had not been considered, although there was nothing to prevent people accessing it. In addition we saw there was a gas fire in use in the dining room. There was no guard around this to help reduce the risk of burns or accidental contact with combustible materials. The use of this fire had not been considered in the provider's risk assessments.

At the previous inspection we found the premises were not always suitable to meet the needs of people who required a hoist to transfer safely. This mainly related to the accessibility of three toilets on the ground floor. At this inspection we found there were now two toilets on the ground floor. Building work had been completed creating one larger room with a toilet and the toilet in the other room had been repositioned to make it more accessible. However, staff we spoke with told us the design of the rooms meant space was still restricted when they were using the hoist and they still struggled to provide people with the support they needed in a dignified way. We saw screening curtains affixed in the area outside the toilet were still being used which continued to block the access route to the other toilet. Following the inspection we contacted the local authority planning team to discuss the building works and we were advised a building inspector would be consulted.

Each person was listed on the provider's Personal Emergency Evacuation plan (PEEP). A PEEP is intended to show the level of each person's ability to understand and respond to any evacuation of the building. However, we saw the PEEPs showed only the level of assistance each person required to mobilise. We concluded the evidence above showed risks to individuals and the environment were not assessed or mitigated which constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with said they would know what to do in the event of a fire, and were confident they had the knowledge needed to keep people safe. We saw one fire drill had taken place since our last inspection, and another was scheduled for the month following our most recent visit.

We looked at the maintenance records for the home. We saw there were certificates showing fire systems and equipment, electrical systems, gas installations and lifting equipment were tested to ensure their safety at appropriate intervals. In addition the provider had records to show fire doors and systems such as break glass points, water temperatures and emergency lighting were tested regularly. There was a rolling programme of health and safety checks and action plans, and we saw these were reviewed by the manager.

Inadequate

Is the service effective?

Our findings

At our last inspection we identified concerns relating to the training and support staff received. We found similar concerns at this inspection.

We spoke with two recently recruited staff about their induction, both of these staff were working unsupervised on the day of our inspection. They told us their induction was brief, and said they did not always have time to read care plans before they began to provide care and support. One staff member, who had no previous care experience, told us since starting in post six weeks previously their induction and training had consisted of an explanation of the fire procedures and training in moving and handling and diet and nutrition.

The other staff member told us, "I had three days shadowing an established member of staff. They observed my practice." They told us they had been observed administering medicines on three occasions to ensure their competency. They confirmed no records had been completed as part of these assessments and we saw there were no induction, training, observation or competency records in their file. The provider told us the staff member had a level 2 NVQ from previous employment; however they were unable to provide evidence of this. This meant there was no evidence to show this staff member's competency and skills had been determined or assured before they started to work unsupervised.

Other files we looked at showed staff completed a large amount of induction training on one day, and this was mostly related to operational issues such as layout of the workplace, explanation of the manager's role and how to contact them, staff meetings, noticeboards, complaints procedures and fire precautions. Some training related to care was also delivered on the same day. This included nutrition and diet, dementia, abuse and neglect, infection control and first aid.

The training matrix given to us by the provider showed staff were generally up to date with training the provider identified as mandatory. This included topics such as health and safety, infection control, fire safety and food hygiene.

Staff gave variable responses when asked about the frequency and effectiveness of supervision meetings and appraisals. One staff member told us, "I filled in a form for my appraisal weeks ago. I'm not sure when it is going to happen. I'm not sure I've had a supervision." Other staff we spoke with said they had supervision meetings, but could not tell us how often these were supposed to take place. We asked to see the provider's policy covering supervision and appraisal. They did not have one. We saw there was a schedule of planned supervisions, and the provider told us the frequency was variable according to need. This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

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

The provider was not always timely in recognising when a DoLS application was required. For example, we saw an undated pre-admission assessment for a person admitted to the home on 6 December 2016 which showed they would need a DoLS. However, the provider had not applied for the DoLS until 30 March 2017. We saw incidents dated 4 and 10 March 2017 which showed the person was putting themselves at risk by attempting to leave the home unsupervised. The capacity assessment relating to their ability to leave the home alone was dated 30 March 2017.

We looked at DoLS applications made by the provider. One person had a DoLS in place with conditions attached. Conditions list actions providers must follow in order for the DoLS to be lawful. The provider could not provide us with evidence to show they had acted in accordance with the conditions on the person's DoLS. These stated formal records should be made relating to any behaviours which challenged the service, to ensure the provider could demonstrate they had always attempted to manage these in the least restrictive way. This had not been done. In addition the provider was required to have an activity plan in place to enable them to demonstrate they had been encouraging the person to socialise with other people living at Savile House. The provider was not able to provide any evidence of this, however after the inspection they sent us a copy of an activity plan for this person dated 6 April 2017, although there was no evidence to show the activity plan had been implemented.

We looked at two other DoLS applications the provider had made. We found the explanation of why the DoLS was required was unclear, and demonstrated a lack of understanding of the processes. On one application we saw the restriction described the person's occasional refusal of their medicines.

Staff we spoke with had variable knowledge of the MCA and DoLS and not all said they had received training in this area of care. One staff member told us, "It is about people's capacity to make decisions. I'd look in their care plan to see what decisions they would make." Another staff member said, "I've not had any training about this, I think it is to do with people who don't know what they are doing." Some staff could tell us the names of people with DoLS in place, and knew where information relating to this was kept. However, one staff member we asked about DoLS said, "I don't know what that is." They were aware some people could be prevented from leaving the home, however said they would prevent anyone from leaving unless they were with a family member.

Care plans we reviewed lacked evidence the provider was making assessments of people's capacity to make a range of specific decisions. Two care plans contained capacity assessments relating to people leaving Savile House unsupervised. Both assessments were clear and concluded the people lacked capacity to make that decision. However, we did not see any evidence to show how decisions had or would be made in the person's best interests. Similarly, another person's care records showed they had bed rails and a sensor mat in place yet there were no capacity assessments or best interest decisions documented in relation to these restrictions.

We saw consent was not always being recorded appropriately. In one person's care plan they had signed their own consent for personal care, photography, medicines administration, information sharing with other health and social care professionals, and administering of vaccinations as required, for example for influenza. In another person's care plan we saw the relative had signed consent for the person to be

photographed, however no other consents had been signed. We did not see anything in the person's care plan which showed how their capacity to make this decision had been assessed. This was a breach of the Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people we spoke with told us the food was good. Comments included, "The food is all right. We get plenty. I am never hungry." "Oh yes I do like the food here." "Sometimes I like it and sometimes I don't. There is usually two things to pick from." "The food is very good here. I enjoy it – there is always a choice. They [staff] come round the previous day and ask you what you want."
However, two people told us the quality of the food could be better. One person said, "I can't get used to the food as I am quite hard to please. The quality of the food could be better."

We observed lunch and saw tables were set with tablecloths, place mats and condiments. Where people in the dining room required support with their meals we saw staff sat with them encouraging and prompting them to eat. People were offered a choice of cold drinks with their meal and a hot drink after dessert. We saw people were offered drinks and biscuits throughout the day.

We spoke with the cook about their approach to meal planning. They told us they had a two weekly menu which was changed at six monthly intervals. They said they had access to a range of fresh produce, and told us they regularly asked people about the meals they were served. We received conflicting information about whether the food was always suitable for people with diabetes. The cook told us they did not adapt menu items such as puddings or cakes to ensure the sugar content reduced the risks to people. They said, "I don't make separate things, everyone gets the same. I think the staff watch people's sugar intake in drinks and jams." A staff member we spoke with told us they believed meals were adapted to ensure people with diabetes received an appropriate diet.

We saw food and fluid charts were in place for people who were low weight or identified as nutritionally at risk. We saw these charts had not been monitored or reviewed by staff to ensure people were receiving sufficient amounts to eat and drink and the provider acknowledged this when we showed them the charts. For example, we saw one person's care plan showed they were prone to urine infections and stated they were to drink between 1800mls and 2 litres of fluid daily. We looked at their fluid charts over a six day period and found they had had received less than 1800mls every day. Another person's care records showed they were low weight and had a low body mass index. Their food and fluid charts recorded very little dietary intake on some days, yet there was nothing recorded to show this had been identified or addressed by staff. We had identified similar concerns at our previous inspection. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us if they were unwell staff would contact a doctor. One person said, "They would call the doctor out if ever I was ill." The care records showed people had input from different healthcare professionals such as GPs, district nurses, chiropodists, dentists and opticians. We spoke with a visiting health care professional who said people were referred to them appropriately and promptly by staff. They said any advice they gave was acted upon and felt communication was good.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection we found people's privacy and dignity was not always respected and we identified the same concerns at this inspection.

Most people we spoke with told us the staff were kind and caring, although comments made suggested there were differences between staff. One person said, "Some staff are nicer than others. The staff work very hard here." Another person said, "On the whole they [staff] are a nice lot. They are kind." A further person said, "The staff need a bit of a kick up their backside sometimes. Some staff are very good – others can be a little sharp when they speak to you and they can't get out of your room fast enough." Relatives we spoke with described the staff as good and kind.

Staff we spoke with knew people well and spoke about them with fondness. They were able to describe people's care and support needs, and could tell us about people's likes and dislikes.

We observed staff during our inspection and saw interaction with people was task based. Staff had little time to chat to people other than when they were providing care and support. For example, at lunchtime there was little interaction between staff and people in the dining room. There was silence whilst people eat their meal. Staff did not ask if people had enjoyed their meal and there were times when there were no staff present in the dining room. We sat in the main lounge after lunch. There were ten people in this lounge. Five people were asleep and five people awake. The five people that were awake were withdrawn, the television was on but no one was watching it and no interaction was taking place. One person kept calling out. There were no staff present during the time we sat observing and speaking with people in this lounge.

We found people's privacy and dignity was not always respected. One person told us they did not always feel safe because their bedroom was used as a thoroughfare. There were three doors in their bedroom. One led to the ensuite toilet and the other two doors led out onto separate corridors. The person told us, "I don't always feel too safe, as there are three doors in my room. One is the toilet door and the other two doors are open to traffic to everyone including staff and trades people. They don't all knock on the door and most don't apologise – they just walk through. There are no locks on doors- as they are fire doors, but there's no lock on the toilet door – privacy is very difficult in this room."

We observed some staff were indiscreet when discussing people's personal care needs in communal areas and saw staff did not always talk to people to offer encouragement or reassurance when performing tasks such as hoisting. One of the downstairs toilets could not be used by some people unless the door remained open. Curtains were in place to screen this area, however this did not ensure people's privacy when using the toilet and staff were not always present to make sure other people did not access this area when the toilet was being used. One person told us, "They could do with more toilets. They only have two toilets downstairs which can be a problem."

Overall the home was clean although there were noticeable malodours in the main entrance near to the dining room and in the lounge throughout the inspection. One visitor commented, "There is a lot of wear

and tear in the home and that is noticeable. The décor is very tired."

We observed most people looked clean and well dressed. However, we noted several people's hair was dishevelled and did not look as it had been combed or brushed. We saw one person had a large hole in their tights

We saw one person at tea time in the lounge and they had food stains all down their jumper from food they had spilt at lunch time. We saw the person had slipped down in their chair and heard the staff member repeatedly say to the person in a loud voice, "[Name) push your bum back." The person's care records showed they were living with dementia and we saw they did not understand what the staff member wanted them to do. The staff member brought a foot stool and put the person's feet up, although this made no difference to the person's seating position. The person then proceeded to eat the food and drink which had been left in front of them and in the process spilt most of it down their clothes as no clothing protection had been offered or given.

We saw another staff member sitting with a person in the lounge assisting them with their meal. The staff member did not engage with the person other than on one occasion when they said, "A bit more [name]" before putting some food in the person's mouth. For most of the time the staff member was looking at the television rather than interacting with the person.

People's care plans lacked information which would help staff build meaningful relationships with people. Good practice would be to include information about people's lives, cherished memories and important relationships; however we did not see this information recorded. We did see information relating to food and drinks people liked or disliked. There was no evidence to show how people had been involved in writing their care plans, and people or their representatives had not signed documents to indicate their agreement with them.

Our discussions with staff about equality and diversity showed some staff were not aware of how to support and respect people's rights appropriately. In particular, in relation to the protected characteristics of disability, race, religion and sexual orientation. For example, one member of staff told us they would prevent someone expressing their identity by wearing clothes of their choice if they considered the clothing was not appropriate to the person's gender.

This was a breach of the Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with all confirmed their friends and relatives could visit at any time and there were no restrictions. Relatives we spoke with also confirmed that they were able to visit at any time.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we found people's care plans were not person-centred, up to date or accurate. At this inspection, although new care documentation had been put in place we found similar concerns.

Care plans we reviewed contained an assessment of people's needs carried out before they were admitted to Savile House. These were used to develop a series of care plans, including those for memory, sleeping, medication, personal care, relationships and interactions, nutrition, mobility and falls. We found these did not always contain up to date information about people. For example, in an application for a Deprivation of Liberty Safeguard (DoLS) we saw the provider stated, 'In addition to this [name of person]'s Alzheimers causes visual and audial hallucinations which can make risks not be apparent.' We did not see any reference to hallucinations in the person's care plan, meaning the provider had not assessed any risks or produced guidance for staff to follow to ensure these risks were minimised. This person's care records showed they had diabetes, yet there was no reference to diabetes in their care plan. Another person had exhibited behaviours which challenged the service, and these had not been documented. A further person's daily records showed they had a sensor mat in their bedroom and bed rails and we saw these in place when we looked in their bedroom. However, there was no mention of this equipment in the person's care plans and no risk assessments, mental capacity assessments or best interest decisions had been completed even though the care records showed this person was living with dementia. There was no evidence to show how people were involved in the review of their care plans.

Risk assessments were reviewed monthly, and we saw records relating to these, for example weight measurements and records relating to falls. However, we found moving and handling assessments and care plans were not always clear or being followed by staff.

We were given conflicting information about which people needed a hoist to transfer. The provider told us there were three people who needed to use the hoist for transfers and one person who had been assessed as no longer needing a hoist. Night staff told us three people required a hoist which included the person the provider told us did not needed one. Our review of the care records showed four people required a hoist. However, we found people's care plans and risk assessments did not provide clear information for staff about their moving and handling requirements. For example, one person's moving and handling care plan stated the use of the hoist depended on the mood of the person and described how two staff and an assistance belt were required when the person was having a 'good period' and a hoist would be required when they were having a 'not good period'. We saw this person being assisted to mobilise by two staff at several times during the day but an assistance belt was not used. We looked at the bedrooms of the four people whose care records showed they required a hoist and found there was restricted space to manoeuvre a hoist in three of the bedrooms. Following the inspection we referred our concerns, regarding the safety and appropriateness of moving and handling practices in relation to people who required a hoist, to the local authority safeguarding team. This was a breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Daily records were kept, however we saw these were functional and repetitive, and did not always evidence

people had taken part in activities. We saw records were made in care plans which showed how the person liked to spend their time, but the daily records did not evidence people had been supported to maintain hobbies and interests. Staff we spoke with said they tried to provide activities when the activities organiser was not present, however they told us they did not always have time.

The duty rotas showed the activities organiser worked an hour a day five days a week. On the day of the inspection we saw this staff member spent time in the morning giving some people a manicure. In the afternoon we saw another staff member had organised a quiz with people in the lounge. The television in the lounge was on continually throughout the day. At one point during the morning there was loud music playing in one corner of the lounge and the television competing at the opposite end of the room. This cacophony of sound was not relaxing and we saw it made it difficult for people to communicate with each other. Conflicting sounds can also be confusing for people living with dementia. One relative said, "There is no quiet room for visitors to talk to their relatives. I have to speak with mum in either the lounge or dining room."

We asked people about the activities provided in the home. One person told us, "We don't generally have any activities. Some mornings we do for about a quarter of an hour – we play skittles or do exercise or have a quiz." Another person said, "We do have some activities such as skittles or a quiz. They [staff] try to do their best." A further person said, "We play skittles or have a general knowledge quiz." Another person said, "We could do with a nice garden to sit in."

One relative told us they came every day to have their lunch and helped their family member with their meal. They said, "The staff are always busy. That's why I come every day at lunchtime. It does take the pressure off them. I pay £2.00 for my lunch which is a nominal charge."

People we spoke with did not always know who they should speak with if they had a complaint or any concerns. One person said, "I don't know who I would speak to if I had a complaint." Another person said, "I would speak with my daughter if I had a complaint or a concern."

Relatives told us they would speak to the staff or manager if they had any concerns about the care their relatives received.

A complaints procedure was displayed in the home. We looked at the complaints file which showed one complaint had been received since our last inspection. We saw correspondence which showed the complaint had been acknowledged and the outcome had been reported to the complainant. However, there were no details of the specific complaint made and although there were statements from two staff, there was no information to show how the complaint had been investigated.

Inadequate

Is the service well-led?

Our findings

At our last inspection we identified shortfalls in the leadership, management and governance of the service. Following the inspection the provider sent us an action plan showing the action they had taken to address these issues and improve the quality of the service. However, at this inspection we found continued regulatory breaches which demonstrated the service had not improved. We concluded the service was not well-led.

The registered manager left the service in February 2017 and the provider informed us the deputy manager was now managing the service and would be applying for registration with the Care Quality Commission. The manager was not on duty when we inspected.

People we spoke with said they thought the home was well run, although two people told us they would not recommend the home. Comments included "Overall, I don't think I would recommend the home. Things could be better. The attitude of some staff could be better." "Overall, I think it is ok here." "I would recommend the home. They could improve staffing as they are understaffed, especially at night." "Overall, I would not really recommend it. There's not even a garden to sit out in. The quality of the food could be better."

Staff we spoke with gave limited feedback about improvements they had seen since our last inspection. All referred to the changes made to one downstairs toilet to improve access, and one staff member told us they thought some paperwork such as care plans had improved. Staff said they found the manager easy to speak with, however they told us they felt the provider did not listen when staff tried to talk with them.

We found the provider had not given sufficient consideration to the design, layout and access of the downstairs toilets for people with impaired mobility who required the use of a hoist. There was no evidence to show that national best practice, in line with requirements of the Equality Act 2010, had been sought to inform the redesign of these facilities. This meant people's privacy and dignity was still compromised when using these facilities and staff reported the difficulties they had in ensuring safe moving and handling practices when supporting people. Following the inspection the provider informed us they were taking action to address these issues.

We found the provider's arrangements for filing and storing information did not always demonstrate good governance practices. For example, information about people's care and support was stored in a number of different places, meaning people's care plan did not always contain a full record of the person's health and well being. Audit information was not well organised and we found there was a lack of evidence to show the audit process was sufficiently robust in ensuring meaningful improvement in the service.

There were not always policies in place to ensure the provider followed standardised processes. For example, when we asked for policies covering medicines management, supervision and appraisals for staff, training and quality assurance activities, we were told by the provider these did not exist. We saw many of the existing policies and procedures were dated 2005. The provider told us they intended to purchase new

up-to-date policies and procedures.

We saw audits and checklists relating to a number of areas in the service including infection control, health and safety, medication, falls and accidents, maintenance, nutrition, staff, complaints and safeguarding. Some audits were not conducted at the frequency the provider stated they should be. For example, there was no evidence of nutrition audits taking place in 2017, although the provider told us these should be done monthly. We saw the monthly medication audit had been completed only once in 2017. A separate medicine audit had been completed by a pharmacist on 15 March 2017 which identified the service needed to obtain guidance about crushing medicines and said staff should complete the back of the MAR when 'as required' medicines were given. We identified both of these issues at our inspection which showed they had not been resolved.

The quality assurance file contained evidence of actions required and who was responsible for completing these. We saw the manager had signed these to confirm completion. We could not understand how the audit activity was conducted without cross-referencing with information kept in other files.

We looked at the audit reports dated 28 February and 22 March 2017, completed by a consultant employed to help the provider drive improvement in the service. These assessed the progress made against the provider's action plan for Savile House. We saw a number of the issues raised, mirrored what we found on our inspection. These included staff requiring training in whistleblowing, a lack of documentation around behaviours that challenge the service, a lack of decision specific capacity assessments, care plans requiring more detail, lack of evidence of people being involved in their care plans, fluid charts not being checked by senior staff, consents not always being signed by someone with legal authority. We did not see evidence the provider had taken action in response to these findings. This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the inspection rating for the service was not displayed in the home. The provider told us the inspection report, which included the rating, had been displayed in the home and they suggested this had been removed by a relative. The provider could not tell us when this had happened. The legislation requires the rating to be displayed legibly and conspicuously in the service and on the provider's website. The provider confirmed they did not have a website. This was a breach of the Regulation 20A of the Care Quality Commission (Registration) Regulations 2009.

The provider held a relatives' meeting on 6 March 2017, and we saw there had been some discussion of our last inspection report and what the provider planned to do in order to improve the service. There had been a residents' meeting with the provider on 17 March 2017, and we saw there had been discussions about the activities people would like and how often they felt meetings should take place.

We asked for minutes of staff meetings held since our last inspection. We saw one had taken place on 4 April 2017, where some organisational changes had been discussed.

We found the monitoring of accidents and incidents had improved. We saw monthly audits for February and March 2017 which included the number of accidents that had occurred and considered any themes or trends so action could be taken to reduce the risk. The audit looked at the number of accidents occurring to individuals and recorded the action taken in response to increased risk.