Elder Homes Wellingborough Limited

# Dale House Care Centre

## Inspection report

125-129 Midland Road
Wellingborough
Northamptonshire
NN8 1NB

Tel: 01933445200
Website: www.elderhomes.co.uk

Date of inspection visit:
25 August 2016

Date of publication:
25 October 2016

## 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 carried out this inspection on 25 August 2016.

Dale House Care Centre is situated in Wellingborough in Northamptonshire. they are registered to accommodation for nursing and personal care, as well as treatment of disease, disorder or injury and diagnostic and screening procedures. They can accommodate up to 66 older people at the service, some of whom may be living with dementia. At the time of our inspection there were 35 people living at the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. 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 service did not have a registered manager in place, however; a manager had been appointed and they were in the process of registering with the Care Quality Commission (CQC). 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.

Risks to people's health, safety and well-being were not effectively managed. There was a lack of sufficient assessment of risks to people and where risks had been identified; staff did not have guidance in how to manage those risks and work to keep people safe. Monitoring of specific health needs was not completed on a regular basis, which increased the risk of harm to people.

Staffing levels were inconsistent and people's needs had not been thoroughly assessed to identify the

numbers of staff needed by the service. A dependency tool was in place, however; it was not used to demonstrate the staffing levels required. Staff were able to meet people's basic care needs, however; there were not enough of them on shift to provide people with stimulation and engagement in activities.

People's medicines were not always administered safely. Topical medicines, such as creams and ointments, had not been administered correctly which increased risks to people's well-being. Stock levels for some medicines had not been well-managed and staff were not able to account for the quantities of stock at the service.

Consent to care, treatment and support had not been sought by members of staff. Care plans failed to demonstrate that people had been involved in making decisions about the content of those plans, or that they had agreed to the way they would be cared for. Where people were unable to make their own decisions, the service had failed to work in accordance with the Mental Capacity Act 2005 and there was no evidence to show that decisions had been made following a best interests' process.

Care plans did not contain person-centred information. They failed to demonstrate the specific needs and wishes of each individual person and did not provide staff with guidance about how to meet people's needs. There were limited activities at the service, which meant that people spent much of their time with little stimulation or activity.

Quality assurance procedures at the service were not effective. Audits were carried out however; they failed to highlight key areas of the service in which improvements were required. There was a lack of management and oversight systems in place, which meant the manager and provider were unable to monitor, assess and drive improvements at the service.

Staff members were aware of safeguarding procedures and worked to make sure people were protected from abuse. They were aware of the requirement to report any suspected abuse and were prepared to follow whistleblowing procedures to ensure people were safe. Incidents were reported appropriately and the manager sent the CQC statutory notifications of incidents at the service.

People were provided with their choice of food and drink and were supported to maintain a healthy and nutritious diet. Staff encouraged independence and provided people with the support they needed with eating and drinking. They also made referrals to health professionals such as people's GP, dieticians or district nurses, to ensure their health needs were being met.

Staff members treated people with kindness and compassion. They worked to develop positive relationships with the people they cared for and treated them with dignity and respect. Visitors were welcomed to the service and staff members spent time getting to know them and working alongside them to ensure people's needs were met.

There was a positive culture at the service. Staff were motivated to perform their roles and felt well supported by the manager. They were able to talk to the manager about any concerns they had, as well as to share ideas about the development of the service. Feedback was welcomed by the provider and there were systems in place to manage complaints if they were raised.

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 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.

Risk assessments were not suitable or robust enough to ensure that staff were aware of risks to people at the service. There was a lack of control measures in place to reduce the levels of risk posed to people.

Medicines were not always managed appropriately. Medicines records were not completed fully and stock controls were not robust.

Staffing levels were variable and not sufficient to meet people's needs at all times. Recruitment practices were not always robust to ensure that all staff members were suitable to work at the service.

People felt safe and were care for by staff that were aware of their responsibilities in terms of safeguarding and potential abuse.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

People's consent to their care, treatment and support arrangements was not always sought by the service. For people who lacked the mental capacity to do this, the principles of the Mental Capacity Act 2005 had not been adhered to.

Staff members did not receive regular supervision, to provide guidance and support in their roles. This was in the process of being addressed and staff members did receive regular training, to equip them with the skills they needed.

Food and drink was provided, to ensure people's dietary needs were met. People had a choice of what they ate and their specific wishes and needs were catered for.

People were supported to maintain appointments with healthcare professionals within the service and the local community.

## Is the service caring?

**Requires Improvement**

The service was not always caring.

People and other relevant people were not always involved in planning their care.

Staff treated people with kindness and support and worked to develop positive relationships with them.

People were treated with dignity and respect by members of staff who worked to maintain their independence.

## Is the service responsive?

**Inadequate**

The service was not responsive.

People were not provided with activities and stimulation by the service/

Care plans were not person-centred and staff were not always aware of people's care and support needs.

There were systems in place to receive and act on any complaints or feedback raised.

## Is the service well-led?

**Inadequate**

The service was not well-led.

The quality assurance systems at the service failed to provide oversight of the service. Management systems did not identify areas which required improvement and there were no action plans in place to help drive improvements.

People and their family members were familiar with the manager and were able to discuss any concerns they had with them.

Staff members were positive about working at the service and working with the people they provided care for. They felt they were supported by the manager.

# Dale House Care Centre

**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 25 August 2016 and was unannounced. It was undertaken by a team of two inspectors.

Prior to this inspection we reviewed information we held about the service. This included reviewing past inspection reports and statutory notifications sent to the Care Quality Commission (CQC) by the provider. Statutory notifications are information about important events at the service, such as safeguarding concerns, which the provider is required to send to us by law. We also spoke with the local authority and clinical commissioning group, who have commissioning and monitoring roles with the service.

During the inspection we spoke with two people about the care and support they received from the service. Most people at the service were unable to engage in conversation with us about their care, due to the complexity of their needs. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We were able to speak with two people living at the service as well as three people's relatives, who were visiting on the day of our inspection, to seek their views of the service. We also spoke with the manager, a nurse, a senior health care assistant, two health care assistants and the activities lead. In addition, we spoke with two members of the housekeeping team and an administration assistant.

We reviewed care plans for seven people to see if they were an accurate reflection of the care that people were receiving. We also looked at staff recruitment files for six staff members, including five staff members that had been recruited within the past six months. Records relating to the management of the service were also seen, such as audit and quality assurance checks, to determine the level of service that was provided.

Inadequate

# Is the service safe?

## Our findings

Risks to people's health and well-being had not been well-managed by the service. Risk assessments in people's care plans failed to provide staff with specific guidance regarding the risks that were identified. Care plans stated that there were risks to people but there was nothing to explain how they were at risk or the actions that staff should take to help reduce the impact of those risks. There was nothing to show that risks had been assessed, which meant that staff members were not provided with information regarding the severity of risks. For example, we saw that one person had a behaviour care plan in place, which stated they were at risk of depression, anxiety, health deterioration and becoming angry. There were no details of the specific behaviour that this person displayed, or how this resulted in the risks identified. There was also nothing to demonstrate what staff could do to support this person and minimise the chances of these risks presenting themselves. This meant that staff members were not provided with information about risks, or guidance about actions they should take to minimise the chances of those risks occurring.

The service carried out monitoring of health needs, such as the Malnutrition Universal Screening Tool (MUST) and Waterlow assessments to monitor the risks of people developing pressure ulcers. However; these were not always completed regularly. For example, one person was recorded as being at high risk following the application of the Waterlow assessment, which had last been completed on the 25 May 2016. This meant that no further monitoring had taken place since then, to review the risk level or to make sure that this person's health did not deteriorate. There was no guidance in place for staff regarding the fact that this person was at high risk and no control measures in place to help reduce the risk. This meant that person was at increased risk of suffering from ill-health, such as developing a pressure ulcer.

We saw that another person had a re-positioning chart in place. There was no guidance in their care plan to inform staff how often this person needed to be re-positioned or why. Staff members were able to tell us that this person needed to be turned every two hours to prevent their skin condition deteriorating, however; the records on the chart did not show that this always took place. For example, the chart showed that this person was not re-positioned between 9.30am and 1.30pm on one day. This meant that this person was at risk of health deterioration as they were not being re-positioned on a regular basis. In addition, there was a lack of guidance in place for staff to follow, to ensure this person received the care and support they needed. The person did not have a pressure ulcer, however; they were placed at increased risk of suffering a decline in their skin integrity as appropriate preventative action was not being carried out. We saw that another person had no records to show that they had been re-positioned after 9am on the day of our visit. We saw that at 2.20pm they remained in the same position as their last recorded re-positioning. This increased the risk of them developing a pressure related injury.

General risks at the service were also not managed effectively. We saw that there were systems in place to manage environmental risks to people, visitors and staff at the service, however these were not always robustly completed. For example, we saw that monthly fire drills were carried out by staff at the service. Between April and August 2016 four drills were carried out, however; during each drill there were recorded concerns regarding staff actions during the drill. These included returning to the areas evacuated without prompting and not being aware of the procedures to follow. This placed staff members and others at

potential risk of harm, as returning to an area which may be on fire could result in injury or fire spreading to other areas. In addition, people and their relatives may take the lead from staff members and follow them into these areas. This meant that in a real emergency situation, staff members may not be able to take action to protect people from the risk of harm.

We spoke with staff members about how they dealt with specific risks to each person. They told us that they referred to the risk assessments in people's files to see what the identified risks were. One staff member told us, "Yes, risk assessments are in place and we use them." Staff members were unable to tell us about specific risks regarding each individual. They did show an understanding of general risks and took action, such as removing obstructions or trip hazards, to reduce risk levels at the service.

People were not always supported to have their medicines as directed by the prescriber. We looked at three people's topical Medication Administration Record (MAR) charts. These showed a number of occasions when topical medicines, such as creams or ointments, had not been signed for, to say that they had been given. We asked members of staff about these gaps, however; they were unable to tell us whether or not creams had been administered in accordance with the directions recorded on the topical MAR charts. This meant that people were not receiving their medicines as directed, which may have had a detrimental impact on their health and well-being.

We also checked stock levels of medicines at the service. We found that regularly administered medicine stocks were correct and matched what was recorded on MAR charts. When we checked as required (PRN) medication we found, for some people, that the recorded stock levels did not match what was actually in stock. In one case we found that there were over 400 additional paracetamol tablets in stock, in another there were 160 additional tablets. We spoke with staff and the manager about this, however; they were unable to explain the differences in actual and recorded stock levels.

The service had not taken appropriate action to assess the risks to the health, safety and well-being of people, visitors and members of staff at the service. There was a lack of guidance regarding risk which meant the provider had not done all that was reasonably practicable to mitigate risks at the service. There were also ineffective systems for the administration and management of people's medicines. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that the service made sure they received their regular medicines when they were supposed to have them. One person told us, "The staff deal with all my tablets, I do not have to worry about that." We observed staff members giving people their regular medications. They checked people's MAR charts before preparing their tablets and gave people the time and support they needed to take them. Documentation also showed that people were given their tablet medicines correctly and in accordance with the prescriber's instructions.

Staffing levels at the service were not always consistent and did not always ensure that people's needs were met. People's family members told us they did not think there were enough staff members on shift to meet people's needs, particularly at busy times, such as meal times.

Staff members told us that staffing levels were variable. For example, during our visit there was one nurse and three healthcare assistants on shift on the first floor. Staff said that this was sufficient to meet people's needs, however; they told us that on some shifts there were only two healthcare assistants. One staff member said, "It can be a challenge with just two [healthcare assistants] and the nurse. The nurse would have to stop what they were doing and do personal care or watch people. No-one was in the lounge with residents." Staff members also went on to tell us that they felt people were safer when there were a total of

four members of staff on this floor on a shift.

During our inspection there was one nurse and three healthcare assistants on the first floor. We saw that people's basic care needs were attended to by members of staff, however; staff did not have time to provide people with meaningful engagement and activities. This meant that people were often left sitting in communal areas with little staff presence or communication.

The manager told us that the service did not have a dependency monitoring tool in place to assess the numbers of staff required on each shift to ensure people's needs were being met. They stated that staffing levels were based on their experience of working in this type of service and the needs of the people living there. When we looked in people's care plans we found that dependency tools were in place. They were used to rate people as being at low, medium or high risk, however; they did not provide information regarding the numbers of staff required to meet that person's needs. In addition, individual dependency tools had not been collated to identify the levels of staffing required across the service as a whole. This meant the provider was unable to demonstrate that the numbers of staff on shift had been assessed as sufficient to meet people's needs.

We checked staffing rotas for three weeks and saw that the numbers of staff on shift did fluctuate. On the first floor we saw that there was always a nurse working however; on some days they were working with two healthcare assistants and other days they were working with three. There was no explanation of why these numbers fluctuated, or whether or not people's needs changed on different days.

Staffing recruitment practices were not always robust. The manager told us that they completed checks for new staff appointed to the service, including a Disclosure and Barring Service (DBS) criminal records check and previous employment references, to ensure that staff were suitable to work at the service and of good character. We looked at staff recruitment files and found that these checks had been completed, however; the provider had not sought full employment histories for new staff or discussed gaps in employment history with them. This meant that staff may not be of good character to be working with people as satisfactory explanations of periods out of work had not been sought.

Staffing levels at the service were variable were not always sufficient to meet people's needs. There was no way of assessing the staffing levels required for people's needs: therefore the manager and provider were unable to demonstrate that staffing levels were suitable for the people living at the service. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living at the service and that staff worked to make sure they were protected from harm or abuse. One person told us, "I am very safe here; I have no worries about that." Another person said, "Oh yes, I feel safe." People and their family members explained that they felt the service was secure and that they could trust members of staff to ensure they were looked after.

Staff members told us that they received regular safeguarding training, which provided them with the skills and knowledge they needed to ensure people were protected from harm or abuse. One staff member said, "Yes we get safeguarding training each year." Another told us, "If I had any concerns at all I would report it." Staff went on to explain the procedures for recording and reporting potential abuse, to ensure incidents were managed and people were safe.

The manager showed us that accidents and incidents, including safeguarding concerns, were recorded and information regarding the correct course of action to take in response to safeguarding concerns was available to members of staff. These records and information showed that incidents were reported locally

and, where there was a safeguarding concern, the local authority safeguarding team and the Care Quality Commission (CQC) were notified. This demonstrated that the service took appropriate action in response to incidents of potential harm or abuse.

Requires Improvement

# Is the service effective?

## Our findings

People's consent to their care, treatment and support was not always sought by the service. We found that care files lacked consent forms to demonstrate that people, or another responsible person such as a family member, had given their consent to the content of those files. In addition, we saw that each individual care plan had an area for people to sign to say that they agreed to the content of that plan, however; none of the care plans we looked at had been signed. Neither people or staff members were able to tell us how people's consent to the content of their care plans had been sought or recorded. This meant that people received care which was not provided with their consent, or the consent of another relevant person.

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 principles of the MCA were not always being followed. Staff members told us that there were MCA assessments in place which found people lacked capacity, when they felt the person was able to make decisions for themselves. One staff member said, "I don't know why they have one [MCA assessment], they can tell you what they want." Records showed that MCA assessments were not carried out in a robust manner. We saw that these assessments were not always decision-specific; rather they gave an overall finding that the person lacked capacity. This is contradictory to the guidance in the MCA and may have prevented people from being able to make decisions for themselves. The assessments also failed to provide evidence of how the person had been found to lack capacity, or what staff did to help provide people with information about the decision in question.

There was also a lack of evidence that a best-interests' approach was taken when decisions were made on people's behalf. When MCA assessments were carried out, the form used at the service contained a best-interests' checklist. These were usually completed, but did not show any evidence of how the answers had been arrived at. There were 'yes' or 'no' answers selected within the checklist, but there was no explanation as to how these answers had been decided. There was also nothing to show that those people involved in a person's care, such as family members or social workers, had been consulted in the assessment or best interests' process. The only person involved in making assessments and decisions on people's behalf was the member of staff completing the form. This meant that the principles of the MCA were not being followed and that there was a risk that decisions made on people's behalf were not in accordance with their best interests'.

Care and treatment was not always provided or planned with people's consent. Where people were unable to consent or make decisions about their care, the principles of the Mental Capacity Act 2005 had not been adhered to. This was a breach of regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff members told us that they sought people's consent on a regular basis. They explained that before they provided any specific care or support they would check with the person to make sure they were happy with what they were going to do. During the inspection we observed this to be the case. Staff members explained what they planned to do and made sure people were comfortable with that. They respected people's wishes and made sure they provided people with care in the way they wanted.

There were also systems in place to make sure that referrals under DoLS were made appropriately. The manager told us that they had completed DoLS referrals for those people who were at risk of having their liberty restricted, however; a back-log with the local authority meant that these had not been processed and approved. We saw evidence of completed DoLS referrals, as well as correspondence between the service and the local authority which demonstrated that the service had done everything they could.

Staff members did not receive regular supervision sessions from the service. They told us that they did not always receive the opportunity to talk about their performance, raise concerns about the care that people received or any learning and development needs they may have. They told us that they did not always receive supervisions with senior or management staff, to provide them with the forum they needed to discuss the service. One staff member told us, "I haven't had a supervision since I started here." Another staff member told us that they had not received any form of supervision since stating at the service, approximately 10 weeks previously. Staff members did tell us that they felt they could approach the manager if they needed to; however there were no records to show that concerns were raised by staff, or acted upon by the manager.

We spoke with the manager, who confirmed that supervisions for staff members had not been conducted on a regular basis since they started at the service. They told us that they had regular staff meetings; however there were no systems in place to ensure that staff received one-to-one sessions on a regular basis. This meant that staff did not always have allocated time to discuss any concerns they may have. The manager had taken action to begin to address this and had started training senior staff members to conduct supervisions within their departments at the service. For example, we saw that senior housekeeping staff were trained to provide supervisions and some members of housekeeping staff had started to receive supervision sessions.

New staff members at the service did not benefit from receiving a formal induction when they started. The manager told us that there was not a formal induction process in place, however; when new staff members started they were shown around the service and started by shadowing more experienced staff before being allowed to work independently. Staff members confirmed that this took place, but told us that they had not received a specific induction to help them settle into working at the service. There were no records to show that staff members received an induction at the service, or to show that they had been assessed as competent to perform their roles without close oversight from another staff member.

Staff members were not provided with sufficient supervision to ensure they had the knowledge, skills and support to perform their roles. This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Members of staff did tell us that they received training from the service; to help equip them with the skills

they needed to perform their roles. One staff member said, "Yes there is quite a lot of training. We do have a mixture of face-to-face and online courses." A member of the housekeeping team told us that they were able to complete the same training courses as care staff. This helped them to gain a better understanding of the needs of people at the service and meant they could lend a hand if required. The manager showed us that they maintained a training matrix, which showed when staff completed training courses and when they needed to be booked in for additional or refresher courses. We also saw certificates for completed training courses, including individual modules of the Care Certificate. This showed that staff members received training in key areas, such as safeguarding, moving and handling and medication administration.

People were happy with the food and drink they were given at the service. They told us that they enjoyed the food and were given a choice of what they wanted to eat and drink on a daily basis. One person told us, "The food is good." Another said, "It is nice, but I'm not a big eater." Staff members told us that people were supported to choose what they wanted for each meal, as well as regular drinks throughout the day. During the inspection we saw that people were given a choice of what to eat and drink, as well as where they had their meals and drinks, including the option to eat in their rooms if they wanted to. Where necessary, staff provided people with support to eat and drink and did so in a calm and patient manner.

Staff members were able to tell us about any dietary needs and preferences that people had, including specific cultural needs that people may have. The manager told us that the kitchen was able to prepare alternative meals to suit people's individual choices, as well as freshly made drinks and snacks, so that people had something to eat throughout the day. We saw that people's dietary needs were recorded and there were systems in place to record and monitor people's dietary intake, if this was required.

People were supported to see healthcare professionals, such as GP's, district nurses and dieticians, by the service. Staff members told us that they regularly arranged for people to see these professionals, to ensure their health needs were being met. The manager also told us that, if required, staff members could support people to attend appointments in the community, including hospital appointments, if necessary. They explained that family members often preferred to do this. During the inspection we saw a GP and a district nurse visiting the service, as well as family member taking somebody to a hospital appointment. There were also records to show that regular contact with healthcare professionals was maintained for people.

Requires Improvement

# Is the service caring?

## Our findings

People were not involved in planning their own care. None of the people who spoke with us had been consulted when their care plans were written, to ensure that they were reflective of their wishes. Additionally, people's relatives or those closely involved in people's care had not been involved in planning their family members care and were not aware of the content of their care plans. One relative told us, "No, I have not seen her care plan." Another said, "The only meeting we have had was about finances." This meant that care plans may not be based upon feedback from people and their family members therefore may not be a true reflection of the way that people wanted to be cared for.

We spoke with the manager about this. They told us that they were not aware of any meetings held with people or their family members to plan their care, or to go over the care plan to ensure it was accurate. They did tell us that family members had been informed during relatives meetings that they could look at care plans at any time, however; most had not done so. We looked at people's care plans and found no evidence to show that people had been consulted in the planning of their care. There was also nothing to show that relatives had been involved, or others closely involved in people's care, such as social workers. This meant that people's care plans may not be reflective of the way they way wanted to be cared for, as steps had not been taken to involve them, or other relevant people.

Staff members treated people with kindness and compassion. People told us that they got on well with the staff and that they treated them well. One person said, "Oh yes, they are all really lovely people, they look after me well." This point of view was shared by people's relatives, who told us that they felt their loved ones were well cared for by members of staff at the service. One family member told us, "Staff are nice and good with her."

There were positive relationships between people and the staff members caring for them. Staff told us that it was important to them that people were well cared for at the service. One staff member said, "I really liked to see that people are looked after and that my residents are happy." During our inspection we saw that staff were positive in their interactions with people. They spoke to people using their preferred names and displayed a calm and empathetic approach. People were not rushed to perform tasks or answer questions and staff used simple gestures and reassuring touch, such as a pat on the arm, to help keep people calm and relaxed. Staff displayed this caring approach whilst meeting people's care needs however; they were unable to spend additional time with people, such as talking over a cup of tea, due to the numbers of staff on duty.

People's privacy and dignity were maintained by staff members. People told us that staff worked hard to make sure they were treated with dignity and took steps to help preserve their dignity. They told us that staff members supported them to be as independent as possible, but they knew they were there to help them whenever they needed it.

Staff members told us that they received training in dignity and respect and worked hard to ensure that people were treated in the way they would like their own family members to be treated. During the

inspection we saw that staff were respectful towards people and were sensitive to their needs and wishes. They spoke to people positively and encouragingly and made sure specific issues, such as personal care needs, were met in a discreet and dignified manner.

People were encouraged to maintain contact with their family members and the service welcomed visitors at all times. One person told us, "I have visitors most days; they can come when they want to." Staff members confirmed that visitors could come to the service at any time to see their loved ones. During our inspection, we saw a number of different relatives come and go. Staff made them feel welcome at the service and were able to share any developments regarding the service or their family members care with them, as appropriate.

Inadequate

# Is the service responsive?

## Our findings

People did not receive person-centred care from the service. Care was not provided in a way that was mindful or sensitive to people's individual needs and wishes and people were not able to access stimulation and activities of interest to them. Staff members were not provided with the information they needed to enable them to provide care which was tailored to people's specific needs and wishes.

People told us that they did not think there were enough activities for them to do. One person said, "It is very lonely here, there is nothing to do." People explained that there were occasional activities, but these did not take place on a regular basis and they were not always of interest to them. Relatives also told us that they felt people lacked stimulation at the service. One told us, "There is little stimulation." They felt that their family member did not receive enough to keep their mind busy and engaged, which meant they were often bored and not able to enjoy their hobbies or interests.

We spoke with the activities lead at the service. They told us that they used to be a member of the care team and knew people living at the service well. They explained that they split their time between the two floors of the service currently in use and provided a range of different activities such as arts and crafts. We saw an arts and crafts session take place in the morning, however; most people were not engaged in this and there were no alternatives suggested for them. Staffing levels did not allow care staff time to supplement the activities provided by the lead; therefore these people were not able to receive engagement and stimulation. We were unable to find an activities schedule on display at the service, which meant people were not aware of what was going on and when it was going to happen. There were some activities provided at the service, however; people were not able to access activities each day and there was no evidence that people had a range of activities to take part in, to suit their individual preferences. This meant that the service were not supporting people to follow their own interests and were not tailoring the activities which were provided to meet people's individual needs.

The manager showed us that there was a schedule, however this had not been made available to people living at the service or their family members. Records did not demonstrate that people had taken part in activities; therefore we were unable to determine people's level of engagement in activities prior to our visit. This meant that people did not have information available to them about what activities they could take part in at the service, in addition; they had not been involved in planning the activities which did take place.

The people who were able to speak with us were not able to tell us if they had been involved in planning their care, and visiting family members told us that they had not been involved. They were not aware of the content of care plans or the specific measures put in place for staff to follow to meet people's needs. Staff members told us that they felt the care plans had improved since our previous inspection on 26 February 2016, however; when we asked staff about specific details regarding people's care; they were unable to tell us about their individual needs and wishes. For example, we asked staff about a specific medical condition which one person was living with. Staff members knew that they person was living with the condition, however; they were not able to explain how they were affected by this condition, or the action they needed to take to support them. This meant that staff did not have an understanding of the specific needs and

wishes of people in their care and were therefore unable to provide them with person-centred care. People'e care plans had been produced without their involvement, which meant the content of them may not be in accordance with their needs and wishes. There was also no system in place to gaining insight into people's wishes, or obtaining information about them from family members to ensure care was provided in a person-centred way.

When we checked people's care plans we found there was no evidence to show that people had been involved in planning their care, treatment and support. Care plans did not have any reference to meetings or conversations with people regarding their specific care and support needs. We found that there were individual care plans in place for different areas of people's needs, however; the same topics were covered for each person. These included areas such as mobility, behaviour and breathing and circulation. In some cases, people had no identified needs in those areas; however care plans were still put in place. This showed that care planning had not been carried out in a person-centred way, as staff had put plans in place which were not relevant to people's specific needs. This meant that care may not be provided in the way that people wanted it to be and showed that the service had not taken sufficient steps to ensure that care was person-centred.

The content of the care plans did not provide up-to-date information which was reflective of people's needs. For example, we saw that one care plan referred to a person's specific medical condition incorrectly, referring to a different condition altogether. This meant that staff members were not provided with the specific information they needed, therefore were unable to provide person-centred care. People's care plans did not contain person-centred information and failed to provide staff with specific guidance about the support that they should be giving people. For example, we saw that one person had a medication care plan in place which stated the person could be non-compliant with their medication at times. It failed to provide details of likely settings or indicators when this may occur, or details of action which staff should take if they did refuse their medication. People's care plans were not person-centred and did not provide staff with details of how to ensure their needs were being met. This meant that staff may provide people with care that was not in accordance with people's needs or interests.

Staff members told us that care plans were reviewed regularly, to update them and make any changes that were necessary. We found that this was inconsistent. Some care plans had been reviewed, but others had not been. In addition, we found that those that had been reviewed had not been updated. One such plan contained the incorrect information regarding one person's medical condition. This showed that the review process had not been robust enough to take notice of this error and ensure the content was corrected for members of staff to use.

There care and treatment of people living at the service did not always reflect their preferences or meet their specific needs. There was a lack of stimulation and activities and care plans were not person-centred. This was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager explained to us that there had been no new admissions to the service since our previous comprehensive inspection. As a result of this, there had been need to carry out additional pre-admission assessments for people, however they told us that any new admissions to the service would be carefully considered to ensure they were able to meet their needs. We checked people's care plans and found that previous pre-admission assessments were in place.

People and their family members were aware of the complaints procedures at the service. They were able to raise any concerns they had both informally and formally if necessary, although none of the people we

spoke with had felt the need to do this. Staff members told us that they encouraged people to raise any concerns they may have so that problems could be put right as soon as possible.

The registered manager showed us that the service had a complaints policy and had a system in place to record any feedback raised, whether positive or negative. We saw that the policy ensured that complaints were fairly listened to and action would be taken to resolve any issues raised. No complaints had been raised since we last inspected the service.

Inadequate

# Is the service well-led?

## Our findings

There were no effective systems in place to assess, monitor and improve the quality of care being provided by the service. Checks and audit systems were in place, however; they were not robust and were not used to identify areas in need of improvement or plan how improvements would take place.

The manager told us that senior staff and themselves completed audits and checks on a regular basis. They showed us an audits file which documented which checks had been completed on a monthly basis. We looked at this file and found that checks were being completed, but not always regularly and were not always complete. For example, a monthly infection control audit had not always been completed and the audits for June and July 2016 had not been completed in full. This meant that not all areas of the service were checked so potential concerns may not have been identified. This also meant that there would not be any plans put in place to address problem areas which were missed.

Some of the checks which were completed had been delegated by the manager to other staff members. When this had taken place, there was nothing to show that the manager had oversight of the process, or awareness of what had been found by staff. For example, on 29 June 2016, care plans for 15 people had been audited by a member of staff. Each of these audits had a section for the manager to complete to show that they had seen them and agreed with the content, however; none of these had been completed. The audits themselves had failed to identify concerns around the lack of person-centred information, ineffective risk assessments, lack of involvement and application of the Mental Capacity Act 2005. This showed that care plan audit processes were not effective in ensuring people had care plans of sufficient quality to meet their needs. In addition, this showed that there was a lack of managerial oversight to monitor the checks being carried out by staff members and to ensure that audits were good enough to help drive improvements.

We saw other areas which indicated a lack of managerial oversight of quality assurance processes at the service. For example, we saw that incident reports were stored in a file within monthly sections. At the start of each section there was a summary sheet to show an analysis of incidents which had occurred during the month, to help get an idea of patterns or trends emerging. None of these sheets had been completed which meant that this analysis had not taken place. This meant that potential patterns in the way incidents occurred had not been identified, which in turn meant that appropriate action could not be taken to address these patterns. This increased the risk of repeat incidents occurring, as lessons had not been learnt from previous ones.

Audits were not always completed in a robust way. For example, we saw that the medicines audit had been completed on a monthly basis, however; it had not been used effectively to drive improvements at the service. The audit tool had a system in place to award the scores for each area checked. These scores were compiled to give an overall score for the service, along with a rating. Only one of the audits we looked at had the scores compiled and rating awarded. This meant the service was unable to measure improvements from one audit to another. These audits also showed that when problems were identified, there was no remedial action recorded. This showed that the audits were completed, however; they failed to identify areas for

improvement and there was a lack of action in response to issues raised.

The manager spoke with us about the provider and the oversight they had of the service. They told us that, since coming to the service in April 2016, they had worked with three different regional managers. They explained that this had made it difficult to establish a working relationship and they felt that this had impacted upon the service. They did tell us that the regional manager had conducted monthly visits to the service to conduct a comprehensive provider audit. They were unable to locate these audits during the inspection visit, or show us any action plans which had been put in place as a result. After the inspection the provider sent us digital copies of these audits. We saw that they did highlight areas which required development, however; they had not been applied within the service to help develop the service.

Quality assurance procedures at the service were not effective. Problem areas were not addressed and action was not taken to improve this. Issue's such as the lack of person-centred information in care plans and lack of information regarding people's specific staffing needs had not been identified, therefore work had not been carried out to drive the necessary improvements. People were at risk as the lack of quality information in risk assessments had not been identified and addressed by the service, nor had the lack of involvement of people, or other relevant people, in their care plans.

The provider failed to ensure that there were robust and effective systems in place to assess, monitor and improve the quality of care being provided by the service. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us that they planned to conduct a satisfaction survey for people and their family members, to collect their opinions of the service and see if there were any areas which they needed to work on. They explained that this had not been carried out since our last inspection, due to the short period of time that had elapsed since. When the survey was completed, they planned to compile the results and use them to help drive improvements at the service.

There was not a registered manager at the service, however; a manager had been appointed and was in the process of registering with the Care Quality Commission (CQC). People and their family members were aware of who the manager was and were able to see them at the service when required. Members of staff told us that the new manager worked openly with them and was receptive to their comments or concerns. There was an open-door approach to the manager's office, so that staff could approach them to share any ideas or issues they may have. The manager was aware of their regulatory obligations to report certain incidents, such as safeguarding concerns or disruption to service delivery. Our records confirmed that the CQC had received statutory notifications from the manager.

There was a positive and open culture at the service. Staff members were motivated and keen to meet people's needs at the service. They told us that they felt they were able to meet people's needs and enjoyed the challenge of working at the service. We observed that staff were positive in their interactions with people and worked together to make sure their needs were met.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>There care and treatment of people living at the service did not always reflect their preferences or meet their specific needs. There was a lack of stimulation and activities and care plans were not person-centred. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>Care and treatment was not always provided or planned with people's consent. Where people were unable to consent or make decisions about their care, the principles of the Mental Capacity Act 2005 had not been adhered to. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The service had not taken appropriate action to assess the risks to the health, safety and well-being of people, visitors and members of staff at the service. There was a lack of guidance regarding risk which meant the provider had not done all that was reasonably practicable to mitigate risks at the service. There were also ineffective systems for the administration and management of people's medicines. |

| Regulated activity | Regulation |
|---|---|

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

Staffing levels at the service were variable were not always sufficient to meet people's needs. There was no way of assessing people's needs; therefore the manager and provider were unable to demonstrate that staffing levels were suitable for the people living at the service. Staff members were not provided with sufficient supervision to ensure they had the knowledge, skills and support to perform their roles