Georgians (Boston) Limited(The)

The Georgians (Boston) Limited - 50 Wide Bargate Boston

Inspection report

50 Wide Bargate
Boston
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13 December 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 12 and 13 December 2016 was unannounced.

The home provides residential and nursing care for up to 40 people. People using the home may be living with a dementia, mental health issues, conditions associated with old age, physical disabilities or sensory impairments. There were 37 people living at the home when we inspected.

There was no registered manager for the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run. There was a new matron in place who managed the home. They had been in post for two weeks prior to the inspection. They told us they were planning to apply to the Care Quality Commission to become registered.

Our last inspection took place on 17 March 2016 we found that the provider was in breach of three regulations. People were not fully protected against the risks associated with care and risks were not fully mitigated. Staff did not receive adequate supervision and the provider did not have effective systems to assess, monitor and improve the quality of care provided or to assess, monitor and mitigate the risks to people living at the home. The provider did not act on feedback to drive and embed improvements in care. In addition to the breaches of regulation we recommended that the provider sought advice and guidance from a reputable source about supporting people to receive person centred care.

Following the inspection the provider sent us an action plan telling us about the improvements they planned to make to rectify the breaches in the regulations. At this inspection we saw that staff had received training and now supported people to move safely. In addition while formal supervisions had not always taken place in line with the provider's policy senior staff observed the care people received and staff were confident in raising any concerns with the matron. However, we saw that there had been no improvement in the way the quality of care was monitored and people's views on the care they received had not been gathered. 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.

Risks to people had been identified and care was planned to keep people safe. Where needed appropriate equipment had been ordered. However, risk assessments had not been reviewed in line with the timescales identified by staff. Where people had the ability to make decisions these were respected even if their decision was unwise and increased the risk of harm to the person.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect themselves. The matron had ensured that

where people were unable to make decisions about where they lived they were appropriately referred for a DoLS assessment. However, other areas of the mental capacity act had not been consistently applied.

There were not always enough staff available to support people's needs in a timely manner and there was no staffing tool in place to support the decisions made around number of staff needed. In addition, the home had been using a number of agency staff and while they had ensured people's needs were met they had not been able to provide the person centred care people received from staff who knew them well. At times staff were task focused and did not stop to consider if they supported people's dignity.

Care plans contained the information needed to meet people's needs safely. However, they did not contain enough information to support staff to provide person centred care and people had not been involved in planning their care. Some activities were in place but people were not fully supported to remain active and occupied.

People had been supported to take their medicines safely and in a timely fashion. People had been supported to access food and drink safely and when needed appropriate action had been take to help people maintain a healthy weight. However, at times food was not presented to support people with dementia to retain their independence.

People were not always clear on who they could complain to and while complaints had been investigated a lack of communication meant that it was not clear if people were happy with the outcome of the complaint.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risk assessments were in place and the care was safely provided. However, risk assessments had not been reviewed in line with the dates identified in people's care plans.

Staffing levels meant that people's care needs were not always supported in a timely manner.

Staff knew how to keep people safe from abuse and how to report any suspected abuse.

Medicines were administered safely and in a timely fashion.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received appropriate training and were happy to ask senior staff for support and guidance when needed.

People had been appropriately referred for assessment around their ability to decide where they lived. However, other areas of the mental capacity act had not been consistently applied.

People were supported to access food and drink safely. However, people with dementia did not always receive food which supported their independence.

Support and guidance had been sought from appropriate healthcare professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's relationship with staff had been compromised due to the high number of agency staff used.

People's dignity was not always supported when staff provided care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Car plans contained the information staff needed to provide safe care. However, they did not contain information on how care could be personalised and people had not been involved in developing their care plans.

There were some activities available but people found they were not enough to support them to remain active and occupied.

People were not always sure about who they should complain to and there was a lack of communication when complaints had been investigated.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was ineffective monitoring of the safety and quality of care and there had been no improvements following our previous inspection.

The provider had not gathered the views of people living at the home.

Staff told us that the matron was approachable and had started to improve the culture of the home.

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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 12 and 13 December 2016 and was unannounced. The inspection team consisted of an inspector and a specialist advisor, who was a nurse.

Before the inspection we reviewed the information we held about the home. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the service. We also reviewed information sent to us by the local authority who commission care for some people living at the home. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with seven people who lived at the service, three visiting relatives and spent time observing care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with a senior care worker, two care workers, a member of the activities team, the administrator and the deputy matron. We spoke with the matron who managed the home.

We looked at six care plans and other records which recorded the care people received. In addition we examined records relating to how the service was run including staffing, training and quality assurance.

Requires Improvement

Is the service safe?

Our findings

When we inspected on 17 March 2016 we found that the provider did not fully identify the risks to people while receiving care and where risks were identified care was not always delivered in accordance with the plans made to keep people safe. This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment.

Following the inspection the provider wrote to us and told us they would provide training in supporting people to move safely using equipment and that they would ensure that incidents were reviewed and action taken to keep people safe.

At our inspection on 12 and 13 December 2016 staff told us they had received training around supporting people to move. In addition staff had raised concerns about some people's mobility plans during the training. These plans had been reviewed and now provided more information on what equipment staff could use when supporting people. People's moving and handling care plans showed which size hoist sling was to be used for each person and one person's care plan identified that a special sling was needed and this had been ordered. However, the risk assessment had not been reviewed in a timely fashion and therefore it was not clear if the new sling had been received and was in use or if further action to chase up the order was needed.

People's risks of developing pressure ulcers were identified and appropriate equipment was in place to keep people safe. We found people had received appropriate support to maintain healthy skin and there were no pressure ulcers at the home at the time of our inspection. However, care plans could have been more specific around the time frames for turns and daily records did not identify the exact turn time but recorded the general time that a number of turns had been completed.

We also saw that a number of pressure relieving cushions were placed on chairs in the upstairs lounge for anyone to sit on. We saw that some of these cushions were no longer in a good condition and would not provide appropriate support if used by a person requiring pressure care.
The matron stated that pressure mattresses and pressure cushions were being checked by the domestic staff as part of the cleaning schedules. However, there was no evidence as to what was actually being checked or if cleaning staff knew when a cushion should no longer be in use.

In addition we identified some risks around the use of wheelchairs. An example of this was some people who were sat at the dining table in a wheelchair. They had their feet on the floor but the wheelchair footrests were still in place and there was a risk the person would knock their legs. Another example was that we saw a person being moved in a wheelchair which did not have any footrests in place.

We saw that the staff were recording that risk assessments and their related care plans were identified as needing to be reviewed monthly in line with the local authority contract. However, we found that reviews around risks had not been completed in line with the monthly timeframe. While we did not identify anyone whose care no longer met their need, this showed that staff were not working in line with the provider's

policies.

People were supported to make decisions that staff may not feel are in their best interests. An example of this was one person who walked independently for short distances. Staff felt that this was not safe for the person and their falls risk assessment showed that they were at an extremely high risk of falls. The care plan recorded that the person had listened to the staff's concerns but had decided to carry on being independently mobile regardless of the risk of them falling.

Some people had needed and agreed to bed rails being in place to protect them from falling out of bed. However, we saw that on some of the beds the height requirement between the top of the mattress and the top of the bed rail was below the minimum required for the bed rails to be effective and to keep people safe. At least two sets were of the 'telescopic' design neither of which had appropriate bumpers and the clamps were not secured which increased the risk of entrapment. In addition there was no evidence of regular checks taking place to ensure the profiling bed and bed rails remained safe to use. We discussed this with the matron who had already identified concerns and had ordered some new bed rails and arranged for on-going monitoring of bedrails.

Accidents and incidents were recorded and action had been taken for each individual to avoid the same incident occurring in the future. For example, where a person had fallen a number of times their care had been reviewed. An alert mat linked to the call bell was now in place to let staff know when they stood up. This enabled staff to provide immediate support. However, the system used to analyse trends was based on individuals, it did not analyse the environment, times or types of accidents and incidents to reduce risks to people.

Personal Emergency Evacuation Plans (PEEPS) were in place but were not of sufficient detail to describe how a person was to be evacuated in the event of an emergency. In addition fire records did not detail when simulated vertical and/or horizontal evacuations had been practiced and/or any lessons learned from such simulations.

At the last inspection we found that there were not always enough staff to meet people's needs in a timely fashion. While we did not see this as a breach of regulation we did include it in our report to show that action was needed to keep people safe and we took the information into account when deciding the rating for the key question of is the service safe.

At our inspection on 12 and 13 December 2016 people told us that there were still issues around staffing and that while people's basic care needs were being met care was not provided in a timely manner. One person told us that at times they were not supported to get up in time to enjoy planned outings. They said, "Two days of the week I am not bothered but the rest of the time I like to be up. Saturday I had to cancel the taxi as I wasn't ready, They didn't get me up or showered. They were short of staff." Another person told us, "The staff are kind, they are not always quick to answer the bell but they come as soon as they can." They told us it would be nice to be repositioned more regularly and made more comfortable.

The matron told us that they reviewed staffing levels in line with the needs of people living at the home. However, they were unaware of the staffing analysis tool implemented by the previous matron. They explained that as well as the care staff the home employed dedicated kitchen staff, domestic staff and maintenance staff so that care staff were free to concentrate on caring for people. People living at the home and staff told us how there had been a reliance on agency staff as there were not enough directly employed staff to cover the shifts. We discussed this with the matron who confirmed this was currently the case but that they were in the process of employing more staff. Staff told us staffing levels were starting to improve

since the new matron had been in post.

The provider had systems in place to ensure they checked if people had the appropriate skills and qualifications to care for people before offering them employment at the service. For example, we saw people had completed application forms and the matron had completed structured interviews. The required checks had been completed to ensure that staff were safe to work with people who live at the home.

People told us they felt safe living at the home. Staff told us and records showed that they had received training in how to keep people safe and how to raise concerns if they were worried a person was at risk of abuse. Staff knew how to raise concerns with external organisations such as the local authority and the Care Quality Commission and this information was available to them in the home.

We spent time watching both the nurse and senior care worker administering medicines. They both ensured that medicines were safely administered and that accurate records were checked. Care plans included information about how people liked to be given their medicines. For example, one person preferred staff to offer them on a spoon. We saw that the nurse and the senior care worker were aware of people's preferences and offered people their medicines in appropriately.

There were some protocols in place to help staff to know when to administer medicines prescribed to be taken as required. An example of this would be painkillers. We saw the senior care worker asked people if they needed any painkillers and asked about the location and level of pain to assess if the medication was appropriate and in line with the protocol. However, there were not always protocols in place for other medicines prescribed to be taken as required. For example, medicines used to help people manage their distressed reaction. This meant people may not consistently receive their medicines appropriately as staff were left to make individual decisions on when to offer the medicine.

Where people required covert medicines there were clear guidelines in place to support staff to administer medicines appropriately. In addition we saw that staff had clarified with a pharmacist that the medicine was safe to be offered in food and that it would not affect the effectiveness of the medicine.

We saw that some of the medicine records had been handwritten; we saw that they had only been signed by the member of staff who had written the record. There had been no checking to ensure that they had transferred the data across correctly. This meant there was a risk that medicines records did not accurately reflect people's prescriptions. We saw that this had been identified as an issue in an audit by a community pharmacy and no corrective action had been taken.

There was no evidence of the first aid boxes being regularly checked for sufficient contents and expired products. We found several items in the first aid box that was out of date. In addition, dates on some medical products had not been checked and we saw a number of blood collection tubes were out of date. We discussed these concerns with the matron who agreed to dispose of all medicine, dressings and medical products that were past their expiry date.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we found that staff were not fully supported to have the skills needed to provide safe care. This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 staffing.

Following the inspection the provider wrote to us and told us they would provide training in key areas where staff lacked skills and ensure staff received appropriate supervisions.

At our inspection on 12 and 13 December 2016 we found that staff had received training in key areas such as supporting people to move. During our inspection we observed staff supporting people to move and saw that this was done safely. In addition to moving and handling staff had also completed training in other key areas such as fire safety and the Mental Capacity Act (2005).

New staff received an induction to the home which ensured they had the skills needed to care safely for people. This comprised of three days in an office covering all the immediate information they needed to know, for example, fire safety. Following this new staff shadowed an experienced member of staff until they had got to know people's need and felt confident they had the skills needed to care for people. One member of staff explained how they had shadowed shifts at different times of the day so that could see how people's needs changed through the day.

For staff new to caring the matron ensured they completed the Care Certificate. This is a nationally set course which provides all the skills need to provide safe care to people. In addition the senior member of staff observed staff giving care so that they could assess their skill level and if any further training was required. An example of this was observing staff washing their hands to ensure it was done in a way which would decrease the risk of cross infection. Following completion of the care certificate staff were encouraged to study further and complete a nationally recognised qualification in care.

The matron told us and this was confirmed by the supervision policy that staff should receive supervision in the first week of starting with the provider and then every two months. However, staff told us that supervisions had not been completed in line with the provider's policy. One member of staff who had worked at the home for over 6 months told us that they had only received one supervision. Another member of staff told us they had not had a recent supervision. However, staff did tell us that they found the new matron approachable and that if they had any concerns about how care was provided for people they would happily speak to the matron.

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

At the last inspection we found that the matron had not submitted appropriate applications for DoLS. While we did not see this as a breach of regulation we did include it in our report to show that action was needed to keep meet the requirements of the MCA and we took the information into account when deciding the rating for the key question of is the service effective.

At our inspection on 12 and 13 December 2016 we found that appropriate DoLS applications had been completed and sent to the authorising authority. Staff we spoke with were able to tell us about the mental capacity act and how on a daily basis they used it to give people choices about their care they received. They explained how it meant that you must assume people had capacity to make decisions unless there was some evidence to the contrary. In addition staff knew that any decisions made on behalf of people must be made in their best interest and include the opinions of family, healthcare professionals and other people involved in caring for them.

However, the mental capacity act had not always been appropriately applied when planning care for people. An example of this was a person whose care plan recorded that they had capacity. However, this was challenged in numerous risk assessments as the person often refused to be compliant with care. For each area of care where they chose not to be compliant a mental capacity assessment had been completed and a best interest decision had been made. We discussed this with the matron who told us that they would review the person's care plan. They explained that while the person could make decisions they may not always fully understand the longer term consequences of their decisions. This meant that care plans identifying that the person had capacity may not always be correct.

People told us they were happy with the food offered and that the cook visited them daily to ask if they had been happy with the quality of their main meal. People who were at risk of being unable to maintain a healthy weight had been identified and appropriate support from healthcare professionals had been sought. Where necessary people had been supported with prescribed high calorie supplements. Care plans recorded where people needed support and encouragement to eat. One person's records showed that they had slowly increased their weight and had moved from being underweight to being a healthy weight. Care plans recorded people at risk of being unable to maintain a healthy weight needed their weight monitoring on a monthly basis or more frequently if required. However, we found that this monitoring had not always taken place.

One relative we spoke with told us how they felt that their loved on would eat more if staff had the time to spend with them encouraging them. However, they told us that staff put the meal down and walk away. They also raised concerns that staff do not always ensure the person is sat in a comfortable position to eat and that they can reach their meal. In addition with all the changes in staff they were not aware of the extra food the family had provided to tempt the person to eat. People told us that at times access to hot drinks was an issue due to the low staffing levels. One person said that they did not get a cup of tea the previous night and she assumed that the staff forgot her request as they were busy.

Where people were unable to eat safely, soft food was provided for them in line with healthcare professional's advice. For example, some people had their food pureed while others could safely eat mashed food. We saw that specific instructions to reduce the risk of choking while eating were recorded

where appropriate. An example of this was ensuring a person was sat up in bed. Where necessary drinks were thickened so people could swallow them safely.

We discussed the needs of one person who was living with dementia as they sometimes chose to eat their meal with their fingers and at times the food they were offered did not support them to do this. The member of staff told us that the person enjoyed their evening meal more than the midday one as it was more suitable to eat with fingers.

There were some people living at the home who received their nutrition through tubes either into their stomach or directly into their blood stream. One person who received their nutrition this way told us they were also offered taste meals so that they could still enjoy small amounts of food. We saw one person's care plan did not clearly identify their routine for receiving their food through a tube. We discussed this with the matron who explained that due to the routine having to be broken when the person went out the start time of the feeds was variable to take into account when the previous feed had been completed.

When we looked through the care plans we saw that some people had do not resuscitate orders in place. These had been reviewed by the NHS community liaison nurse. However, at times records did not clearly identify if people's views had been taken into account when making the decision. While it is not the provider's responsibility to complete do not resuscitate paperwork, they must ensure that there are complete and accurate records which detail how people's wishes have been included in the decision making process.

Individual care plans included all the information needed to support people's day-to-day health needs. Additionally, we saw people had been supported to arrange and attend for eye tests and their prescriptions had been updated where necessary. Records showed other health professionals such as GP's and the community mental health team had been included in people's care when needed.

Requires Improvement

Is the service caring?

Our findings

At the last inspection we found that staff did not always ensure people's dignity was protected and that the care provided was tailored to meet people's individual needs. We recommended that the provider seek advice and guidance from a reputable source about supporting people to receive person centred care. While we did not see this as a breach of regulation we did include it in our report to show that action was needed and we took the information into account when deciding the rating for the key question of is the service caring?

At our inspection on 12 and 13 December 2016 we found that some improvements had been made. For example, people were hoisted in the toilet area instead of the main lounge. People told us that if anyone was hoisted in the lounge then screens were used to protect their dignity.

However, we saw other examples of where staff had not supported people's dignity. We saw one person was sat at a table which had not been set for them. Instead the table had been used by the staff to store the drinks offered to other people over the lunch period. This did not support the person's right to have the same standard of care that everyone else received.

Three people were sitting alone in the downstairs lounge. We saw a care assistant came to support them with their drinks. One person was trying to tell the carer something but they said to the person, "I can't understand you." They made no effort to go to the person to speak quietly to them to try and understand. Instead they walked across the room to help another person with their drink. We also saw that this carer was loud and did not support people's dignity shouting across the room at them to drink their tea, instead of going over to them and supporting them.

The meal was served from a hot trolley in the dining room and while people had been offered a choice of the main meal no record of how the person would prefer to have their meal personalised was recorded. We saw that staff discussed amongst themselves what people would like to have on their plate instead of going and asking the person. An example of this was staff deciding amongst themselves if a person would prefer chips or mash potatoes without asking the person.
In addition staff held discussions across the dining room on the level of support people needed to eat their meals. This did not promote people's dignity or respect their right to confidentiality. One person told us that staff respected their privacy and always knocked before entering their room.

All of the comfortable chairs had 'kylies' in place. Kylies are absorbent, washable waterproof pads used to protect soft furnishings. This assumed that everyone who sat on the chairs may have problems maintaining their continence. However, not all of the people living at the home had continence issues which needed them to sit on protected furniture. This did not support people's dignity.

One person had chosen not to wear their dentures as they were uncomfortable. However, no action had been taken to refer to a dentist to see if anything could be done to improve the situation for the person. No thought had been given to whether the lack of dentures corresponded to a lack of dignity for the person.

People living at the home told us that there had been lots of changes in the staff which had impacted on their relationship with staff. One person said, "I've never met the new matron and would like to. There have been so many changes of faces that you forget who is who and you never get a chance to know their names." Another person told us that while the staff were pleasant, they did not get the opportunity to build a relationship with the agency staff as they never stayed for long. They told us that they would like to have more regular staff so that they could build a relationship with them.

Relatives also told us that the staffing levels impacted on the relationships between people living at the home and staff. They told us that while there was no problem with people receiving personal care and being supported with meals they felt that staff did not have time to sit and talk to people and get to know them. In addition while people were asked to join in activities there was no gentle encouragement to get people to participate and so at times people were a bit fed up with the same routine. They told us that everyday was the same for people.

We saw when staff supported people with their meals there was a lack of interaction to support the person to enjoy their meal and build a relationship with staff. We saw that at times staff spent more time talking to each other than they did interacting with people. An example of this was staff asking each other about people's preferences instead of speaking to the individual. Staff did not support people to eat as a group, removing one person's plate and giving them their pudding while other people were still eating their main course. We saw in one case staff started to clear the table of table mats and condiments while a person was still eating.

However, we did see some individual examples of caring staff. For example, we saw one member of staff was welcomed on the floor by a person and was clearly a favourite of them, the member of staff spent the time to acknowledge the person and give them a hug

The home had some double bedrooms and there were privacy curtains in place. The curtains were not full length and did not fully protect the privacy and confidentiality of people's conversations with family or visiting healthcare professionals. The deputy matron advised people did not choose who they wanted to share with but that the matron and deputy matron tried to put people together who they thought would get along. There was no evidence in the care files that people had been consulted and consented to share bedrooms.

People were given the opportunity to make decisions about their everyday lives such as what time they got up and went to bed and where they spent their time. People who had capacity were engaged in decisions about their healthcare needs. An example of this was where people were offered the flu vaccination.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found that care plans did not contain enough detail to support staff to provide care which was tailored to individual needs and at times that care did not always meet people's needs. In addition activities did not support people who chose to send their time in their own room. While we did not see this as a breach of regulation we did include it in our report to show that action was needed to meet people's care needs and we took the information into account when deciding the rating for the key question of is the service responsive?

At our inspection on 12 and 13 December 2016 we found that some work had been completed on improving the care plans. However, they still did not contain the level of information needed to support staff to provide person centred care. One member of staff told us, "The care plans need work, it's hard to find information." An example of this was one person who was recorded as having a rash in August 2016. However, in the review at the end of August 2016 it shows that there were no issues with the person's skin when they were in fact having on-going treatment for dermatitis. We also found the care plan for a person with a moisture lesion had inconsistent information about dressing the area. A statement in the care plan advised a full sacrum dressing should be used, but there was no evidence that this was in place. In addition there was no information on the current state of the lesion and if it was improving. We discussed this with the matron who told us they were not dressing using any dressings on the area.

The matron had also identified that care plans did not contain the person centred information that staff needed to provide individualised care for people. They had set up a system where staff could record their knowledge of people's preferences so that this information could be included in people's care plans. The care plans identified that they should be reviewed monthly and we found that this had not always happened.

In addition we found that people living at the home and their relatives had not been included in planning the care they needed. None of the people or relatives we spoke with had seen their care plans. This meant that they had not been able to contribute the detailed information staff could have used to individualise the person's care. Staff told us that they did not always have the time to familiarise themselves with people's full care plans. However they explained that each person had a one page sheet on display their bedroom which outlined their care needs and which equipment should be used when caring for the person.

People told us that the staffing levels and the use of agency staff had impacted on the quality of care that they received. An example of this was a gentleman who had not been shaved over a weekend. One person said, "We feel that they have nothing like enough staff. Whenever you ring the bell it takes ages sometimes you have to ring multiple times." This person told us that they were anxious and that their anxiety increased when staff did not respond to the bell. In addition they told us that as the home was short staffed when staff were ill they carried on working instead of taking the time to get better. The person was worried for both the staff and in case germs were spread around the home.

One family member we spoke with told us that standards had slipped. An example of this was that their

relative's morning wash water was still in the sink and the bed had not been made in the middle of the afternoon. As the person spent a lot of time in their bedroom this meant that it was not such a nice experience for them. In addition one afternoon the person had not been supported to recline their chair and when their relative visited them they had nearly fallen out of the chair.

There were two new staff dedicated to providing activities for people. One member of the activity staff told us that their induction had been unorganised and that there had not been any activity plans in place for them to follow. They had not received any specific training around providing activities for people living with dementia. However they had watched a DVD about dementia which had helped them understand the condition. They told us that they would like more training around dementia and that they would find some training around supporting people when they were distressed.

The activity staff had worked together and had developed a programme of activities which included some group activities such as arts and crafts and some time spent one to one with people in their bedroom. Both activities staff worked 15 hours a week, and both worked on a Wednesday to give them time to plan future activities. This supported people to receive activities between 11am and 4 pm Monday to Friday. They had also started to produce a monthly newsletter to update people on what was happening in the home.

The activities staff ran a mobile shop with sweets and toiletries which they took round to people once a week. This supported people to maintain their independence in purchasing required items. In addition if people wanted something different to that available in the mobile shop staff would go out to make the purchase for them. During the inspection we saw that some school children had visited the home to sing carols. We saw that people enjoyed this entertainment. However, people told us that they were not supported to remain active and occupied with the activities.

Some people told us that with the recent changes in management they were unsure of who to raise a complaint with at present. One person said, "I don't know who to complain to, we used to have a matron and now we don't have one. I would probably speak to a nurse." While another person told us that they would complain to the new matron but felt it was slightly awkward as the matron had not taken the time to introduce themselves. Only one person we spoke with knew who the new matron was, they also knew the provider and was happy to raise any concerns with either of them.

We saw that three complaints had been received since our last inspection. There was some evidence that investigations had taken place, for example we saw statements had been taken. However, there was a lack of communication with the people making the complaint to ensure that they were happy with the outcome.

Requires Improvement

Is the service well-led?

Our findings

When we inspected on 17 March 2016 we found that the provider did not have effective systems to improve the quality of care or to mitigate the risks to people living at the home. The provider did not act on feedback from people living at the home to drive improvements in care. This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance.

Following the inspection the provider wrote to us and told us they would compile an audit programme for quality standards for care planning, medication, environment and infection prevention and control, training and supervision. They also said that they would ensure staff meeting were in place. They told us they would use residents meetings to gather feedback on the care provided.

At our inspection on 12 and 13 December 2016 we found that the new matron had not received any handover information from either the previous matron or the provider. We asked to see the audits around the monitoring of the care provided, for example, medication and infection control and the matron did not know if they had been completed or where they would be kept. Individual care plans had been audited and actions identified to correct the data in each file. However, there was no analysis to show what issues were repeatedly occurring in each care plan so that staff could make changes in the way they recorded information. In addition, while individual falls and accidents were reviewed and changes made to people's care plans to keep them safe there was no overarching audit to see if there were patterns in the time of day or area of the home where the falls were occurring.

The matron had not seen a copy of the last inspection report or a copy of the action plan the provider submitted to us following the inspection. This meant that they were unable to assure us that all actions identified at our last inspection had been completed. They were also unaware of the recommendation we had made in our previous report that the home seek advice and guidance from a reputable source about supporting people to receive person centred care. At this inspection we again identified that people had not been receiving person centred care. This showed that the provider had not taken robust action to make improvements following our last inspection.

The provider is required by law to let us about certain events which happen in the home, we call these notifications. We found that the provider had not submitted appropriate notification to tell us about safeguarding alerts and when Deprivation of Liberty Safeguards (DoLS) had been authorised. This meant that we did not know about certain events and could not take them into account when assessing the level of risk the home presented. The matron explained how the provider visited the home twice a week to support the matron and to see if people were happy with the care they received. However, considering the lack of action around audits from our last inspection it was not clear how the provider was monitoring the quality of care people received.

People living at the home told us that there had been a residents' meeting following our last inspection. However, they had not routinely been invited to meetings to discuss the quality of the care they received and any changes they would like to see. Records showed that the last residents' meeting had been held in

April 2016.

In addition we saw that staff meetings had not been taking place on a regular basis. Records showed that the last staff meeting had taken place in June 2016. Staff told us that when they had not been able to attend a staff meeting there had been no information available to them of what issues had been discussed in the meeting.

The matron explained that as they had been promoted from a nurse that had left the home short of nurses. They were therefore still covering nursing shifts as needed. However, this meant that they were unable to focus on the management of the home and improving the quality of care people received.

This was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activity Regulations 2014.

Staff we spoke with told us that the new matron had been good for the home. They said that the matron was more aware of how the care staff were feeling about the changes at the home. In addition they told us they were more confident that the new matron would take appropriate action about any concerns that were raised. They explained that their growing confidence in the new matron had led to them being less stressed and they were much happier to be at work. In addition it was clear that the new matron was working collaboratively with the deputy matron and that staff saw them as a management team which could be relied on. Staff told us that they were happy to raise concerns with either the matron or the deputy matron.

Before we visited the home we checked all the information we held about the provider on our systems and reviewed other information available to us about the provider. We found that the address we had for the provider did not match that which was registered with the authorities who monitor the activities of companies. We discussed with the provider the need for the provider's address to match the address given to us in the company's statement of purpose and that given to other authorities.

Before the inspection a visiting relative had raised concerns with us regarding the quality and cleanliness of the pillows. We looked at the pillows in four rooms we saw that although they were clean some had brown stains, in addition some of the pillows had been washed so frequently that they filling had settled into lumps and had lost it's support.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems to assess, monitor and improve the quality of care provided. The provider did not assess, monitor and mitigate the risks to people living at the home. The provider did not act on feedback to drive and embed improvements in care. Regulation 17(2) (a)(b)(e)