Townsend Life Care Limited

Port Regis

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Overall summary

This was an unannounced inspection that took place on 20 and 22 January 2015.

Port Regis is located on the outskirts of Broadstairs. It is a large building with two separate wings set over two floors. Some bedrooms are en-suite. The service provides accommodation for a maximum of 70 people and provides care to older people and those living with dementia. There were 56 people living at the service when we carried out our inspection.

The service had a registered manager who was present on both days of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Policies and procedures were in place relating to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people using services by ensuring if there are any restrictions to their

Summary of findings

freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. When people did not have the capacity to make more complex decisions appropriate advice was not always sought, although DoLS applications were applied for.

Risks to people were not managed safely. People told us they felt safe but there were situations when people's safety was being compromised because staff did not make sure that people were monitored and checked regularly. People were in unsafe situations and care plans did not give guidance about how to reduce the risk of this happening. The environment did not always support people to stay safe or help them to orientate themselves because there was a lack of signage and some people could not find their bedrooms. There had been some improvements in the cleanliness of the kitchens, but there were shortfalls in other areas as infection control procedures were not always followed.

Staff understood what abuse was and knew about the importance of whistle blowing, but were not confident that any concerns they had raised were acted on. The registered manager did not take timely and appropriate action when staff reported an incident of abuse. Staff told us that morale was low and that they did not feel well supported by the registered manager and provider. Staff did not feel that the training gave them the skills, competencies and confidence to meet people's needs.

Most of time people felt there were enough staff but also said they thought there were times when staff were not around to help them. Staff interactions with people varied. Staff mostly treated people in a kind and respectful manner, but there were times when staff did not treat people with consideration or fully respect their dignity.

People received their medicines when they needed them, but were at risk of receiving the wrong creams because staff did not make sure that people had their own creams when they needed them. People received appropriate healthcare support. Advice and guidance was sought from relevant health care professionals such as GP's, district nurses and dieticians.

People enjoyed their meals and were offered a range of nutritious and suitable foods. The provision of activities varied and not everyone was supported to be involved in meaningful pastimes that met their needs and suited their preferences. Care plans did not take into account people's life histories and what their preferences were.

The complaints procedure was on display, but was not accessible for people who could not mobilise or had poor vision. People felt they could talk to staff but there were no systems to help people make their opinions known.

Audits and quality assurance processes were in place to monitor the quality of the service provided, but these were not effective because they had not identified the shortfalls we found.

Staff knew what the aims and objectives of the service were. We have made recommendations to the provider so that they can make improvements to the service.

The last inspection was carried out in June 2014. At that inspection we found breaches in regulations and asked the provider to make improvements. We asked for an action plan and received this within the stated timescales. At this inspection we found some changes had been made but also found further breaches of regulations.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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.

The provider did not notify the relevant authority when there was an allegation of abuse.

Risks to people were not always managed and the environment did not support people living with dementia. People said there was usually enough staff on duty to meet their needs.

Infection control procedures did not protect people from the risk of infection.

Medicines were managed and people received their medicines when they needed them. People did not always receive their prescribed creams.

Is the service effective?

Requires Improvement

The service was not effective.

Staff received basic training but did not feel confident about the training they received. Staff did not feel supported.

Staff understood how to support people to make daily living choices. People's mental capacity to consent to care or treatment was not assessed and recorded. The Deprivation of Liberty Safeguards were not adhered to.

People enjoyed their meals and were supported to eat a variety of food and drink. People were supported with their healthcare needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People or their relatives were not always involved in decisions about their care and treatment.

Interactions between people and staff were generally positive but staff did not always show kindness and compassion. People's privacy and dignity was not always respected.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care plans did not always contain sufficient information about people's needs to allow staff to deliver care in a personalised way.

There was a lack of activity provision to meet people's individual needs.

The complaints procedure was on display but was not accessible although people felt they would be happy to make a complaint.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led.

Some actions had been taken to address previous breaches of regulations but there were still shortfalls and new breaches in other areas.

Staff views and opinions were not listened to and staff morale was low.

Quality monitoring systems were in place but not all were effective in identifying shortfalls.

Although the registered manager and staff told us the people were 'the centre of the service', some of our observations did not support this.

Port Regis

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 20 and 22 January 2015 and was unannounced. The inspection was carried out by one inspector and a specialist advisor. The specialist advisor was someone who had clinical experience and knowledge of working with people who are living with dementia.

Before the inspection we looked at previous inspection reports, the action plan sent to us by the provider and notifications we had received. A notification is information about important events which the provider is required to tell us about by law. We looked at information received from the local authority.

We can ask providers to complete 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. We did not request a PIR as we carried out this inspection at short notice.

Some people were not able to tell us their experiences so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us. We spoke with nine people using the service. We observed care and support people received in the communal areas and observed meal times.

We spoke with eight staff including the registered manager and the registered provider for the organisation. We looked at a variety of records including eight care plans and associated records as part of pathway tracking the care provided. We looked at records relating to the management of the service including audits, some policies and procedures and staff records.

The last inspection took place in June 2014 when we found breaches in regulations. At this inspection we found that some changes had been made but also found further breaches in regulations.

Inadequate

Is the service safe?

Our findings

Although most people told us they felt safe, there were other people who told us they did not always feel safe. Relatives had mixed views with most relatives feeling their loved ones were safe, but other some relatives did not have the same opinion We observed some people in unsafe situations that put them at risk.

Some people became agitated. One person was shouting out in the dining room. Staff took this person out of the dining room and staff said this was because, 'They upset other people'. One person told us that this person often became agitated and told us that they felt, 'Uncomfortable' when this happened. They said, "There are some people who can be a right pain. I know they can't help it but it's not nice. Staff will usually take them out though". There was no information in the person's care plan about how to support this person. Another person was walking around and shouting out. Staff were busy and did not distract the person or try to reassure them. Another person was upset by this and said, "I can see why people get upset with other people, there is often someone causing problems". They told us they did not like this when it happened.

People said, "They make sure I have everything I need", "I feel safe and happy here" and, "I feel quite safe in my room and if I needed anyone I am sure they would help me". Two people did not feel as confident, they told us they felt uncomfortable because of the way other people sometimes acted. Another person said, "I have a friend here and we look out for each other to make sure we are alright, so that is ok".

There were situations when people were not safe. One person was in a hallway on the second floor. This person was struggling to walk and was using a Zimmer frame (walking aid) to help them keep their balance. They said they were lost and couldn't find their way back to their bedroom or how to get out of the hallway. They did not know how to use the lift and said they were, 'tired', 'scared' and that they, 'needed to sit down'. There were no staff around and there were no places for this person to sit down. We had to look for staff to alert them that this person was alone and lost in an area where there was no staff present. Staff told us that this person had moved 'in a few days ago'. The care plan was still in the process of being written, a senior member of staff said that this person could walk a few steps with the, 'Help of a Zimmer frame, but would not be able to use the lift'. There were no safeguards in place to make sure this person was helped safely from their room and supported to use the lift.

Staff did not regularly check on people who stayed in their rooms for long periods of time to find out if there was anything they needed or to make sure that there were alright. There were no systems to allocate staff. Staff told us that they all took it in turns to check on people, but no one took overall responsibility to make sure this happened. The risk assessment for one person stated that they 'required half hourly observations to see what she is doing'. We walked past this person's room and heard them calling out for help. We knocked on the door and went into the room. The person was sitting on their commode and was in distress and upset. They told us they were, 'in pain and needed help'. They said, "Please care for me". There was no call bell in reach for this person to contact staff. We alerted staff to this situation and asked when then the person was last checked on. A member of staff told us that they had taken them to their room, "About an hour ago". This person had not checked on since they had been taken to their room. The person's care plan stated and staff confirmed that this person was not mobile and needed staff to help them to move. They had been sitting on their commode for approximately an hour and staff had not checked on them to make sure they were safe and comfortable.

People had call bells in their rooms, but they were either not in reach or people did not know how to use them. Some of the call bells were not connected. The call bell in one room was out of reach of the person. Staff said, "It's there if they want it". The person could not walk on their own, so they could not reach the call bell. Staff told us that they regularly checked on people who could not use their call bells but could not tell us how often this happened. There were no systems to check, monitor and record that people were safe in their rooms.

One person had been referred to a consultant following a number of falls. A recommendation from the consultant dated November 2014 stated that this person would benefit from wearing 'hip protectors'. The letter also stated that these were not available on the NHS, but could be purchased privately. The person had not received any hip protectors to help keep them safe should they fall.

Some parts of the environment were not safe. There were uneven floor surfaces in one of the dining rooms which had

Is the service safe?

the potential to cause a trip hazard for people. Accidents had been looked at to try and identify trends and patterns. When an increase in falls was identified, people were referred to the falls team.

The provider had failed to take action to identify, assess and manage risks relating to the health, welfare and safety of service users. This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understood about safeguarding people and knew the signs of possible abuse. They knew about whistle blowing procedures and who to report their concerns to in the service. However, staff did not feel their concerns were listened to. More than one member of staff told us that they did not have confidence that the registered manager would act on their concerns. One member of staff said, "I have given up telling them anything because they don't listen to me". Other staff told us that when they reported concerns they had no confidence that, 'anything was acted on', and, "It's a waste of time". Although staff told us that they did not have confidence in the registered manager and were aware of who else they could report concerns to, such as the local authority safeguarding team, they had not done this.

The last inspection in June 2014 found that the policy and procedure for safeguarding people did not give staff the proper information about the steps to follow should there be an incident of abuse. At this inspection the policy and procedure had still not been updated and stated that the manager or director would start a, 'full-scale investigation'. This was not the correct procedure as the local authority takes the lead in safeguarding investigations.

Staff told us about an alleged incident of abuse that had been reported to the registered manager in December 2014. They said that, 'nothing was done it about it'. The registered manager told us they were aware of the incident, and that they had carried out an investigation in January 2015. This was not in line with the local authority safeguarding protocols and no action had been taken to prevent the risk of reoccurrence. We reported this to the local authority.

The provider had not ensured that people were protected against the risk of harm was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection there was a breach in the regulations with regard to infection control procedures as the kitchen had not been kept clean. The provider sent an action plan that detailed the action they had taken to rectify this. At this inspection there was a schedule for cleaning the kitchens and these areas were now improved. There were, however, other shortfalls in infection control procedures which meant the cleaning procedures in the service were not adequate and did not protect people from the risk of infection. There was an opened tube of cream left in one bathroom with dried faeces on the nozzle. In another bathroom a soiled incontinence pad had been left in an open bin. Both of these bathrooms were used by people on their own and so posed a risk to people if they touched the items. Staff used a sling (which helped people to move in a hoist) and this was soiled with brown stains. They told us that they did not have a spare sling of that size, so they could not wash it as they needed to use it. The mattresses in some rooms were torn and split and could not be cleaned effectively. One person had their lunch served to them in their room on a table placed next to the commode. The commode had not been emptied or cleaned. The person had to eat their meal sitting next to an un-emptied commode.

There were no cleaning schedules to keep people's bedrooms, bathrooms and the communal areas clean. A cleaner told us, "I just work my way round the rooms and then clean them like I do at home". They also said, "I haven't done any training because it's all common sense really so I don't need it". An audit had been carried out on the cleanliness of the environment but it did not take into account the Department of Health's publication, 'Code of Practice on the prevention and control of infections' which provided guidance about control measures to reduce the spread of infection. The audit had not been effective at picking up shortfalls in infection control procedures.

This was a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

The environment did not support people to stay safe or orientate themselves. Some corridors and hallways had lights which were motion controlled and only stayed on for a certain length of time. In darker areas of the environment, where there was no natural light, when these lights went off people were in darkness. This could be disorientating for people and put them at risk of falls. Bedroom doors were all one colour with no personalisation to aid people to be able to recognise their rooms and find their way around the environment. There was no signage to help people recognise different areas or help them to find their way around. Recognised dementia care research recommends that there should be appropriate signage, flooring, lighting and colour schemes to support the well-being of people living with dementia.

We recommend that the provider seeks guidance and advice about best practice in ensuring the environment supports people living with dementia.

People were not protected against the unsafe use of creams and sprays. There were no procedures for making sure that people had the creams that they had been prescribed. In several bedrooms there were creams belonging to other people and staff told us they used the creams which were in people's rooms.

People were not able to manage their own medicines so they were administered by staff. People felt happy that they received their medicines when they needed them. One person told us, "The girls are good they always make sure I get my tablets and I if I have a headache I can ask for something".

Medicines were stored in accordance with the manufacturer's instructions in either locked cabinets or a suitable fridge if they needed to be kept at certain temperatures. Bottles of medicines, packets of tablets and eye drops were dated on opening. Each dose administered was recorded on a medicines administration record (MAR chart). The MAR charts included a photograph of each person to confirm their identity, and highlighted any allergies. The charts had been accurately completed.

Records were kept of all medicines delivered and of any medicines returned to the pharmacy. Actions were taken if someone refused to take their medicines and staff would contact the GP for advice.

The registered manager used a dependency assessment tool which worked out the number of staff needed at any one time. This took into account the needs of the people using the service. Staff rotas showed that the assessed number of staff was allocated on duty. There was an emergency contingency plan for unforeseen staff shortages such as sickness. Most people and some staff felt there were 'usually' sufficient numbers of staff on duty. However, some people told us that they had to wait for staff to help them. They told us, that there was, 'often a lack of staff' and sometimes, "There was no one there" when they needed them. Staff told us that the emergency contingency plan, 'Didn't always work' and there were times when there, 'weren't enough staff'. At lunchtime there were sufficient staff to assist people who were sitting in the dining area. When staff were available they responded to people and any requests for assistance.

People were protected by safe recruitment procedures. The provider carried out appropriate checks including obtaining references and checking people's employment history by exploring and recording any gaps in employment. The provider also obtained a Disclosure and Barring Service (DBS) check. The DBS check helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. There was proof of identity in the staff files we looked at. Before employment started prospective staff completed an application form and attended an interview. Records were kept of the interview.

Requires Improvement

Is the service effective?

Our findings

A relative told us that they thought the staff understood their relative. They said, "They know exactly how to help Mum". One person said, "They always help me with what I want". Another person said, "I do trust them and they are there if I need them".

Staff were given a supervision record to read and sign to say they agreed with it. They did not spend time with the manager to talk about any concerns, training needs and receive feedback.

Staff told us they did not feel they received the support they needed. Staff said, "If I report anything I feel worthless because it is always dismissed", "If I say anything I am made to feel like a trouble maker" and, "I have made a complaint to the manager and nothing was done".

More than one member of staff told us that they lacked the confidence to bring issues to the attention of the registered manager or provider. Staff told us that, 'morale was low'. One member of staff spoke to us in confidence and they burst into tears and told us, "I have been moved about because I've been told I am no good at my job, but they haven't told me what I am no good at. I just come to work now, keep my head down and my mouth shut because that is the best way". They said that they had not received support and they told us, "It doesn't happen. It's not worth it. I am not even going to ask".

Staff meetings had not happened. These were important because meetings gave the registered manager the opportunity to go through policies and procedures so staff were aware of their accountability. Staff told us that meetings had, "Fallen away". They said, "We used to have them but not anymore". One member of staff said, "It wouldn't matter if we had meetings, no one listens to us". The registered manager said that there had been no staff meetings.

The provider did not have suitable arrangements in place to ensure staff were appropriately supported to carry out the regulated activity. This was a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of staff's induction and ongoing training registered providers are expected to ensure that staff have the skills, qualifications and experience to perform their role. The length and delivery of training may vary but the outcome should be that staff were competent to perform their role. People felt that staff gave them the help they needed. Overall staff supported people with their needs and supported them appropriately, but there were times when they did not notice that a person needed assistance

Staff gave us mixed reviews about the training they received. Two members of staff told us that they were happy with the training, but other staff we spoke with said that they thought the training was not appropriate. They told us, "Just answering a lot of questions doesn't really help much", "I would really like some decent training where I feel I have really learnt something" and, "It's ok, but it would be much better if we could have some proper hands on training". One member of staff told us that they didn't know anything about people with dementia, although they had completed the question and answer sheet training. Staff told us and the registered manager confirmed that staff were given a hand out and question sheet on individual subjects and were instructed to return the completed questionnaire. Staff were then issued with a certificate to confirm they had completed the training. Staff did not have any other method of training including face to face, practical sessions or e learning to support them to develop their skills. The registered manager confirmed that they only used the question sheets for the training.

Staff completed an induction work book which consisted of a set of instructions about what staff should know. The registered manager told us that they followed the Skills for Care Common induction standards (which are standards that staff working in adult social care need to meet before they can safely work unsupervised). One member of staff told us that they had not worked in the care sector before. They said they had relied on other members of staff to give them guidance and support because the induction did not give them the skills they needed.

The Mental Capacity Act code of practice states that capacity must be presumed unless proven otherwise. All of the care plans had an assessment that identified if people lacked capacity to deal with their post, finances, investigations and medical appointments. None of the assessments were individual to the person. There had been no individual capacity assessments carried out for people

Is the service effective?

to determine who did not have capacity to make a decision for themselves in their own best interest. One person's care plan stated they could not make day-to-day decisions. There was no assessment to show how staff had reached this decision and there had been no best interest meeting. The care plan for one person stated that there was an agreement for 'A Lasting Power of Attorney' in place. The registered manager said that this was for their representative to manage their health and finances. There was no information about how this affected the care and support provided to this person. Staff showed some understanding of the need to ask people for their consent before they gave them care and support.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). An application had been made to the DoLS office for one person and a member of staff told us that the authorisation had been granted. There was no care plan to guide staff as how to support this person with regard to any concerns about potential Deprivation of Liberty Safeguards. Another part of this person's care plan stated that they were able to make a decision about going out which contradicted the DoLS application. Staff could not tell us how they supported this person so that their liberties were not restricted unlawfully.

The provider had not made suitable arrangements to act in accordance with people's consent in relation to the care and treatment provided to them. This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People liked the meals. They told us, "The meals are nice", "The food is good and I always have a choice." One person who had finished their lunch told us, "That was really nice". The way people were offered and received their meals was not consistent. At lunchtime the people in one dining room were shown the two meals that were available and could choose which one they wanted. People received their meals quickly and they were served from a heated trolley. In the other dining room people were asked, rather than shown, the choices so they were not given a visual choice. Some people using this dining room were living with dementia so a visual choice may have been useful to them to help them choose. Meals took longer to be served and there was no hot trolley to keep the food warm in this dining room. Some people waited over half an hour for their lunch.

Meals and snacks were offered throughout the day. There was a choice of two main meals at lunchtime and a range of desserts. People could have sandwiches and / or a hot snack for their evening meal and were offered a range of cakes or other cold desserts.

Meals included fresh vegetables and homemade foods such as savoury pies and desserts. The cook knew about people's different dietary needs. This included whether people were diabetic, or if they needed a soft diet because they had difficulties with swallowing. Food allergens were identified for each meal to make sure that people were not eating anything they had an allergy to, such as nuts, eggs and shell fish.

People were weighed to check for any weight loss and people who had been assessed as having nutritional needs had been referred to the dietician. Some people had been assessed as having skin that might easily be damaged and had pressure relieving equipment such as special mattresses and cushions to help prevent the likelihood of developing pressure sores. People received support from the district nurses to make sure they were supported with any pressure area care.

Records for monitoring people's care such as their food and fluid intake and charts to make sure people were turned to prevent pressure sores were not always completed consistently by staff. There were some gaps in the entries and food charts lacked the detail to ensure people's nutritional needs were being fully monitored. People were referred to appropriate health care professionals as needed and advice was acted on by staff. There had been no increase in pressure sores and records now kept in the kitchen meant people got the meals that were suitable for their individual needs.

One person told us they could see their GP when they wanted and had been supported to attend hospital appointments. A relative said, "They always ring the doctor if Mum is unwell". Staff told us about changes in people's health care needs and what actions they took if they were concerned about anyone.

Requires Improvement

Is the service effective?

A visiting GP told us that staff kept the surgery informed of people's healthcare needs. They said that there had been no cause for concern such as an increase in pressure area care or infections. A district nurse said that when they gave staff advice they acted upon the instructions given.

Requires Improvement

Is the service caring?

Our findings

The majority of people we spoke with were positive about the way staff cared for them. They told us, "They are all caring and kind", "They (the staff) are all very nice" and, "Lovely, lovely and so cheerful". One person said, "Some staff are nice, but some are nicer that others". They did not expand on this. Relatives told us they thought staff were caring and kind. One relative said, "They (staff) are really interested in people". Another visitor said, "Mum is always clean and tidy and they are very caring towards her".

Staff interactions with people varied. Most of the time staff treated people in a kind and respectful manner, but there were times when staff did not treat people with consideration or fully respect their dignity. One person was upset and needed help to use the lift. They asked an inspector for help. While looking for a member of staff to help this person the inspector accidently set off an alarmed door. A member of staff responded to this alarm and when they saw the person they were abrupt in their manner and said, "What have you done now? Who opened that door? Why are you out here?" When the member of staff saw the inspector their tone changed and they became friendlier. The person apologised to the member of staff who responded by saying, "Well we are doing the best we can". They did not try to comfort or reassure the person. The staff member did not apologise for their earlier tone. Another person was sitting in a lounge and was visibly upset. There was a member of staff close by writing records, but they did not look up or go to comfort the person.

In the lounge area, staff used a hoist to move some people from their chair to their wheelchair. One person was wearing a dress and when staff helped them to move, their underwear was visible to people who were in the room. Staff did not take steps to protect the person's dignity.

The provider failed to make sure that staff treated people with dignity and respect. This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each care plan file contained a 'This is me' section which was used to record people's life histories, likes, dislikes, preferences and things that were important to them. Not all the care plans we looked at had this section completed. There was a lack of information about how people liked to spend their day or how they wanted to be helped with their care.

There were some limited opportunities for people to have a say about their care and support. Before people moved in an assessment was completed and the registered manager told people about the service provided at Port Regis. People were involved in this assessment, but the care plans did not identify how else people were involved and supported to further contribute as their needs changed. Staff told us they asked people how they wanted to be helped, but could not tell us how else people were involved in their care. One person told us, "I just take it for granted that staff know what they are doing".

Relatives told us that staff were always available and approachable. People said that they could talk to staff and tell staff anything they wanted. People felt they were listened to. However there were no formal ways to encourage people or their representatives to give their views on the service provided, such as meetings. The activities coordinator talked to people on a one-to-one basis and asked them about things they liked such as activities and meals. The menus had been changed following feedback from people.

On occasions staff were kind, caring and respectful. At lunchtime staff spent time with people to help them with their meals. One person was having difficulty with their meal. A member of staff sat next to them and spent time using gentle encouragement to help them eat their meal.

One person was frightened of using the hoist. Their relative said, "Mum hates the hoist but the carers are so good". The person was later being hoisted and staff encouraged this person to sing as it, 'Took their mind off the hoist'. One person needed assistance to be repositioned in their chair so they were not at risk of falling out. They told staff they were, 'scared to move'. One member of staff did a little dance to make this person laugh so that they relaxed and staff then spent time encouraging and supporting this person. Once the person was seated more comfortably, they thanked staff for their help. One person kept saying to staff, "I know I am a nuisance", and each time staff reassured them that they were not. When staff helped people to walk to the bathrooms, they closed the door and waited outside to make sure they were safe, but also had the privacy they wanted.

Requires Improvement

Is the service caring?

People's records were kept confidentially. Care plans were kept in lockable drawers. Confidential information was not displayed where it was accessible to other people. Staff were able to access all the records and were able to answer questions if we needed to clarify anything.

People said they could have visitors when they wanted. One person said, "My son can always pop in at any time". A relative said, "It's never any problem when I visit. I can come unannounced at all different times".

Requires Improvement

Is the service responsive?

Our findings

People did not know they had a care plan. One person said, "I haven't seen a care plan" and another person told us, "I don't know what that is". A relative said, "I can look at the care plan if I want and I have been asked about different things". Most people told us that they thought staff gave them the help they needed, although we observed that some people were in difficulty and needed help during the inspection and did not receive it in a timely manner.

Assessments of people's needs were carried out before they moved into the service. Information was obtained from the local authority or other service providers. Once someone moved into the service a care plan was written by the staff. There was limited detail to provide staff with the information they needed to give safe and personalised care. Care plans were focussed on people's physical needs but did not describe in detail what support people needed to receive personalised care. Care plans contained statements such as, 'cannot self-dress, but cooperates', 'help with personal care', 'needs support to eat' and 'requires help to mobilise'. Care plans did not identify what people could manage for themselves, which did not support people with maintaining their independence.

The care plan for one person identified that they could become verbally abusive and, 'should be removed from the area' when this happened. This person was moved from the dining room just before lunchtime because they had started to shout. They were not given any explanation and were just moved out of the area and taken to their room. Another person told us, "They often move them out because they shout at other people and can be a right pain". A member of staff told us that they would take this person to their room because it was, "Not nice for other people to have to listen to them swearing'. The person had been assessed as having a high score for, 'Pain, continence and challenging behaviour'. There was no consideration given by staff or noted in the care plan to show if any of these factors affected the person's behaviour. There was no guidance about how to reassure or support this person.

Care plans had a section for emotional needs but there was a lack of information about how to support people with these needs. Care plans did not take into account people's interests, social activities and types and stages of dementia. People living with dementia did not have care plans that were individualised. People's individual physical, social and psychological needs were not recorded. Staff concentrated on completing tasks like taking people to the toilet or giving out medicines. People who did not ask for help sat quietly and were not involved in any conversation or activity. Care plans did not identify how to involve people in activities or in their care.

There was no information in any of the care plans we looked at about what people liked to do and what their hobbies were. Published guidance from the Department of Health and recognised best practice organisations state that meaningful and enjoyable activities are a key part of helping people living with dementia to 'live well'.

The provider had not ensured that people received care that met their individual needs. This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's opinions about the activities were mixed and the amount of activities and support people were given to take part in meaningful pastimes varied. One person said, "I can join in if I want, but I don't like them (the activities) much. Another person said, "I don't know what's going on really". A relative said, "I think they can join in things if they want". Another relative said, "There isn't always much going on".

In the west wing there was a dedicated activities room. People who spent time in this room were engaged in a range of activities and pastimes. The activities coordinator for this wing was not on duty so there was a member of staff playing dominoes with a group of people and another group of people were listening to music. People's artwork was displayed with different crafts that people had made. People were laughing and chatting to each other.

People who were in another lounge area had very little stimulation. Staff were not always present in this lounge. They walked through and checked on people, but did not spend time interacting with people. There was a television on, but not everyone could watch the television because of the way the chairs faced. There were no activities on offer apart from watching television. People were not asked or encouraged to go through to the activities room to join in if they wanted to.

In the main building there was no activities area. A second activities coordinator spent time with people in this wing. The activities coordinator arranged for a reminiscence quiz

Requires Improvement

Is the service responsive?

to take place. They sat in the centre of the room but not everyone could be involved in what was going on because they were sat in a different part of the room or were sat behind the coordinator and could not see or hear what was happening. Some people were asleep and not listening and only about three or four people out of the twelve people who were in this lounge area participated in the quiz. There were no other activities offered to people in the main building.

The activities coordinator split her time between Port Regis and another service owned by the provider. When the activities coordinator was at the other service, the onus fell on staff for them to organise activities for people. They told us that they had, 'very little time' to do this. Staff said that they would try to sit and, 'chat to people' when they had time. Some people were encouraged to undertake small tasks such as folding napkins or clearing plates from the table, but only happened when there was a member of staff available to support them.

We recommend that the provider seeks advice and guidance about supporting people living with dementia to support them to access a range of activities.

People told us they did not have any complaints. One person said, "I have nothing to complain about. I would ask my son to do it for me if I ever did but honestly no complaints". The registered manager told us they had received three complaints. At the time of our visit, these complaints were being investigated. The complaints procedure was on display in different parts of the service. Although it was on show, it was only available in one format which was written. For people who could not mobilise or had visual impairments it was not accessible. There were no other formal ways of supporting people to access the complaints procedure.

Inadequate

Is the service well-led?

Our findings

People told us the provider, "Often popped in and said hello". One person said, "I often see the manager" and relatives said that they could talk to the registered manager when they wanted. Whilst we were inspecting relatives visited the manager's office to talk to her.

A member of staff, who had followed the whistle blowing procedures, told us they felt their confidentiality had not been maintained. They said, "I reported something to a senior and everyone knew it was me". We asked the registered manager about this and they said, "Sometimes staff tell each other when they have reported something which means we can't protect their identity". The registered manager was not aware that staff felt their confidentiality had not been maintained. Staff had told us that they were not confident that their concerns would be acted on when they reported them. There were no systems to the keep the day-to-day culture under review, such as staff meetings, and the registered manager was not aware that staff morale was low.

Staff were not supported with proper guidance or instructions to help them understand their role. The induction programme contained a set of instructions about what staff should know, but not how they would learn about this. Guidance for staff in induction about eating and drinking instructed staff that 'dietary needs must be catered for and you will need to be able to understand reasons for personal diets'. There was no supporting programme to help staff understand different dietary needs.

Staff signed disclaimers for any potential poor practices such as using wheelchairs properly, reading care plans and following policies and procedures. There were no systems in place to monitor and check that staff understood their responsibilities and put them into practice. Staff knew what their roles were, but these were not always organised effectively during the shift. For example when people stayed in their rooms, no member of staff took responsibility to make sure that people were checked regularly so ensuring they were safe and did not need any assistance.

Staff did not always recognise risks to people and did not take appropriate action to reduce all the risks. Care plans lacked guidance and staff did not always follow care plans. Half hourly checks were not carried out as stated in the care plans and one person was not helped with their mobility as described in the care plan.

The service had appointed a quality assurance lead. This person was now responsible for carrying out quality assurance checks and audits to ensure people were receiving a service that met their needs. Although these checks were in place, they had not always identified what improvements were needed. This member of staff told us that this was still, "A work in progress but things are starting to become embedded". They also told us, "I am still learning and trying to improve the systems". The audits were not identifying all the issues with infection control procedures and the quality of staff support and training.

The registered manager was not fully aware of their responsibilities to ensure that concerns were acted on appropriately. They did not notify the Care Quality Commission (CQC) or the Local Authority when an allegation of abuse had been raised. They had not taken immediate action to reduce the risk of possible reoccurrence.

There were limited systems for gaining formal feedback from people to enable them to have their say. An annual questionnaire had been sent out in January 2015 which asked people what they thought about the service. There were no meetings planned for people so they could a say in how the service was run. A relative's forum had been planned but this had not happened and the registered manager had not followed this up. Stakeholders and staff were not asked their opinions of the service.

The registered provider did not have systems in place to monitor the quality of the service. This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Questionnaires had been sent to people in January 2015. The latest results showed that people were happy with the support provided. People had wanted more entertainment at Christmas and the opportunity to go out for walks more often. The registered manager had arranged for people to go out more and stated that they would start the Christmas event plan earlier for next year.

Inadequate

Is the service well-led?

Relatives said that they could speak to staff and the registered manager if they had any concerns. One relative told us that they had spoken with the registered manager about the care provided and felt that they had been listened to.

The registered manager had 'signed up' to take part in a number of different schemes that could help them to improve the quality of the service provided. This included regular meetings with clinical nurse specialists, involvement with a 'pilot scheme' with the GP's and an 'out of hours' paramedics to ensure that there was continuity of health care support and that people received the care and the support they needed at the time they needed it.

Staff told us, "This is people's home. We need to make sure they feel comfortable and are happy" and "I feel that people are at the centre of what we do". Although staff said that it was about supporting people, not all of our observations supported this ethos as there were times when people were not getting the support they needed.

The registered manager told us that they made sure people knew about what the home provided. They told us that it was about being open and transparent at all times to ensure they could meet people's expectations. Although relatives felt they could talk to the registered manager, staff did not feel that they could contribute and did not feel valued.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not ensured: That care and treatment was provided in a safe way for service users and taken all reasonably practicable action to mitigate any such risks. 12 (1)(2)(b) That the risk of preventing, detecting and controlling the spread of infections had been assessed. 12 (2)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not ensured: That staff were appropriately supported in relation to their responsibilities as is necessary to enable them to carry out the duties they are employed to perform. 18 (2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person did not have suitable arrangements in place to make sure care and treatment was provided with the consent of the relevant person 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

This section is primarily information for the provider

Action we have told the provider to take

	The registered person did not have suitable arrangements in place to ensure people were treated with dignity and respect at all times. 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person had not ensured that care or treatment was designed with a view to achieving service users' preferences and ensuring their needs are met. 9(3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not have suitable arrangements to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity 17 (1)(a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment because systems and processes were not established to operate effectively. 13 (1)(2)(3)

The enforcement action we took:
A warning notice was issued