Croft House (Care) Limited

Croft Dene 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

Croft Dene is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection 39 people with physical and mental health related conditions were using the service.

This unannounced comprehensive inspection took place on 1 and 2 November 2017. At the last inspection on 31 May 2017, we identified breaches of regulations which related to safety, person-centred care, complaints and governance of the service. We asked the provider to take action to make improvements. We found some improvements had been made but not enough to ensure compliance with all of the statutory requirements.

This is the third consecutive time the service has required improvement. 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.

A new on-site care manager was in post who managed the service on a daily basis. The registered manager of the service attended part 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.

People and relatives told us they were unsure of who was in charge at the home and were confused about the ownership of the home. They also told us further improvements were required.

We undertook an initial observation around the home to look at the safety issues which had been highlighted to the provider and registered manager at our previous two inspections. We found some action had been taken; however we found audits and checks on the service were still not robust enough to ensure compliance with all of the regulations. Several serious safety concerns remained at the home which had either not been wholly addressed or had not been properly monitored to ensure that staff complied with the directions given to them.

The provider had told us in an action plan that the on-site care manager carried out daily and monthly checks on the quality and safety of the service and together with the registered manager were confident that issues had been addressed. We did not find sufficient evidence to corroborate these checks had taken place. Although two ad-hoc checks had taken place, they had not been consistently carried out and were not robust enough to identify the continued issues we highlighted during our visit.

Routine audits that had previously been carried out in relation to medicines, infection control and health and safety had ceased. The registered manager took some immediate action to rectify issues which we drew their attention to. After our inspection the provider told us that the leadership and governance shortfalls at the service would be swiftly and thoroughly addressed this time.

Medicine audits had not been completed since May 2017. This meant the issues that we highlighted during the inspection has not been identified or addressed by the management team. In particular, the application of topical medicines and the completion of medicine administration records were not safely monitored.

The activities coordinator post was now vacant. We saw there was no information on display about constructive activities. People told us they were bored and relatives and staff added that structured activities had not taken place for some time and there was much room for improvement. We found there were no meaningful and stimulating activities taking place on the days we visited and care staff had minimal spare time to socialise with people. Records related to people's participation in activities had not been completed for two months and previous records were unacceptable.

The upper floor of the home was designated for people living with dementia or similar health conditions. A care team leader was responsible for ensuring the environment was suitable for people's needs. We saw a lot of progress had been made towards improving the design and décor of the environment and they had coordinated some communal activities with people such as films or sing-a-longs.

Staff training had not been monitored and as a consequence of this, some staff were overdue key training such as moving and handling training. Formal routine supervision and appraisals had also fallen behind which meant the registered manager was not assured of ongoing staff capabilities or competence. Although staff told us they felt supported by the on-site care manager.

Staff continued to be safely recruited and we considered that there were enough care staff employed at the service, however they were sometimes not deployed appropriately throughout the service, particularly at mealtimes.

The mealtimes we observed were not well organised and they continued to lack an opportunity for socialisation in most of the communal dining areas. A hot meal was prepared at lunchtime; we saw some people had asked for alternatives which they had been given. The food looked attractive, healthy and well balanced. Some people told us they enjoyed their meals whilst others waited so long for assistance that they meals went cold. Special diets were catered for and the kitchen staff were familiar with people's dietary requirements.

People told us they felt safe living at Croft Dene. Relatives confirmed this. Staff were trained in the safeguarding of vulnerable adults and they were able to demonstrate their responsibilities with regards to protecting people from harm. Policies and procedures were in place to support staff with the delivery of the service.

Accidents and incidents continued to be recorded, investigated and monitored by the on-site care manager. Actions taken to reduce the likelihood of a repeat occurrence were recorded. All incidents had been reported to external agencies as necessary.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. Applications had been made on behalf of most people to restrict their freedom for safety reasons in line with the Mental Capacity Act 2005. All staff demonstrated an understanding of the MCA and worked within its principals.

We saw care workers treated people with dignity and respect. Staff displayed friendly, kind and caring attitudes and people told us staff were nice to them. We observed people enjoying a pleasant relationship with staff and it was evident they knew each other well.

Support plans were person-centred, descriptive and regularly reviewed. We examined five people's care records in detail and reviewed three others. Individual care needs were assessed and reviewed as necessary. Risks which people faced in their daily lives had been assessed and preventative measures were in place to minimise the possibility of an incident occurring. We found some discrepancies which we followed up in relation to the safe use of equipment.

The management of complaints had been improved since our last inspection. We reviewed complaints and saw there had been an acknowledgement or outcome letter sent to complainants. Investigation notes had been made in response to complaints and there was written evidence to suggest the procedures were now properly followed.

We have identified three on-going breaches and one further breach 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 consistently safe.

Serious safety issues were identified in relation to the premises and equipment used. Some of which remained unaddressed from the past two inspections of the service.

We found shortfalls with the safe management of medicines.

People told us they felt safe living at the service.

Staff were safely recruited and there were enough care staff employed to meet people's healthcare needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training was not up to date and staff had not been formally supported in their role through supervision and appraisal.

Mealtimes had not been suitably improved throughout the service. Some people still experienced a lack of care at mealtimes.

Decisions were made in people's best interests and staff worked within the principals of the Mental Capacity Act (2005).

Improvements had been made to the décor of the dementia care unit.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Due to the shortfalls identified throughout the service, staff were not supported to provide a caring service in all aspects of their role.

Staff knew people well and respected their wishes and preferences as much as they could.

People told us the staff were friendly and kind to them.

Advice and guidance was available to help people find other beneficial services.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was no proper arrangements in place for activities and people told us they were bored.

Staff did not have the time to engage in stimulating and meaningful activities with people which met with their preferences, interests or hobbies.

Care was not always delivered in a person-centred manner although care records were detailed and specific to each individual.

Complaints were managed in line with company policy.

Is the service well-led?

Inadequate

The service was not well-led.

Established systems were not always operated effectively to ensure compliance with the regulations.

Governance systems were inadequate and had disregard of the serious concerns raised by the Care Quality Commission in the past.

The provider and registered manager had failed to adhere to their own action plan with regards to previously identified concerns. These concerns had not been fully addressed in order to improve the safety and quality of the service.

People were confused about the management of the service.

Croft Dene 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 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 site visit took place on 1 and 2 November 2017 and was unannounced. The inspection consisted of two adult social care inspectors, a specialist advisor and one expert by experience. A specialist advisor is a person employed by the Care Quality Commission to support inspectors during an inspection; they have specialist knowledge in a certain area. The specialist advisor on this team was a qualified nurse. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed all of the information we held about Croft Dene Care Home, including any statutory notifications that the provider had sent us and any safeguarding and whistle blowing information we had received. Notifications are made to us by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. These are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

Additionally we liaised with the local authority contracts monitoring and safeguarding adults teams and the local NHS clinical commissioning group (CCG) to gather their feedback about the service.

During the inspection we spoke with nine people who used the service and three visitors to gain their opinion. We spoke with 11 members of staff, including the registered manager, a care manager, a deputy manager, an administrator, two nurses, one senior care worker and four care workers. We spoke with the provider and two external social care professionals after the inspection. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of care records and the management records kept regarding the quality and safety of the service. This included looking at five people's care records in depth and reviewing two others.

Inadequate

Is the service safe?

Our findings

At our last two inspections of this service we identified a breach of Regulation 12 entitled, Safe care and treatment. We have highlighted multiple safety issues with the premises and equipment to the registered manager and provider on both occasions. After those inspections the provider and registered manager told us what action they would take to ensure compliance was achieved.

Before this inspection, we asked the provider to confirm that all actions had been completed in order to achieve compliance. They told us that in conjunction with the registered manager and the care management team at the service, they were assured that all actions in order to be compliant with regulations, continued to be carried out. We found this was not the case and serious concerns remained about the safety of the service.

On arrival we undertook an initial tour of the home. We found multiple risks to people's safety which were repeated from our previous two visits. For example, emergency pull cords which should hang to the floor were propped out of reach. Equipment storage rooms were left unlocked and the laundry room was left accessible and unattended. This meant people remained at risk from potentially dangerous equipment, hazardous substances and they may not have been able to summon help in an emergency.

A severely cracked bath panel in an assisted bathroom remained unrepaired from the previous two inspections. We found the sharp edges projected out from the corner of the bath at the entrance of the bathroom. This meant people and staff remained at risk of injury.

In communal kitchenettes, two 'touch-free' pedestal bins were not working and this had not been reported to the management. Staff continued to use the bins by lifting the lid with their hands which could cause cross contamination and increase the spread of bacteria to food, crockery and cutlery.

Additional safety concerns were also raised at this inspection. We saw a communal bathroom was being used as a storage area. The bathroom was not locked or marked 'out of use' and contained one hoist, two wheelchairs and three shower chairs. This posed a significant risk to people who may have entered the room and could have potentially tripped or become trapped amongst the equipment. There was an additional risk in this bathroom as the emergency pull cord was propped out of reach.

We found fire escape routes were partially blocked by rubbish which posed a tripping hazard to people, visitors and staff. We also saw two large industrial bins obstructed the same pathway from the fire exit to the assembly point. The bins were also pushed up against the side of the home in an unsecured position away from the external designated bin area. We observed the external designated bin area was not secured and we saw this area included two containers of used cooking oil and one gas bottle. We found a further seven containers of used cooking oil were not stored in line with FSA (Food Standards Agency) guidance. We were told by the registered manager that these were awaiting collection from a recycling company; they were stacked up against the outside wall of the home, unprotected and unsecured. They were also on the pathway from a fire exit to the assembly point. This was a fire hazard and posed a serious risk to people,

visitors and staff who may needed to use the routes to escape the building in an emergency, particularly those who required wheelchair access.

We saw three main ceiling lights were off inside the entrance to the dementia care unit which affected one corridor. It was documented that this had been reported to the management six days earlier. A delay in attending to this issue posed a serious risk to people as poor lighting is a well-known cause of falls and it also may have disorientated people with health conditions such as dementia. One person sitting in this area said to us, "It is dark today, isn't it."

We were told by staff that the secured key pad entry system to leave the dementia care unit was not working. This has been reported to the management five days earlier. This posed a considerable risk to people's safety as people who suffered from conditions such as dementia may have left the safety of the unit without a member of staff being aware of it. Furthermore, people who resided on the unit had access to the residential unit, the lift and a stair case. Staff told us they were distracted in their duties because they had to monitor one person who preferred to sit in a communal area near the door and was known to try to leave. A handyman was instructed to fix this on the morning of the second day of our inspection; however we had to inform the on-site care manager that this issue still remained in the afternoon.

We found anomalies in staff training records which showed that between five and nine members of care staff did not have their moving and handling skills updated in line with company policy. This meant the management team had not assured themselves that all staff were competent with the safe use of moving and handling equipment such as hoists and slings for people who are unable to weigh bear and required the use of this type of equipment.

We noted two people were lying on airflow mattresses which were incorrectly set in line with the manufactures guidance and their weight. One person who weighed 44KG and their mattress pressure was set to 140KG. Another person who weighed 52.3KG and their mattress pressure was set to 100KG. We brought this to the attention of the deputy manager in order for them to adjust the settings accordingly. This posed a serious risk to the skin integrity of these two people and would have considerably reduced their comfort whilst in bed for long periods of time.

Domestic staff were on duty during our inspection and overall we found the home to be clean. We observed domestic staff followed some best practice guidelines in relation to reducing the risks associated with infection control. However, we observed a small quantity of vomit on a sink unit in a communal toilet. We also found a large amount of faeces on the outside of a toilet bowl in another communal toilet. Both of which remained uncleaned for several hours during the first day of our inspection. This posed a risk of cross contamination to service users and visitors.

We also saw a large reclining chair in a communal lounge which was completely worn with the fabric severely cracked on the seat and the arms. This made it impossible to be cleaned properly. This was also a possible source of cross infection.

We reviewed 39 medicine administration records (MARs). We found that 15 MARs were hand written and did not include the signatures of two members of staff as described in NICE guidance, "Care home providers should ensure that a new, hand-written medicines administration record is produced only in exceptional circumstances and is created by a member of care home staff with the training and skills for managing medicines and designated responsibility for medicines in the care home. The new record should be checked for accuracy and signed by a second trained and skilled member of staff before it is first used." This meant there was a risk of medicine errors occurring.

We found staff were regularly recording a code for four people without a defining explanation. This meant that neither we nor the management team could ascertain the reason why these people had not received their medicines.

We found some topical medicines such as creams and eye drops had not been labelled with an opening date. This meant that nursing staff were not aware of when the medicine would expire and therefore they could have potentially administered a topical medicine which was not fit for purpose.

We were told by staff that no audits of medicine administration records had been carried out since May 2017. There was no evidence that a thorough medicine audit had been carried out by the registered manager or provider to ensure the proper and safe management of medicines.

Annual medicine competency assessments had not been kept under review by the registered manager or provider for the senior staff who were responsible for medicine administration. There were no records available as to when the qualified members of staff were due competency assessments.

The evidence above is a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to the safety of the premises, equipment and medicine management.

We looked in the treatment rooms and observed nurses carrying out their duties throughout the home. The nurses on duty during our inspection demonstrated full awareness of their responsibilities. There were no other issues with the ordering, receipt, storage, administration or disposal of medicines. The supplying pharmacy has recently conducted an annual audit of the medicines but their report was not yet available.

We asked people if they felt safe living at Croft Dene and with the staff who supported them. Comments included, "I feel safe, everything makes me feel safe", "Yeah, I'm safe, it's the staff here", "I'm safe enough, the main doors always locked", "I'm happy, it's alright. The people around me make me feel safe and the staff" and, "Yes, I feel safe, they've got all the staff". One relative told us, "[My relative] is safe, I know the staff here".

Staff were aware of safeguarding procedures and were familiar with the company whistle blowing policy. The safeguarding policy remained in place and staff were trained and displayed an understanding of their own responsibilities towards protecting people from harm.

Accidents and incidents were recorded, investigated and monitored by the on-site care manager to minimise the likelihood of a repeat occurrence. Appropriate action had been taken and they had notified the relevant external agencies as necessary.

The deputy manager, nurses and senior care staff assessed the risks people faced in their daily lives. Care records were up to date with information about people's needs such as mobility, cognition, nutrition and continence. This meant the service had recognised the individual risks and ensured steps were taken to meet people's needs in a safe manner.

Personal Emergency Evacuation Plans (PEEPs) were in place, the fire alarm and fire fighting equipment had been serviced in February 2017 and a fire drill had been carried out in July 2017.

Annual tests of the boilers, gas appliances and water supply had been carried out but the portable appliance testing (PAT) was still overdue from our last inspection. The registered manager told us the handyman has recently obtained a qualification to complete this task and would attend to it within a week.

There had been no new staff employed since our last inspection. There were vacancies for an activities coordinator, senior care workers and night time nursing staff. The on-site care manager and administrator demonstrated that they were fully aware of the safe recruitment procedures in place and would ensure new staff were appropriately checked and vetted. Disciplinary processes were in place and had been used to ensure staff remained suitable for their role.

The on-site care manager reviewed the service's dependency tool regularly. The staffing levels during our visit were appropriate but we saw examples, particularly at mealtimes when staff were not deployed correctly. One member of staff told us that some staff did not like to work on a particular unit because there was so much to do. We asked people if they thought there was enough staff. They told us, "I think there's more staff upstairs than downstairs, they could do with an extra two or three", "No, staff don't even come in and talk to me" and, "No, I don't think there's enough staff, I don't think they can afford to pay them." A relative told us, "When there are two staff it is OK, could do with more. Occasionally they drop to one [staff] when there's an emergency". We asked people if the call bells are answered quickly. A relative said, "Sometimes they get answered quickly, sometimes they don't. The staff get busy." Two people told us, "My bell is normally answered quickly unless there is only one staff on" and, "It's often left ringing a while, it depends on what the girls are doing."

Requires Improvement

Is the service effective?

Our findings

Staff training had not been kept under review and as a consequence of this; several staff were overdue training in the safe moving and handling of people. The training matrix showed that up to nine care workers or nurses had not had a practical assessment of their skills within the last 12 months. Routine refresher sessions had not been carried out consistently which meant some staff skills and knowledge were not up to date with current best practice.

Training in topics which were specific to individual service user needs were not carried out. For example, the majority of staff had not received training in challenging behaviour, nutrition awareness or meaningful activities, despite these skills being necessary to meet the current needs of the service users they cared for and supported. Infection control training had not been completed by the majority of care staff.

The management team had not kept track of when staff supervision and appraisal were due. The on-site care manager had completed some ad-hoc supervisions with staff following specific events but routine meetings had not been carried out or planned in advance. Staff told us they had not received regular or recent supervision and some staff told us they were overdue an annual appraisal. This meant staff were not appropriately supervised to ensure their competence was maintained. It also meant their performance was not regularly appraised to ensure they were suitably trained and skilled. Staff learning and development needs had been neglected and not formally supported.

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

We observed mealtimes during our visit and we found that satisfactory improvements had still not been made to make the experience more positive and stimulating for people. Most dining rooms lacked any atmosphere and staff were preoccupied with the tasks they had to complete and lacked the time to socialise and interact properly with the people who used the communal dining areas. People were sitting separately and not talking to each other. We observed one care worker supporting a person who required full assistance to eat their meal. On the same unit there were no other staff around for a long period of time and three other people who required the same level of assistance were left waiting. Their hot meals had been served onto a plate and left by their bedside, thus going cold whilst they waited. One person told us, "I can feed myself, I help others because there's not enough staff" and a relative told us, "I come in twice a day to feed [my relative]. I eat here too though."

This is a continuing breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 9 Person-centred care.

On one occasion we saw there was only one option of a hot meal on offer which consisted of gammon casserole and vegetables but we saw the cook had prepared lighter alternatives for people who did not want the main meal. One person told us, "I've had a little mini pizza, that's what I wanted, I didn't want the casserole." On another occasion we heard two staff tell people they did not know what the options were and

the menu board in the dining room had not been completed. When the cook arrived there was a choice of chicken curry and rice or hot pot and vegetables which was served out to people based on choices they had made the previous day. Two people did not want what they were served and become increasingly distressed by this. One person then refused to eat and would not accept anything else.

We observed care staff tried their best to prompt people to eat their meal. They offered alternatives and different sized portions to encourage people to eat something. There was plenty of food available which looked attractive and smelled nice. On one unit the atmosphere was much better, a radio was playing and the staff were relaxed and chatting with people who were sitting together in small groups.

The kitchen staff were aware of people's special dietary requirements and catered for people's needs such as providing soft and pureed food, a diabetic diet, a calorie controlled diet or a fortified diet. Staff monitored people's food and fluid intake and this was communicated to nursing staff to make daily evaluations and review care needs as necessary.

There were mixed comments about the food. People said, "The food's nice, I get enough. If I wanted more I would get more", "The food's lovely, we get a choice, it's all fresh", "The food's lovely in here, I get plenty", "It's alright, I eat it" and, "The foods poor, especially at weekends. We get a choice of two [meals]. I'm sick of chicken, it's always tough."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when it is in their best interests to do so and when it is legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We saw that the on-site care manager had kept the DoLS register up to date. There were 17 applications to deprive people of their liberty for safety reasons and 12 were granted. The register also showed details of when authorisations were due to expire to enable the care manager to re-apply to the supervisory body within the appropriate timeframes. We saw staff worked within the principals of the MCA and best interest decisions had been recorded with relevant people involved in the decision making process.

Care staff meetings had taken place recently. We reviewed minutes from the last care staff meeting in October 2017 which covered agenda items such as on-line training, rosters, documentation, activities, uniforms and care planning. A nursing staff meeting took place during our inspection and we saw all qualified staff attended this. They were able to discuss our initial feedback around medicines and implement changes straight away. Handover meetings took place on a twice daily basis to ensure staff were notified of information about people's daily needs as well as medical appointments and any issues raised. Daily notes and other monitoring tools such as food and fluid charts were completed to a good standard. This meant effective communication between all of the staff who cared for people had been sustained.

People continued to have access to external health and social care professionals to support their general well-being. Care records showed that people regularly saw their GP, dentist, optician and social worker. People told us, "I see the chiropodist and the dentist. The girls [staff] in the office make the appointments", "The girls [staff] phone if I need a GP. The nurse here sees to everything else" and, "The girls [staff] take me to hospital twice a month for my appointment if there's no family to". A relative told us, "[My relative] has had one or two infections, staff have called for the GP. The Parkinson's nurse comes every three months and the

chiropodist".

The care home was purpose build and had all of the necessary adaptions expected such as walk in shower facilities and specialist bathing equipment. The decoration was homely and welcoming. The care team leader on the dementia unit was responsible for the design and décor on this unit and we saw they had made a remarkable improvement to the environment. Best practice guidance around a dementia friendly setting had been thoroughly implemented. Corridors had themes walls such as 'Newcastle United', 'The 1950's', 'Dress-making' and 'Memory Lane' which displayed old pictures of Wallsend, its places and people. There were hats and knitted scarves hanging up for people to try on and an old style typewriter and sewing machine on display to stimulate conversation and memories. A conservatory was furnished with comfortable arm chairs and had jigsaws and games readily available. The communal lounge had been adapted into a 'sensory room' designed to develop a person's sense through special lighting, music, and objects.

Requires Improvement

Is the service caring?

Our findings

We found that although most people made positive comments about staff, the staff were not supported by the registered manager and provider to deliver a wholly caring service. Due to the shortfalls we found at the service, the ability of staff to provide a holistic approach to people's care needs was constrained due to staff vacancies, lack of supervision around staff deployment and staff being task focused as opposed to having the time to sit with people and interact in a meaningful way. This meant that people were not always at the centre of the care they received.

We asked people if the staff were caring and respectful. Comments included, "Oh aye, the staff are lovely", "Girls [staff] are lovely, I couldn't say a bad word", "I enjoy a joke and some banter, the staff are lovely here they really look after me and I'm very happy", "The girls [staff] are lovely. They give me their time", "Definitely, the girls are all lovely", "I haven't lived here long, its different living here. The girls [staff] look after me", "Some [staff] are good, some are so-so", "Most of the staff are lovely, it's the odd one that's not, but you get that anywhere" and, "They certainly respect me. I did have to tell one off, she wasn't nice."

Staff demonstrated in their approach that they protected and promoted people's dignity and that people were given privacy as necessary. One person told us, "I've got my own bathroom; the girls [staff] always close the curtains." Another person said, "The girls [staff] ask permission before they help me and tell me what they are doing." A relative told us, "I've been here when staff have needed to change [my relative's] incontinence pad, I got asked to step outside." During our inspection all staff spoke nicely to people and were kind, considerate and caring when interacting with people.

We observed staff treated people as individuals and respected their preferences. One person told us, "I'm able to do things in my time, I'm never told. I can lie in bed all day if I wanted to." A member of staff told us, "I really enjoy my job. I just want to give people the best care that I can."

We saw staff considered people's varying needs and abilities when going about their duties. Staff showed that they knew people well and people's needs were met in a way which reflected their own wishes and choices. People had been involved in their care planning and had been asked for information about themselves to help staff get to know them better. One person said, "I told them about my past, even about the bombings when I was younger. It was all written down in a file." Two relatives told us, "The manager was very good and went through everything" and, "I was involved in the care plan, it gets reviewed annually and I'm involved with that." We spoke with staff about specific people's individual care needs and they were familiar with these as well as their life histories, preferences likes and dislikes. There were lots of 'Thank you' cards on display around the home which demonstrated that relatives had appreciated the care and support their loved ones had received.

Information, advice and guidance remained on display around the home to benefit people who use health and social care services. There were staff designated to 'champion' roles and information about this was on display in the foyer. For example, there was a dementia care 'champion' whose responsibility it was to promote best practice and share new initiatives with staff to increase their knowledge and awareness. An

external social care professional told us," I find them having a dementia champion quite proactive; they appear to have a sound knowledge of people with cognitive impairments and behaviour issues."

A service user guide and statement of purpose was made available to people and their relatives which provided information on the service and what to expect from the staff.

There was no-one who used the service accessing an independent advocate. Most people had family or friends who acted on their behalf. Legal arrangements continued to be recorded in people's care records to ensure staff knew who had the legal right to make decisions on people's behalf. An advocate is a person who represents and works with people who need support and encouragement to exercise their rights, in order to ensure that their rights are upheld.

People's personal data and sensitive information continued to be stored securely in the office and treatment rooms which were kept locked when unattended. Staff maintained people's confidentiality and spoke discreetly to each other when necessary.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, we identified a breach of Regulation 9 related to person centred care due to a recommendation that we had made at an earlier inspection having not been considered. The service had failed to achieve a thorough review of the activities provision in order to provide meaningful activities which encouraged people to socialise or pursue their hobbies and interests.

Overwhelmingly people told us they were bored. Their comments included, "I liked the activities but we can't do them anymore, the girl [activities coordinator] went to work upstairs", "There hasn't been any activities since last month", "There's no activities but there's talk of bingo starting up", "We do very little here. It's boring. I get sick of just sitting, no one comes and sits just to talk", "We exist here, not live", "We sit in our rooms, there's nothing to do. Used to be but not now", "There are no activities at all, we just sit here", "'No don't be silly, the only activity is that TV" and "There's no activities, maybe at Christmas." Relatives also told us that the activity provision required much improvement. This demonstrated that people suffered from a reduction in their quality of life.

The activities coordinator post had been vacant for a month and no succession plans had been made. There was no other member of staff designated the role whilst recruitment was on-going despite our existing concerns. We saw no significant activities were carried out during our two day inspection which met with people's social, emotional, cultural, religious and spiritual needs. There was no plan of stimulating activities in place for people to participate in and there were no formal arrangements made for future dates. The staff on duty during our inspection had arranged for a film to be put on in a communal lounge and whilst we were there a sing-a-long was arranged. However there was no formal one to one sessions taking place.

On the whole people were either sitting in communal areas or alone in their bedrooms. One person who appeared agitated told us, "I can't sit here and watch this all afternoon!" Some people who were mobile wandered around the corridors, looking at the décor and speaking to people and staff as they passed.

We carried out a SOFI (Short Observational Framework for Inspection) assessment and found there was very little staff interaction over the 30 minute timeframe with the people we monitored during mid-morning. We also observed three people in the dementia unit who were transported in wheelchairs by care staff into the communal lounge after lunch; they remained there for 45 minutes with no staff interaction.

We reviewed the records kept to demonstrate people had participated in social events or one to one sessions. Entries had not been made in the activities record book since September 2017. Previous entries made by a staff member did not describe meaningful and sociable activities which would stimulate and engage people. For example entries included, '1-1 smoke break', 'family visiting', 'watched a film', 'taken for a hospital appointment' and 'wheelchair receiving a safety check'.

We found these entries were not person-centred and did not meet with each person's individual holistic needs, interests and hobbies. Activity care plans had not been routinely evaluated or reviewed and we found notes to be unorganised, brief and not up to date.

This is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to person-centred care.

The new on-site care manager and deputy manager has started to change the care records and we looked at some updated examples. They contained a pre-admission assessment which included personal details, past and present medical history, medicines, DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) status, care needs, likes and dislikes. A photograph had been taken for identification purposes and people had consented to this. The new documentation included a six week review form and a dependency tool which would be reviewed monthly and updated if changes occurred.

Each person had plans of care that reflected their health, mental and social care needs. For example, maintaining safety, medication, communication, capacity, nutrition, continence, personal care and hygiene, skin integrity and end of life. Other specific care plans to address individual needs included, osteoarthritis, diabetes, choking, leaving the building, behaviours that challenge and pain control.

We found these care plans were in depth, person centred, cross referenced to other
care plans and truly reflected what the person wanted and how they want to be cared for. The plans were really informative and clearly explained how care and support should be delivered for each person. The care plans also incorporated risk assessments and risk management plans. These reflected individual needs such as, weight loss, bedrails, use of equipment and falls. Care monitoring tools, such as MUST (Malnutrition Universal Screening Tool), body maps, food and fluid charts and falls diary were used to supplement the documentation. All of these assessments, risk assessments, management plans and care plans were designed to ensure that each person had individually planned care that is safe and meets their individual needs.

Care plans and assessments had been regularly reviewed and kept up to date when changes occurred. This meant staff could respond to people's health and personal care needs in the way people wanted. However a holistic approach to people's overall needs was not always achieved, for example, social, emotional, cultural, religious and spiritual needs were sometimes overlooked.

There was no-one currently receiving end of life care although people were living with terminal illnesses. However, the service had provided end of life care to two people until very recently when they sadly passed away. We saw in care records that staff had asked people and their relatives (where appropriate) to consider sharing their end of life wishes to ensure that the service continued to care for people as they would prefer when they may no longer be able to communicate those wishes themselves or in an emergency situation. Advanced care planning, emergency care and resuscitation preferences were documented where these wishes had been shared.

At our last inspection we identified a breach of Regulation 16 related to the management of complaints. After that visit, the provider told us what action they planned to take. At this inspection, we found the provider had achieved compliance with this regulation.

People and their relatives told us they knew how to complain and that they were satisfied with how the matter was dealt with. One relative said, "I've made a complaint, it was handled well and immediately cleared up." Another said, "I've no complaints, these two [on-site care manager and deputy manager] are absolutely brilliant." One person said, "I've never had to complain. I'd go to that new manager but I don't know what her name is."

Since our last inspection, the complaints policy and procedures had been adhered to and maintained. We

reviewed the last five complaints made to the service and found that acknowledgement and outcomes letters had been communicated in writing to the complainants. We saw notes had been made to show that an investigation had taken place. There was evidence that the registered manager or on-site care manager had spoken to staff and if appropriate relatives to communicate actions and outcomes. This meant the provider was able to demonstrate that people had been responded to and their complaints had been acted upon in order to improve their service.

Inadequate

Is the service well-led?

Our findings

At our last two inspections of this service we identified a breach of Regulation 17 entitled, good governance. After those inspections the provider and registered manager told us what action they would take to ensure compliance was achieved.

Before we inspected on this occasion, we asked the provider to confirm that all actions had been completed in order to meet the regulations. They told us that in conjunction with the registered manager and the care management team at the service, they were assured that all actions in order to be compliant with regulations, continued to be carried out. We found this was not the case and serious concerns remained about the leadership and governance of the service as well as continuing non-compliance with regulations.

We received an action plan from the registered manager which addressed the serious concerns raised in the two warning notices issued to the provider on 14 June 2017 in respect of Regulations 12 and 17. This action plan stated the actions were completed and some actions would be ongoing to ensure continued compliance. At this inspection we found six of these concerns remained at the service.

The provider and registered manager had failed to ensure effective governance and quality assurance systems were in place. Where shortfalls were identified at the last two inspections, they had failed to appropriately plan and address these shortfalls to implement improvements. They also failed to fully protect people's safety, as the governance arrangements related to the safe care and treatment of people were not robust. As a result of this people, visitors and staff had been exposed to avoidable risk of harm.

We found that previously identified concerns about auditing aspects of the service had not been addressed and there were further concerns identified at this inspection. Namely, there were no records of regular registered manager's audits at the service (except one 'observational report' dated June 2017). There was no evidence of regular care manager daily or monthly checks of the service (except one 'daily walk-around' recorded in August 2017). There was no evidence at the service of a provider's visit. We were told these would be forwarded to us, but to date we have not received any information about this. Consequently, safety issues and the required repairs identified at the previous two inspections remained unaddressed.

There had been no analysis carried out of complaints, accidents, incidents and safeguarding matters since May 2017. This showed that these events had not been monitored for trends or shared with the provider for oversight across the organisation in order to implement action which may reduce the likelihood of a repeat occurrence.

There had been no medicine audits carried out since May 2017. This meant that neither the provider nor the registered manager had assured themselves that medicines were being managed safely. During this inspection, we highlighted issues around safe medicine management with staff which has not been previously identified.

An infection control audit had not been carried out since March 2017, which we reviewed at our last

inspection. We were told by a member of staff that these audits were completed six monthly which meant this audit was overdue for completion.

We were given two training matrices which contained contradictory information about when staff were due refresher training. For example, one matrix showed five staff were overdue a moving and handling refresher training session and the other showed that nine staff were overdue. The care management team were unclear about which staff were due refresher training.

We found there was no monitoring in place of when staff supervision or appraisals were due. This meant that neither the provider nor the registered manager had assured themselves that staff were properly supported in their role and that they remained suitable to work with vulnerable people.

The new on-site care manager at the service was not aware of the disciplinary records of some staff and had consequently made decisions around staffing that were inappropriate. There were discrepancies as to what information had been formally handed over from the registered manager to the new on-site care manager. There was no written evidence of a formal handover or induction.

We observed one care worker assisted a person to eat their lunch. We saw three other people waited for the same assistance. There were no other staff present to help with this task. We addressed this with the care manager who told us more staff were supposed to be available. It was determined that without adequate supervision staff had deployed themselves in other places on this occasion.

We saw mealtime experiences were still not as positive as they could have been because care workers were pre-occupied with task based interactions to allow sufficient time for social engagement. This issue was highlighted at the previous two inspections and did not appear to have been improved in all dining rooms.

We found that a recommendation regarding the activities provision highlighted in a previous inspection and a subsequent requirement notice issued following another inspection had still not been thoroughly implemented or robustly monitored. Concerns around the provision of activities remained at this inspection. An action plan submitted to us prior to this inspection described the required improvements as "on-going" and would be addressed by December 2017. We considered this to be an unsatisfactory timeframe and have asked the provider to look at this again.

The care management team were aware that no planned activities were in place and that people were not engaged in meaningful activities. There was no evidence available to demonstrate that people had recently received any one to one support which met with their own personal wishes, preferences, hobbies or interests.

We acknowledged that the activities coordinator post was vacant; however this had only been the case for the past month. Following our last inspection the activities coordinator remained in post for four months before transferring to another role within the home. We did not find any evidence that activities had improved in those four months. Furthermore, the activities coordinator had been allowed to transfer to another role without any succession planning taking place to cover the vacant post. We considered this to be an inappropriate managerial decision bearing in mind the improvements that were required with activities provision.

Records relating to activities had not been maintained since September 2017 and previous records had not been quality checked. We identified very inappropriate 'activities' were recorded which we highlighted to the registered manager.

People were confused about the management and the ownership of the home. They told us, "I have no idea who is in charge now", "I don't talk to the manager, I think they are nice though", "I think the buildings been taken over, but not sure who it is. There hasn't been any changes", "I know who the manager is by sight but I'm not sure of their name" and "I don't know who the manager is, they keep changing."

Most staff told us they had not seen the registered manager or provider at the home for a long time. One member of staff said, "They [registered manager] haven't been near" and another said, "I think they [registered manager] have forgotten about us."

This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to good governance.

The new on-site care manager and deputy manager had been in post since August 2017. The registered manager was not based at the service although she told us she was contactable at all times.

We asked staff about the leadership of the service. We asked them if they felt supported. They told us the new managers were "supportive", "approachable" and "good listeners". Their comments included, "I feel much more supported now and less stressed in fact I enjoy working here again", "Yes, very supported by [on-site manager and deputy manager]" and "Oh yes, when they first came they spoke to me about [a personal matter] and they were great."

We read in the most recent 'resident and relatives' meeting carried out on 6 October 2017 that the provider had shared their plans to sell the home and that the new on-site care manager and the deputy manager would continue to manage the service once the sale was completed. People had an opportunity to give their feedback on the proposals. A relative told us that they attended the meetings every three months but could not recall if the improvements had been discussed. They also told us that no surveys had been sent out to people or relatives.

During the inspection we discussed our immediate findings with the registered manager and on-site care manager and brought several issues to their attention which they promptly addressed. We later spoke with the provider to discuss the inspection. They assured us that immediate action would be taken to address the safety issues and an action plan would be drafted to respond to the shortfalls, governance and leadership of the service to ensure the standards improved as a matter of urgency.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care A holistic approach to people's care needs had not been adopted throughout the service. Activities were not provided to people based on their individual preferences to enable them to pursue their interests and hobbies. Regulation 9 (1)(2)(3)(b)(e)(h)

The enforcement action we took:

We issued the provider with a Notice of Proposal to remove this location from their registration.

We also issued the registered manager with a Notice of Proposal to cancel their registration.

These notices of proposal were withdrawn following improvements made at the service which we found when we re-inspected In March 2018. A further report detailing the new findings will be published soon.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe manner. The provider and registered manager had not always ensured that risks to people's health and safety were removed or reduced. Serious environmental, equipment and premises risks were identified, some of which remained unaddressed from the last two inspections. Regulation 12 (1)(2)(b)(c)(d)(e)(g)(h)

The enforcement action we took:

We issued the provider with a Notice of Proposal to remove this location from their registration.

We also issued the registered manager with a Notice of Proposal to cancel their registration.

These notices of proposal were withdrawn following improvements made at the service which we found

when we re-inspected In March 2018. A further report detailing the new findings will be published soon.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Established systems were not operated effectively to ensure compliance with the regulations. The provider and registered manager failed to adhere to their own action plan with regards to previously identified concerns. These concerns had not been fully addressed in order to improve the safety and quality of the service. Governance systems were ineffective and had disregard of the serious concerns raised by the Care Quality Commission in past inspections. Regulation 17(1)(2)(a)(b)(e)(f)

The enforcement action we took:

We issued the provider with a Notice of Proposal to remove this location from their registration.

We also issued the registered manager with a Notice of Proposal to cancel their registration.

These notices of proposal were withdrawn following improvements made at the service which we found when we re-inspected In March 2018. A further report detailing the new findings will be published soon.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider and registered manager has not ensured that all staff were suitably trained or competent in their role. Staff has not been formally supported in their role through supervision and appraisal. Regulation 18(1)(2)(a)

The enforcement action we took:

We issued the provider with a Notice of Proposal to remove this location from their registration.

We also issued the registered manager with a Notice of Proposal to cancel their registration.

These notices of proposal were withdrawn following improvements made at the service which we found when we re-inspected In March 2018. A further report detailing the new findings will be published soon.