Irvine Care Limited

Chiltern Court Care Home

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**

Summary of findings

Overall summary

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

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

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

This unannounced inspection took place on the 13, 14 and 16 November 2017. During our last inspection in February 2017 we found breaches of Regulations 9, 10,12, 13,14 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA RA Regulations 2014) and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Registration Regulations 2009)

As a result we imposed conditions on the provider's registration. This meant we asked the provider to supply us with information on a monthly basis to evidence improvements in these areas. They were legally required to do so and complied with these conditions. During this inspection we found improvements in regulations 13 and 14 HSCA RA Regulations 2014 and Regulation 18(Registration Regulations 2009).

However we found continued breaches in regulation 9, 10, 12 and 17 of the HSCA RA Regulations 2014 with additional breaches in regulation 19, 15 and 18 HSCA RA Regulations 2014.

The home had not had a registered manager in post since April 2017. Since the last registered manager left their post there have been three further managers covering the position, none of whom have remained in employment or applied to be registered with us.

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.

Chiltern Court Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single packages under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Chiltern Court Care Home is a nursing and residential home for older people. The home is registered to accommodate up to 53 people, at the time of our inspection 23 people were living in the home. The accommodation is spread over three floors. The bottom two floors have lounges and dining areas. Only one person was living on the third floor.

We found improvements had been made in some areas of the safe handling of medicines. However, records were not always up to date or used appropriately to prevent people from being harmed by medicines or lack of medicines. For example patches. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection we found the provider had failed to notify us or the local authority of safeguarding concerns that had taken place in the home. During this inspection we found this had improved and there was only one outstanding safeguarding notification we had not received. Staff had understood the indicators of abuse and systems were in place to report concerns and to take appropriate action to keep people safe.

During our previous inspection in February 2017 we found failings in the recruitment practices of the service. During this inspection we found the same failings as gaps in employee's previous employment histories had not been investigated and recorded. This placed people at risk of harm. This was a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found the standards of hygiene and infection control were of concern in some parts of the home. Some areas were not clean, and catering and domestic staff had not all received training in infection control. This was a breach of 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Health and safety checks had not been carried out continuously in the months since our last inspection. We found some areas of the building required attention to ensure the security and safety of the staff and people living in the home. This is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Maintenance contracts and service checks on gas and electricity had been maintained and were up to date.

During our previous inspection in February 2017 we recommended to the provider they gave consideration to the deployment of staff. This was because staff were not always available when people needed them due to taking breaks at the same time. During this inspection we found improvements had been made and staff were more accessible and able to respond quickly when people needed assistance.

During our last inspection we made a recommendation for the provider to improve support to staff through appropriate training, supervision and appraisals. We found this area had improved and the rate of training had increased. However, we found staff that required specific training to carry out their roles had not all received training. Supervision and appraisals were not being provided in line with the provider's policy. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found during this inspection a continued breach in regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because records were not always available, up to date or accurate. The provider had failed to monitor the management of the home and address issues that affected the safe provision of care and support for staff.

Records showed people's mental capacity had been taken into consideration when making decisions for themselves. Staff supported people in the least restrictive way possible; the policies and systems in the service supported this practice. However, people were not always supported to have maximum choice and control of their lives. People's dignity and privacy were not always protected by staff. This was a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also observed good care practices from staff including how they communicated with people and their general caring attitude towards the people living in the home.

We found a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care plans did not always consider how people could be supported with their mental health. They did not always reflect the involvement of people and did not always consider how to support people to be as independent as possible. People still remained at risk of social isolation as the provider had failed to improve the provision of person centred meaningful activities to people living in the home.

During our last inspection and this inspection we found people did not always know how to make complaints.

We have made a recommendation in relation to end of life care planning for people within the home, as this was not a consistent practice throughout.

Due to the lack of consistent management in the home, we found staff had been put under pressure to repeatedly change the way they were working, this had affected morale, and their understanding of what was required. The provider had failed to monitor the quality of the management in the home and this had resulted in a lack of progress with regards to the expected improvements. A new regional manager and acting manager are now in post and improvements have been reported from the local authority contracts team since our inspection.

We found a number of breaches 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 the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Records related to medicines had not always been completed accurately. Some medicines had not been administered when needed which meant one person was experiencing pain.

Recruitment practices were not safe, as previous employment checks were not always carried out, and gaps were not always interrogated. This did not ensure staff were always suitable to work with people.

Standards of hygiene and infection control were not up to standard. Health and safety checks had not consistently been completed. This placed people's at risk of harm or illness.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not always suitably trained or supported to carry out their role effectively. People were therefore at risk of receiving inappropriate or unsafe care.

Records related to food and fluids had not been completed accurately or consistently. This meant the provider could not accurately gauge people's intake. This placed people at risk of dehydration or malnutrition.

People's ability to make decisions for themselves was considered by the provider. Records showed where people's liberty was deprived to ensure their safety; appropriate applications had been made to the supervisory body.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider failed to ensure the care provided in the home was suitable and safe. This did not demonstrate a caring approach.

People did not always experience dignified care and were not

always shown respect by staff. This did not protect their self-esteem or self-worth.

Care plans did not always reflect people's mental health needs and did not focus on supporting people to remain independent. People did not always experience person centred care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Where people needed aspects of their care recorded by staff, these records were not always consistently or accurately maintained. This meant the provider could not effectively monitor the care provided to ensure it met people's needs.

People were at risk of social isolation and boredom as activities and stimulation were not always available to people when they needed or wanted it. This did not protect people's mental health needs or encourage social interaction to prevent loneliness.

People did not always know how to raise a complaint. This meant the provider could not drive forward improvements, without considering the experience of people living in the home.

Is the service well-led?

Inadequate

The service was not always well led.

The provider had failed to ensure a registered manager had been in place to provide suitable guidance for staff and to effectively manage the service people received.

The provider had failed to ensure that where improvements were required to the practices and care being provided this had taken place in a timely manner. This meant people were not consistently receiving good quality care.

Quality audits had not identified the areas of concern we found during the inspection. There was a lack of accountability and poor monitoring by the provider of the experiences of people and staff in the service.

Chiltern Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

Following the last inspection, we met with the provider and asked them to complete an action plan to show what they would do and by when to improve the key questions, is the service, safe, effective, responsive, caring and well-led to at least a good standard. We found there had been little or no improvement in any of the areas.

This inspection took place on 13, 14 and 16 November 2017and was unannounced. The inspection was carried out by an inspector, a specialist nurse advisor and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was as a family carer of older people, people with dementia and those who use regulated services.

Before the inspection we reviewed all the information we held about the service. We looked at notifications the provider was legally required to send us. Notifications are information about certain incidents, events and changes that affect a service or the people using it. We contacted and received information from the local authority safeguarding, contracts and commissioning teams. For this inspection we did not ask the provider 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 spoke with 11 people, two visitors, and a health care professional. We spoke with 10 staff including the acting manager and regional manager, permanent and agency nurses and care staff. We also spoke with housekeeping and catering staff.

We looked at care records for 10 people; four staff recruitment records; eight people's medicines and topical medicine administration records and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

At our previous inspection in February 2017 we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff did not follow the policy and procedures in regards to recording the stock and administration of medicines and reporting medicine errors. As a result we imposed a condition on the provider's registration. We found during this inspection that some improvements had been made however, there were still concerns related to some areas of medicines.

Records showed there had been 12 medicines errors since February 2017. During this inspection we found that stock checks had been completed but we found gaps in one record. The record had not been completed for three dates. The balance showed there were six tablets missing. This had not been identified during the daily audit and had not been investigated. We also found one controlled drug had been destroyed by staff, this was because staff believed there was an extra tablet in stock and wished to balance the records. This was partially investigated, but this was not thorough. The regional manager told us they would reinvestigate it and ensure learning was taken forward from it.

The service used body maps when patches are applied to people's body. The site of the patches was alternated. The records from the 23 October 2017 to the 13 November 2017 for one person showed a number of omissions such as no body maps being used, no removal dates recorded, no names and no signature of staff. When we brought this to the attention of the acting home manager they put a body map in place. They told us an agency nurse was responsible for the most recent omission. This placed people at risk of harm, as staff needed to be aware of the specific site of the patch. This ensured they could locate the patch when it needed to be removed, and would prevent overdosing if a second patch was accidently applied. There was also a risk of skin irritation if the site of the patch was not changed.

For one person the recordings on their chart showed they had not had their bowels open for six days. The person was at risk of constipation due to restricted movement and lack of exercise. There was no care plan in place for the management of constipation and the staff had not recognised they had not opened her bowels. They were not prescribed laxatives. When we brought this to the acting manager's attention they rang the GP for advice. The person was not showing any signs of discomfort. However, during our visit we met one person who was calling out for help. When we visited their room they were lying in bed and explained they had stomach ache as they were constipated. The person was prescribed PRN (when required) laxatives, but this had not been administered to them until we brought this to the attention of the nurse. The PRN protocols for other people gave detailed guidance for staff on when to administer the respective medicines, however this person's protocol did not.

This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that all the permanent staff that dispensed medicines were trained in the management of medicines. They had also undergone a practical medicine competency test. There was a clear process for

the ordering, checking, and disposal of medicines. The medicines were stored in two locked trolleys that were attached to the wall of the clinic room. The clinic room was also locked.

All the medicines contained in the trolley were checked to ensure that they had not expired. The creams had opening dates both on the box and the tube. The dates and the reasons people refused medicines were written on the recording sheet and at the back of the sheet. Controlled drugs were stored separately in a locked cupboard and the keys were kept by the nurse at all times. All unused medicines were kept disposed of in a secured box. However, the labels with the person's names had not been removed from the medicine bottles and boxes to protect the person's identity. The service followed the legal requirements for the ordering, storage, dispensing and disposal of controlled drugs.

At our previous inspection in February 2017 we found a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was not an open and transparent culture in relation to the sharing of information with the local authority or the Care Quality Commission (CQC) in relation to concerns of abuse. As a result we imposed a condition on the provider's registration. During this inspection we found this area had improved, however records showed a safeguarding concern had been raised with the home and they had informed the local authority.

It is important the provider shares this information with us, as we need to be aware of concerns within the service and to ensure people remain safe. The provider failed to notify the CQC about this incident. From the documentation we could see the concerns had been investigated and improvements had been made where necessary. We discussed this with the regional manager who assured us notifications would be sent to us as per their legal responsibility.

Staff understood the indicators of abuse. They were clear about the reporting of concerns and actions they needed to take to support people. One staff told us "I can confidently tell you that I have not witnessed any abuse since working here for more than a year.

During our previous inspection in February 2017 we found failings in the recruitment practices of the service. This was because staff recruitment was not always carried out using safe processes to ensure the fitness of staff to work in the home. For example, we found gaps in two applicant's previous employment histories. We were given assurances by the provider this would be investigated and improved on. During this inspection we found this area had not been improved upon. We looked at the recruitment files for four staff. We found two staff appointed since our last inspection had gaps in their employment history. There was no documentation to verify that these gaps had been explored with the staff member prior to employment.

It was brought to our attention during the inspection a staff member had been employed at the home whose conduct in their previous employment had raised concerns. Once the provider had been made aware of this they terminated their employment. However, if the provider had researched the employee's registration with a regulatory body, their employment history would have been identified.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other checks were in place for recruitment of staff which included Disclosure and Barring Service (DBS) checks, written references, health declarations, and proof of identity and of address.

During this inspection we found standards of hygiene were of concern in some areas. For example, the infection control lead was unable to tell us in detail what preventative measures were in place to protect

people from the risk of infection. They had not received any training in this area. No infection control audit had been completed. We found bins were in place in a bathroom and kitchenette which required people to touch the lid in order to open and close the bin. This did not prevent the spread of infection. We found faecal deposits on the inside of a toilet roll, and on the underside of toilet seats and the underside of toilet commode seats. The staff toilet had brown splash marks on the side of the sink pedestal which remained over the four days from the start to the end of the inspection. Colour coded mops were available for use in specific areas, however, we found one mop in dirty water stored in a room after the cleaner had finished their shift. Cleaning schedules showed gaps in recording for example, a shower room had no record of being cleaned for eleven days.

The regional manager carried out an infection control audit on the kitchen area whilst we were absent from the home between the second and third day of the inspection. They shared their findings with us. They found several issues that needed addressing. For example, not all catering staff had received infection control training. Protective gloves, shoes and aprons were not being worn by all catering staff. Food hygiene standards had not been met. They had drawn up an action plan to address the issues they had found.

Another concern related to infection control was the cleanliness of hoist slings. These are used to assist people to manoeuvre from one position to another when being hoisted. Staff told us that slings needed to be washed at least monthly. Staff told us people needed to remain in bed if their slings were washed due to the time it took to wash and dry them. They could not tell us when people's slings were previously washed. People only had access to one sling. This meant that people's freedom of movement was compromised to allow the slings to be washed. The service did not ensure that all people's slings were washed regularly to minimise the risk of infection.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we brought this to the attention of the regional manager they were surprised and proceeded to order a second sling for everyone who required one.

We found that health and safety checks had not been completed between February and November 2017 as the designated person was absent from work. This involved the testing of equipment such as window restrictors and ensuring the environment was safe. There had been no recorded health and safety walk through the building in this time. The health and safety audit completed in March 2017 showed only 54.55% compliance. From our observations we had some concerns with some aspects of the building. For example, the staff room which was on the first floor had an internal door which locked. The acting manager told us people living in the home could not access the staff room. However the external door opened onto a balcony. We saw the balustrades had not been maintained and cement was crumbling and falling away leaving a metal frame exposed. The lock on the staff room door out onto the balcony was broken. The acting manager and regional manager were unaware of this. This posed a risk to staff who had access to the balcony, and also posed a security risk to staff and people in the home from intruders. The crumbling concrete placed people on the ground at risk of falling debris. There was no risk assessment in place to identify or minimise the risk of harm to people.

A plug socket in a person's bedroom was hanging out of the wall and there was a hole where the switch should have been. This was a danger to anyone using it.

This is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Maintenance contracts ensured equipment within the home was safe to use. Records showed these had been regularly checked, for example fire equipment and electrical and gas appliances.

Risk assessments had been carried out in relation to the care provided. The risks associated with dehydration and malnutrition were documented along with risks associated with pressure sores and risk of falls. We found care plans described the care to be provided clearly, however, staff daily records related to care were not always completed accurately or up to date.

During our previous inspection in February 2017 we recommended to the provider they gave consideration to the deployment of staff. This was because staff were not always available when people needed them due to taking breaks at the same time. We found during this inspection the number of people living in the home had reduced since our last inspection and the staff numbers had recently increased. The breaks for staff had been revised to ensure there were always staff available to assist people.

There was a mixed response from people when asked if they felt there were enough staff, some told us there were but others differed, their comments included "There are not enough [staff]. There have been some days when I feel I have disappeared off the map. They pop in just to make sure I've got everything, and go" Another person who felt there needed to be more staff told us they did not have to wait long for staff to respond to their call bell. We observed most people had call bells in an accessible place and when pressed staff responded quickly.

Requires Improvement

Is the service effective?

Our findings

During our inspection in October 2015 we had concerns the provider was not protecting people against the risks associated with unsafe or unsuitable practice because of inadequate staff training and supervision. During our inspection in February 2017 we found this area had improved but still had concerns there were still areas where staff needed training and support. We made a recommendation about sourcing appropriate training for staff. During this inspection most staff told us that they had received training which prepared them to do their job effectively. Staff told us "The company is very good with training and encourages staff to attend training". Another staff member said "We have trainers coming around to train staff, recently we had somebody coming to train us in bedrails management. If you require training, all you have to do is ask the manager. I am very happy with the training that I have had so far".

However we found training was lacking in some areas. For example, the infection control lead had not received training in how to carry out their role. The food safety audit showed that two out of five catering staff had received training in the control of substances hazardous to health (COSHH). None of the kitchen staff had received training in infection control and only three staff had up to date food safety training. None of the chef's training was up to date at the time of the inspection. The activities co-ordinator had not received training to enable them to effectively perform in their role.

One member of the cleaning team told us they had not received any training or induction they said, "I have just learnt as I went along." Other staff comments included, "I wish that I had training in dealing with challenging behaviour, there is nobody trained in challenging behaviour. This is not very good because I get the feeling that staff try to avoid people who [display behaviours that challenge]". Another staff member told us, "I do the best I can and I am not sure whether it is the right way to react. I think I need some training. Yes, everybody here will tell you they need training if they are honest." Staff did not feel confident to carry out some aspects of their roles. Although staff had received training in the Mental Capacity Act and the Deprivation of Liberty Safeguards, only two out of six care staff knew how this applied to the work they were doing. This increased the risk of unsafe or inappropriate care being provided to people.

We also found during this inspection the provider had failed to support staff with regular supervision. The provider's policy stated staff should receive supervision six times a year and an annual appraisal. The records showed the service had not met this target. One staff nurse had not had any supervision between July and October 2017. Two other staff nurses had two supervisions each from January to November 2017. One team leader had not had any supervision since September 2017. However, the records showed that the acting home manager had carried out 10 supervisions in November 2017. There were only two records of supervisions in September 2017, this increased to 14 in October and 12 in November 2017.

The acting manager told us, "I am trying to ensure that there are regular group supervisions and individual supervisions, but there is only so much that one person can do." Since taking on the role a few weeks ago the acting home manager has had group supervision with the staff nurses. There is no record that the acting manager had received supervision. There were only three recorded appraisals on the matrix. The provider had failed to demonstrate they had provided staff with adequate support and supervision to ensure they

were carrying out their role appropriately.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection in February 2017 we had concerns about the way people were not being supported effectively with food and hydration. This was because records were not completed accurately and people were not positioned or offered the appropriate support to eat and drink safely. As a result we imposed a condition on the provider's registration. During this inspection we found more people were eating in the dining rooms, previously most people were eating in their bed. From our observations we saw people were adequately supported with food and drinks. However, records related to food and fluid intake had not improved.

During our previous inspection we found the records related to people's food and fluid intake were not accurately or consistently recorded. We found the same concerns during this inspection.

In one person's care plan it clearly identified the daily fluid intake target required for the person to remain hydrated. The daily notes and the fluid records did not indicate the amount consumed over 24 hours. This did not allow the staff to be able to check the person's fluid intake as required; this placed the person at risk of dehydration.

The care records and the weight charts showed that people at risk of malnutrition were assessed at least monthly using the Malnutrition Universal Screening Tool (MUST) tool and this was reviewed monthly. Where a person's risk increased to a high level due to weight loss, they were monitored weekly and referred to a dietician. Where people required extra calories, their food was fortified to increase the calorific value. However, the records detailing a person's consumption were not always detailed or consistently recorded. Without this, the aim of the care plan could not be fulfilled. Records sometimes described the food but not the amount eaten, for example, "Pizza, sandwich and cup of tea." On the same person's records their mid-day meal was recorded as "Lunch, pudding." Other records stated "Didn't eat a lot."

Records of people's weight were not always centralised, this made it difficult to establish if the person's weight was stable, for example, for one person their weight was recorded on the weight chart, however no weights were recorded between July 2017 and November 2017. We found the weights were recorded elsewhere in other records and on the evaluation sheets. We shared this with the regional manager and the acting manager who told us they would look at this area with a view to improving it. The action plan we received from the previous home manager stated that "spot checks" were carried out to "ensure foods and drink charts are up to date." This was not in line with what we found.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions

on authorisations to deprive a person of their liberty were being met.

Key pads were in place on some doors which presented a restriction to some people, applications had been made to the local authority in this respect. Other DoLS applications had been made to the local authority's supervisory body for restrictions for example, when bed rails were used.

No authorisations were yet in place from the local authority, so we could not assess if the provider was meeting the conditions. Care records reflected the fact that people had been involved in making decisions by stating that they were present when the meetings took place and during reviews. Records showed that the service ensured family members were involved when a 'best interest decision' was needed on their behalf about their care and support. People's mental capacity had been considered and recorded. In one person's care plan we saw detailed information regarding their ability to make decisions, this included that the person required time to make decisions, was more alert later in the day, and may request the assistance of relatives. 86% of relevant staff had completed training in MCA and DoLS although not all staff understood how this applied to their role and the lives of people they were caring for.

Prior to moving into the home people had their needs assessed. One relative confirmed this was the case. From this initial assessment care plans were devised to direct staff as to what care people required and how this was to be achieved. Where people required specific equipment this was provided, for example, pressure mats were in place; these alerted staff if a person got out of bed or left their room. Where people had health concerns external professional advice had been sought. There were appropriate health care professionals involved in the care of the people. For example, a speech and language therapist (SALT) was involved in the care of a person with swallowing difficulties. The records showed that staff incorporated the recommendations of the health care professional to assist with the prevention of choking. For example, the person was having puréed food and thickened fluid as recommended by the SALT. A choking risk assessment and care plan were in place.

Requires Improvement

Is the service caring?

Our findings

During our previous inspection in February 2017 we had concerns regarding the lack of respect shown to people by staff. This included staff not knocking on people's doors before entering, not giving people choices and people being discussed by staff in ear shot of others. As a result we imposed a condition on the provider's registration.

During this inspection we found some improvements had been made, however we observed the same situations as we had seen during the last inspection. We observed a person in the dining room had an apron placed on them without their permission; they were given no opportunity to consent to wearing it. We observed staff knocking on people's doors but we also observed some staff did not. For example, whilst we were speaking with a person in their room a nurse entered without knocking or asking permission. She spoke only with the inspector not with the person. She apologised for interrupting the conversation to the inspector not to the person. Whilst with the same person a cleaner entered the room without knocking, they carried out a task and left with no interaction with the person.

We observed staff talking about people in the corridor. One person told us they could hear staff conversations outside their door. Another reported to us that staff talk audibly outside their open door about the personal care they have to give to other people. We observed that a staff member left the door open whilst attending to a person. Part of the person's lower body was exposed. Since the person preferred their door open, a dignity curtain or screen could have been used. Alternatively a room at one end of the corridor could have been offered to in order to give more privacy. This had not been explored with the person.

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

Our observation of staff resulted in a mixed impression of whether staff were caring. For example we saw good practice where staff approached people with respect, talking to them and giving them time to respond. They spoke in a calm manner. We observed one staff member got down on their knees in order to maintain eye contact with the person during a conversation. Alternatively we observed a staff member responding to a call bell. They entered the person's room and spoke kindly to the person but never once asked why the person had pressed the call bell before leaving again. We observed one agency staff member standing at the end of the lounge alone. They were not interacting with people or other staff and not supporting anyone, even though people were sat alone un-stimulated.

The care files were tidy with the information arranged in an orderly manner. There was a process for capturing the likes, dislikes, preferences and the person's personal interest and hobbies. A lot of this information was not completed in the files. The information gathered was either insufficient and was not always planned in a manner to allow the person to exercise choice. For example, there was insufficient information about how a person liked to have a bath, the time of day or frequency. The person's records did not have any personal activity programme and did not always reflect their preferences. A person told us, "I

love shopping. But I have not been out since I came. My friends are coming to take me out this afternoon."

Records did not reflect the involvement of people. They were not always signed by the person. For example, one person who was described as having the ability to make simple and complex decisions had not contributed to the dependency assessment. This asked the question "Do you agree to this assessment being completed?" and "Do you understand the reason for the assessment taking place?" Neither questions had a recorded response or evidence of consent. Evaluation of the care plans did not include the views of people or their relatives.

We also had concerns about how people were encouraged to communicate their wishes to staff and how people's independence and autonomy could be maintained. For example, one person was identified with anxiety and depression. They also had physical care needs. They were seated in one corner of their room with the door open. There was no care plan about their psychological care, or about their depression and anxiety. The care plan did not inform staff on the importance of forming a relationship with the person, how to keep them occupied, how to reminisce, or engage in social interaction. We observed that when we engaged in interaction with them they were very forthcoming and their mood lifted. We observed for most of the day they were isolated sitting alone with the television on. The care plans reflected the provision of physical care but not how staff could provide mental health support.

The same person had difficulty in mobilising and required the support of staff to walk short distances and a wheel chair for longer distances. They were also doubly incontinent. To manage their incontinence the staff provided them with incontinence pads. These were checked regularly and the person was washed and changed whenever required. The person told us they were afraid of the pain they experienced when mobilising. As a result this prevented them from using the toilet. Without the pain their continence needs might have been met. The records showed the assessment process did not explore ways of preventing or reducing the pain or encouraging independence in this area of need. The service did not demonstrate a person centred approach to the care being provided.

This is a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People described the staff as "kind" "polite" "very good" "lovely" and "Very very helpful." One staff member told us how they showed respect for people "I love these residents; it is like having another family. So I show them the same respect I show to my family. When offering care I knock on the door greet them and offer them choice. When giving personal care I put the "Care in progress" signs outside so that nobody comes in. I always make sure that they are covered when giving personal care and allow them to do as much for themselves."

Requires Improvement

Is the service responsive?

Our findings

During our previous inspection in February 2017 we identified concerns in relation to the lack of pre-admission assessments, the provision of personal care and the risk of social isolation due to a lack of activities within the home. The provider was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found there was a continued breach of regulation 9.

During this inspection we found pre-admission assessments had been completed, although care plans had not been fully written for people who had recently moved into the home. This was work in progress and had been delayed due to the changes in management.

During our previous inspection in February 2017 we found records related to personal care had not always been completed. The action plan sent to us told us this had been rectified by the introduction of personal care forms to be completed when personal care had been carried out. We found there were still gaps in the recordings. For example, one person's daily body wash chart was completed between 1 November and 9 November 2017. There were no further recordings. We asked a staff member if the person had received any body washes in the four days since the 9 November 2017. They assured us they had however; there was no recording sheet in the room to evidence this.

Another person's records showed they had refused care at night for 12 nights between October and November 2017, however the daily records sheet recorded they had received care on some of these nights. This meant that one of the records was incorrect. We also found records related to fluid and food intake and bowel movements for some people had not been completed consistently. On two people's records we found reference to the fact they had been diagnosed with Lewy body dementia. When we checked this with the acting manager, we were told they did not have this condition.

There were some discrepancies regarding the information recorded on some charts in respect to repositioning and sleeping. Staff told us for one person "We use sliding sheets to reposition [named person] we need two staff and it takes at least 10 minutes." The records related to Check Charts and Position Changes from the 31 October to 4 November 2017 and 07 November 2017 showed that staff on night duty were repositioning the person whilst they were asleep. This would not be possible given the amount of movement involved in the process. The exact same times were used for the person sleeping and being repositioned on different nights. The time of 4.14am was the time the person was repositioned and was asleep on 31 October and 4 November 2017. 12.11am was the time recorded on 31 October, 3 November and the 7 November 2017. Given the precise nature of the records and the variable duties required of night staff it was unlikely these records were accurate. We could not be assured the person who had pressure ulcers was being repositioned regularly at night. We shared this with the regional and acting managers. They agreed with our findings and told us they would investigate this further.

Some people's records showed they had not been involved in any form of activities for prolonged periods of time. For example, one person's records showed they had not participated in any activities since 30th

October 2017, another since the 23 October 2017. Another person's records showed they had a chat and their nails painted in May 2017 and then no involvement in any other activities until 29 September 2017.

Activities were provided by an activities co-ordinator. They told us they enjoyed their job but had not received any training in how to carry out the role effectively. The home had provided equipment for people to participate in activities and this was accessible to all staff. However, we observed an activity taking place in the sitting room. One person was playing snakes and ladders with the activity co-ordinator, whilst six other people sat in the lounge with two staff. The staff members did not appear to chat or interact with them in any meaningful way. The television was on but no one was watching it.

We observed people sitting in their rooms with the television on or no stimulation at all for long periods of time. Some people told us they did not wish to participate in the activities, one person told us they liked the music of Ambrose's Big Band from 1930's/40's which they used to listen to with their mother. Another person told us "The one thing I miss is going out in the fresh air. They like you to be supervised if you go outside." They said the staff knew they would like to go out for short walks in the garden and they said they would take them, "But they get waylaid doing something else." A third person told us the activity co-ordinator did visit them and some carers did visit for a chat. We asked what would make their life at the home better: They told us "Get me out of bed sometimes so I can go outside…. Maybe some decent music; if they played classical or Sinatra or Crosby I would go to the sitting room to listen." It was apparent that if the activities on offer were centred on people's preferences and personal histories they would be more engaging, enjoyable and meaningful to people. This would protect people from social isolation.

This is a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The activity coordinator had provided activities for people including, cake decorating, planting poppies for Remembrance Day and visiting the garden centre. They understood the need to keep people stimulated, but admitted they needed training to understand the aims and objectives of offering people activities that were meaningful to them. The regional manager told us they had discussed with the activities coordinator a plan for them to attend training in the future.

During our previous inspection we found people did not know how to make a complaint we made a recommendation on how the complaints process could be improved. During this inspection we found some people and relatives were not aware of how to make a complaint. The regional manager was not aware of any complaints having been made. We were aware of two complaints that we had passed to the home manager since our last inspection. These had been investigated, but it appeared the records related to these had not been made available to the provider.

Some people had end of life care plans in place which directed staff to what provision they preferred when nearing the end of their life, whether to attend hospital or stay in the home. However, we found no evidence that other people had their choices and decisions recorded. Do not attempt resuscitation forms had been completed for those people whose choice was not to be resuscitated. This confirmed some people's choices had been listened to and recorded.

We recommend the service consider current guidance on the completion of End of Life care planning and take action to update their practice accordingly.

Inadequate

Is the service well-led?

Our findings

During the last inspection in February 2017 we were informed the registered manager had left the home with immediate effect. The post of home manager was then covered by the regional manager. Since that time the regional manager left their position and a further acting manager and a permanent home manager had been employed but also had left their posts. At the time of this inspection the home had not had a registered manager in place since April 2017. The deputy manager is the new acting home manager with the support of the new regional manager who had been in post eight weeks at the time of our visit. We were told the provider was advertising for the post of registered manager.

It was apparent to us from speaking with people and staff the change of management and lack of consistent support had resulted in a negative effect on those concerned. One person told us they had requested information from the two previous managers, "but nothing happened." Another person commented, "We've had five managers since I arrived here 12 months ago. If you've had that many managers there's got to be something wrong at the top. These people who work here must feel unsafe about their jobs and we feel unsafe about our home." Other comments from staff included, "I have seen so many managers come and go and when I see a manager coming in I ask myself how long will he or she last". One staff member explained what the impact of the change of management was having on the staff team. They explained "There have been so many changes, each one wants things done differently. If staff feel unsettled it makes the residents unsettled. These constant changes make the staff scared."

During our last inspection in February 2017 we found a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to the lack of dignity and respect shown to people and the concerns related to the lack of personal care in relation to body washes, baths and showers. We also had concerns as we found records related to the provision of care were inadequate, for example, how much food or fluid people had consumed. Audits had not identified the same concerns we found during our inspection. As a result we imposed conditions on the provider's registration.

During this inspection we found very little had improved. Although the number of notifications we received had improved there was still one outstanding. Recruitment practices had not improved. Support for staff was not achieving an adequate standard. In addition the home lacked effective systems and procedures in infection control. People still did not know how to make a complaint.

As a result of us imposing conditions on the provider's registration they were required to send us an action plan each month. The information on the action plan was confusing and not always in line with what we found. For example, the plan told us that records related to the carrying out of personal care were "embedded in the home." It also stated that, "Senior staff in charge will check completion of this document on a daily basis." We found no evidence that this had happened, and the personal care charts were not always in place. A further comment on the action plan stated, "Standard of documentation has improved, some gaps still evident, action will remain amber until consistently good practice is embedded." This contradicted the previous statement. We asked the acting manager about the lack of scrutiny, they explained there had been only one nurse in place and therefore the checks had not happened. This had not

been shared with us until the inspection.

Despite us being sent a monthly action plan from the provider, we found that although some areas of the service had improved, others had not. There appeared no evidence to demonstrate that since our last inspection in February 2017 the provider had not monitored the running of the home. There was a lack of accountability and action by the provider for the shortcomings we found. For example, when the employee who was responsible for health and safety in the home was on leave, their role was not covered by anyone else. The lack of staff supervision and training had not been monitored by the provider. Some areas identified for improvement such as record keeping had not improved. This placed people at risk of receiving inappropriate and unsafe care.

We spoke with a health care professional who had been working with the home since our last inspection. Following our previous inspection they had witnessed improvements in the clinical leadership of the home. However this had declined over recent months. They described the current situation as "static". They told us of their frustration at carrying out visits to the home. This was because the nurses had not prepared information about people's health status prior to their visit. Time was wasted for example when checking records to establish when a person's symptoms started. They had also found inconsistencies with record keeping. They stated there was poor clinical leadership, although this has improved slightly since the acting manager has started.

This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations
2014.

Feedback had been sought from staff on how the service to people could improve, we were told the only issue identified was staff did not feel supported by the previous management. Visiting professional comments were on the whole positive. Relatives did make comments which were also positive. There were a couple of negative comments about the lack of communication and trust between the staff and the relatives. Predominantly this was in relation to access to the property. Although another report showed this had been resolved, there was no information as to how this had happened. The people who lived in the home provided positive or neutral feedback.

Staff knew how to report concerns and information was available to staff on how to whistle blow. Staff seemed confident to raise concerns. One staff member told us, "If I was to see any abuse I will have no hesitation to inform the manager immediately and if the manager does not do anything to protect the person I would whistle blow." This helped to protect people and staff from harm. Staff had the opportunity to feedback through team meetings and daily meetings. Contact with the acting manager was available and they were approachable and accessible to staff.

Although some staff were upset by the continuous change of management, we received positive comments about the current management arrangements. The week before our inspection the deputy manager had been promoted to acting manager. A new regional manager had been in post for eight weeks. We could see they worked well together. The acting manager told us they were learning a great deal from the regional manager in how to carry out important aspects of the role. Staff comments included, "Since [acting manager and regional manager] have been here the atmosphere is better already. They want the best for here, the previous manager didn't." "The acting manager is brilliant and I will work with her anytime, anyplace, if she leaves I leave. She is all over the place and full of energy. She helps every one and seems to have time for everybody except herself. I don't know how she does it because I couldn't." "The place has picked up again thanks to the two managers we have. They have been constantly on the floor helping staff,

helping the residents. I have seen improvement since they have started, for example there has been a reduction in agency staff and that can only be good". "I love [acting manager]. This whole place will fall apart if she was not here. I have recommended her for the company's award. She more than deserves it".

We dealt with both the regional and acting manager throughout the inspection. The regional manager although new to the role didn't shy away from our findings and was keen to establish improvements. However, this would only be achievable with the support of the provider, who we have found over previous inspections not to have provided the standard of support required to improve the service in the areas needed.

Following this inspection we received feedback from the local authority contract monitoring team. They had visited the home and reported improvements had taken place since our inspection. They felt the management team in place was having a positive effect on the home and the standards of care.