Care Quality Commission

Corvan Limited

Cordelia Court

Inspection report

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Ratings

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

Overall summary

We carried out an inspection of Cordelia Court on 22 and 27 July 2015. The first visit was unannounced and the second visit on 27 July 2015 was announced.

Cordelia Court provides personal care and accommodation for up to 23 older people including those living with dementia. Accommodation is provided over two separate floors. There were 21 people living at Cordelia Court when we inspected the service.

A requirement of the service's registration is that they have a registered manager. 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 and associated Regulations about how the service is run. There was no registered manager in post at the time of our inspection. This was because the previous registered manager had left the service in November 2014. The provider had recruited a new manager, who was in the process of applying for their registration.

At our previous inspection in December 2014, we found three breaches in the legal requirements and regulations

Summary of findings

associated with the Health and Social Care Act 2008. Two of these breaches were carried forward from our September 2014 inspection due to insufficient improvements being made.

Following our inspection in December 2014, we met with the provider and asked them to take the necessary steps to ensure the required improvements were made. These improvements were to ensure there were accurate records kept about people so they were not placed at risk of unsafe or inappropriate care. To make sure there were sufficient numbers of suitably qualified, skilled and experienced persons employed at the home, and ensure people's privacy, dignity and independence were maintained. The provider sent us an action plan outlining how these improvements would be made.

During this inspection we found there had been some progress in addressing the actions required following the last inspection but sufficient improvements had not been made. The manager told us that when she started working at the service there had been improvements needed in a number of areas and she had taken steps to implement a number of these. However, we found that these improvements had not ensured people were consistently safe and their care needs met. The manager had identified she needed additional support to enable the on-going improvements to be made and maintained. The provider had responded to this need by identifying a member of staff to provide administration support to the manager for 16 hours per week. The staff member appointed confirmed they had recently taken on this role and were providing this support.

Risks associated with people's care were not always being identified and managed to keep people safe. This included the management of risks associated with people's behaviours that were sometimes challenging.

People told us they received their medicine when needed but there were some improvements required regarding medicines management. Night staff were still to be assessed as competent to enable them to administer medicines at night. This meant people who may need medicines during the night such as for pain relief may not receive them in a safe or timely manner.

There were not always enough suitably trained staff to keep people safe and meet people's preferences and needs. An increase in the number of people needing close monitoring and support from staff had not resulted in a review of the staff skills and numbers to ensure their needs could be met.

Staff training had been improved in that most staff had completed basic training essential to support them in their role. However, staff had not completed all of the training linked to people's care needs so they had the skills needed to support people effectively. Their competencies following their training had not been assessed to ensure they carried out their roles safely and effectively. We identified staff had not completed training in 'challenging behaviours' to support them in managing people with behaviours that were challenging. This is despite a number of people living at the service with this specific care need.

We spent time observing care interactions in communal areas over the course of the day. Staff were friendly in their approach towards people but most interactions were linked to delivering care and support. We found that people's privacy and dignity was not being maintained despite this being an issue that we had identified previously as needing improvement. There were some social activities provided but these were limited and were not always in accordance with people's interests and preferences.

There had been some improvements carried out in regard to the maintenance and refurbishment of the premises. However these were on-going and there remained areas where improvements were needed.

People's care records had improved following our last inspection but some had not been updated regularly and lacked the detail required to support staff in delivering care.

The manager had set up regular 'resident' meetings and had implemented a satisfaction survey for people and their relatives to gather their views of the service. The manager used meetings to discuss any areas of concern and provided feedback on changes being implemented in the home. However, it was not always clear that issues people had raised had been addressed.

We found when we looked at the records of accidents and incidents that had occurred at the service there had

Summary of findings

been some that had not been reported to us as required. This meant we had not been able to check appropriate actions had been taken to keep people safe when they had occurred.

The manager completed a number of audits to monitor the service but recognised these needed to be further developed to make sure people received the quality of care and services required to meet their needs.

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.

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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Staff were not always available to meet people's needs and maintain their health and safety. Staff had not completed training to help them support people with behaviours that were challenging which placed them and others at risk. Risks to people's health and safety were not identified and people's medicines were not managed effectively.

Inadequate

Is the service effective?
The service was not consistently effective.

People who used the service did not always receive effective care and support because staff did not always have the skills and knowledge to meet people's needs. People told us they mostly enjoyed the food but when they had lost weight, it was not always clear sufficient actions had been taken to address this. The manager understood their responsibilities in relation to the Mental Capacity Act 2005 but where people were being deprived of their liberties these had not always resulted in an appropriate referral being made to the authorising authority.

Requires improvement

Is the service caring?
The service was not consistently caring.

People and relatives were positive in their comments about the staff and we saw staff were friendly when they approached people. However, people were not always given choices about their care and people's privacy and dignity was not consistently maintained.

Requires improvement

Is the service responsive?
The service was not consistently responsive.

People did not always receive care that was personalised specifically to them. Care records were sometimes not followed or were not sufficiently detailed to support staff in delivering care in accordance with people's preferences and needs. Social activities were provided but they did not always reflect people's interests and hobbies.

Requires improvement

Is the service well-led?
The service was not well led.

The provider had not ensured that effective quality assurance procedures were in place in order to assess and monitor the quality and safety of service people received. This meant that a number of shortfalls in relation to the service people received had not been identified. The manager was not registered at the time of our inspection but was in the process of registering with us.

Inadequate

Cordelia Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22 and 27 July 2015. The first day was unannounced and the second day announced. This inspection was undertaken to follow up on previously identified breaches to ensure action had been taken to make the required improvements.

The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service. We looked at information received from agencies involved in people's care and spoke with the local authority. They told us they had been monitoring progress against an action plan they had instigated at the service. We analysed information on statutory notifications received from the provider. A statutory notification is information about important events which the provider is required to send us by law. These can include safeguarding referrals, notifications of deaths, accidents and serious injuries. We considered this information when planning our inspection of the home. We looked specifically at five care plans but also viewed other care documentation such as people's daily records, weight charts, food and fluid charts and medication records. We looked at the complaints file, accidents and incident records and records of safeguarding incidents at the service. We completed observations during the day including over mealtimes in both the dining room and the lounge to see what people's experiences of the service were like.

We spoke with six people who used the service and six relatives, a cook, the manager and six care staff (including night staff). Some of the care staff we spoke with also undertook other duties such as cleaning and the provision of social activities.

Inadequate

Is the service safe?

Our findings

When we visited Cordelia Court on 17 December 2014 people and relatives told us there were not enough staff to care for people safely. We found suitable arrangements were not in place to ensure there were sufficient numbers of suitably qualified, skilled and experienced staff to support people's needs. This was a breach of Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing.

The provider sent us an action plan outlining how they would make improvements. This included the introduction and ongoing completion of a "staff audit tool" (also known as a 'dependency tool'). The manager advised at the last inspection this tool would help them determine how many staff were needed in accordance with people's needs. During this visit we saw a 'dependency tool' had been devised in March 2015. After completing this, the manager had determined that no changes in staff numbers or skill mix were required. We identified that since March 2015 there had been changes in the number and dependency of people who lived at Cordelia Court. However, the dependency tool had not been reviewed to identify any potential changes to the skill mix and numbers of care staff required. As the dependency tool had not been updated to give an accurate reflection of people's needs, this could not be relied on to confirm there were sufficient numbers of staff available to support people's needs.

When we spoke with people and relatives, half of them felt there were not be enough staff to meet the needs of people and keep them safe. Comments included, "There are not enough staff here. When I ring my buzzer it takes between five minutes and half an hour for them to come," and "I don't think there is enough staff. When there is an incident, the staff go off in a hurry and they leave people in the lounge area and the garden unattended."

We asked staff whether they were able to support people to get up during the morning as well as observe people who were already up to make sure they were safe. They told us they could not always be with people to observe them. They told us this was particularly a problem if people were up and walking around and call bells were going off, because they were usually busy supporting other people with their personal care. We identified that at least one person who walked around the service had been assessed as being at risk of falls and would sometimes not use their frame. This meant staffing arrangements were not sufficient to enable staff to manage risks and meet people's needs.

During our last inspection we identified there were periods of time when the lounge was left unattended which placed people who required close supervision at risk. At this inspection, there continued to be periods when there was no member of staff in the lounge to manage any potential risks. We identified a number of people at Cordelia Court required close supervision and monitoring to manage their behaviours and care needs. We observed a person who was unsteady on their feet trying to walk upstairs without a staff member present. We followed behind them as we was concerned that they could have fallen. They eventually got to the first floor but had great difficulty in opening the landing door. The outcome of a recent safeguarding incident that had occurred following a person experiencing a fall at the service was that the risks associated with their care had not been appropriately managed. We saw one person in the lounge fall asleep holding a cup of tea which could have resulted in a potential risk of burns. The lack of staff presence and observation of people meant people's health and safety was compromised.

This was a breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing

People were not always protected from potential abuse and harm. One person told us "I don't like it when people come in to my room without my permission, it makes me feel unsafe." Staff had completed training on safeguarding people and they could tell us about the different types of abuse. They told us that they reported any incidents of concern to the manager. Staff told us that this involved the completion of an incident form, however they did not know what happened with the information once it was given to the manager. In addition, staff were not aware of the process for reporting incidents in the absence of the manager. This meant when there were incidents occurring in the manager's absence they were not always being appropriately reported and acted upon.

There had been a recent serious incident at the service where a person's behaviour had escalated causing injury to a staff member. Staff had not ensured this was reported to the local authority when the manager was away. When we discussed this person with a staff member they told us the person would "hit out" at people because they wanted to

Is the service safe?

go home. They stated, "We are afraid he will hit one of us or one of the other residents." The provider had not ensured the safeguarding procedures at the service were sufficiently robust to protect people and staff. The manager had subsequently recognised that this person's needs were not being effectively met at the service and confirmed they no longer lived there.

There were other people who used the service who had behaviours that challenged others. Some people were also at risk of falls. We looked to see how these risks were being managed. Staff knew about the triggers that could lead to people's behaviours escalating but didn't always act on them in a timely way to prevent them escalating and putting others at risk. For example, one person became very agitated when they wanted a cigarette and staff told us they were restricting how many they were given. Staff told us the person would smoke cigarettes constantly if they did not restrict how many they smoked. We saw on several occasions that this person stood outside the door of the management office calling out for staff's attention because they wanted a cigarette. Staff did not respond to their request and they became more and more agitated the longer they had to wait as they began to look for someone to respond to their request. We saw an angry exchange of words with a person who walked past them which could have led to the other person being put at risk of harm. Another person had told staff they did not like other people going into their room. We saw they had been involved in an incident where they had hit another person who tried to gain entry into their room. On speaking with staff and the manager there was no clear management plan in place to prevent or manage the risks associated with people going into other people's bedrooms which could have prevented this from happening.

When we spoke with staff they gave different accounts of which people they felt had behaviours that were challenging. They had differing views about people who could potentially place others at risk if their behaviour was not appropriately managed. When we looked through the accident and incident folder there were a number of incidents recorded, mainly altercations between people. When we discussed this with a senior member of staff, they understood that some of these incidents did fall into the category of a safeguarding incident. However, these incidents had not been reported to the local safeguarding team to ensure any risks associated with people's behaviours could be reviewed and managed to ensure the person's needs were met.

There was no evidence to confirm that when people sustained bruises these were investigated and acted upon. One relative we spoke with told us, "[Person] has had bruises and I have questioned staff but they didn't know how [person] got them." We saw a number of body maps in the accident and incident folders which showed a number of people had recent unexplained bruises. Entries included three bruises across a person's chest, a large bruise to the left thigh, a bruise to the back of a left hand and bruise to a right hip. There were no potential causes identified no information about how to manage any risks.

When we walked around the home we found call bells were missing in eight of the rooms we visited. A member of staff told us most of the people at Cordelia Court could use a call bell. This meant people would not be able to alert staff if they needed assistance. The manager advised she had not noticed the call bell leads were missing.

This was a breach of Regulation 13 Safeguarding service users from abuse and improper treatment

Other people told us that they felt safe at the service. Comments included "I am safe at the moment," and "I have never felt unsafe."

Staff were clear on the procedure to follow in the event of a fire or emergency. They knew which people would need a wheelchair or support to evacuate the building. However, we found potential fire risks were not being assessed and managed. For example, there were no personal evacuation plans for people to show how they would need to be supported by staff or the emergency services in the event of a fire or emergency. The manager showed us a room plan detailing who was occupying the bedrooms should this be needed by emergency services. This had not been updated to include everyone currently at the service, to make sure everyone was accounted for in an emergency situation. We saw a stool was used to keep a fire door open which meant it would not automatically close in the event of a fire. The front door was kept locked with a key which meant people would not be able to exit the building in an emergency unless they found a staff member to open the door for them.

Inadequate

Is the service safe?

We spoke with staff about their experiences of how they were recruited at the service. Staff told us they had to wait for police and reference checks to be completed before they were able to start work. The manager confirmed that new staff members were not able to work at the service until all their recruitment checks had been completed to confirm they were of good character and suitable to work there.

We looked at how medicines were managed and found, overall that people received their medicines as prescribed but there were some areas where improvements to the management of medicines were required.

Medicines were stored safely and we observed staff to administer these appropriately during the day. Each person had a printed Medicine Administration Record (MAR) from the pharmacy with their photograph on to help prevent the risk of medicine being given to the wrong person. MAR's had been signed by staff to show they had administered the medicines. Medicines were colour coded to assist staff in knowing which medicines were to be given in the morning, midday, afternoon and night. At lunchtime we saw a staff member administering the medicines. They went to each person and asked discreetly if they were in pain and if they required their pain relief to manage this.

Where people had been prescribed a variable dose of medicines such as for pain relief capsules or tablets, the number given had been recorded. This was to ensure the person's health was not put at risk by staff administering above the recommended dosage and to assess the effectiveness of the medication. However, there were not always clear protocols in place so that staff were clear on how these medicines should be managed. We identified one person had been prescribed a medicine for 'agitation' to help calm them. A side effect of this was that the person could become drowsy which potentially could place them at risk of falls. Staff told us they did not give one of the doses if the person was drowsy however, we could not be sure all staff would know to take the same approach.

Staff had completed medicine training but some staff had not been assessed as being competent by the manager to administer medicines. This particularly applied to the night staff. Staff told us medicines were given by the day staff late in the evening so they did not need to be given at night. However, this did not take into account if people required pain relief. The daily care plan records we viewed showed a person at night had requested this. Records stated, "[Person] was a bit upset because she wanted pain relief." This suggested it was not given when they needed it. We also identified there were some people who had breathing problems who relied on medicines to help relieve their symptoms. Staff told us that they had supported people to take this medication despite not being assessed as safe to do so.

Requires improvement

Is the service effective?

Our findings

During our last inspection in December 2014 staff had not completed training in dementia care to make sure they had the skills and knowledge to care for people with dementia effectively. This was an area that we identified for improvement to ensure people's needs were met.

During this inspection we asked people and relatives if they felt staff had the skills required to meet people's needs. We were told, "They are nice, I think they know what they are doing, never unkind." "Yes, on a physical care basis fine. I don't think they are knowledgeable about Alzheimer's or dementia."

We found action had been taken and staff had undertaken dementia training. A staff member told us this training involved "watching a video and answering questions with [manager]". We checked to see if staff competencies had been assessed by the manager following this training, to make sure staff had learned from this and could support people with dementia effectively. We were told this had not happened but was planned. We asked a staff member what they would do in a situation where a person may present challenging behaviours. They told us, "We try and talk them down, ask them to go outside and try to help them." Staff told us there was no specific information within care plans to help them understand how to manage these behaviours. They told us that this impacted on their ability to manage risks associated with people's behaviour and in meeting people's needs.

Staff had access to a range of training the provider considered essential to support them in their role. Although staff had completed this training, it was evident they were not always putting their learning into practice. For example, staff had undertaken training about infection prevention, however we observed a staff member collect soiled bedding from a bedroom without wearing any protective clothing such as gloves and an apron. They also carried the bedding in their arms as opposed to in a plastic bag. These unhygienic practices meant there was a potential risk of the spread of infection. A senior care staff member told us it was an expectation staff wore protective clothing and carried soiled laundry in a plastic bag.

The manager had organised supervision meetings and induction training to support staff in their roles. When new staff started work at Cordelia Court they shadowed more experienced staff for three days to help them to get to know people and how to support them. After three days they worked as part of the staff team on duty but always worked alongside another staff member until they felt confident to work independently. New staff, as well as existing staff, had supervision meetings with the manager to discuss their ongoing performance. These meetings provided staff with an opportunity to discuss personal development and training requirements. Staff we spoke with confirmed supervision meetings took place although the frequency of these varied. One staff member told us, "[Manager] will ask me how I am feeling, if I need any training, if there is anything I need to improve on, if there is anything I would like [manager] to do and if there are any problems."

We asked the manager about their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission is required by law to monitor the operation of the MCA and DoLS and to report on what we find. The MCA ensures the rights of people who lack mental capacity are protected when making particular decisions. DoLS referrals are made when decisions about depriving people of their liberty are required, to make sure people get the care and treatment they need in the least restrictive way. The manager and staff were able to explain the principles of MCA which showed they had some understanding of the legislation. People told us "I have seen them asking if [person] wants' her nails done," and "They [staff] always ask permission, can I do this or that." However following conversations and our observations of people, the principles of the MCA were not always being followed. For example, people and relatives told us their consent was not always sought and they were not always involved in making decisions. They told us "They don't ask [person's] permission. The other day they said "Come on [person] it's time for your shower," and "Some mornings I think I'd like to stay in bed. They tell me if you are not well you can stay in bed otherwise you have to get up."

Staff were not clear in their understanding of DoLS and how this impacted on people. Staff told us they had not completed training about this. The manager had some understanding about DoLS and had completed three DoLS applications. However, we found restrictions impacted on more than three people. For example, one person was subject to restricted visiting by a family member. This was being imposed by staff who explained to us the reasons why. There was no application for a DoLS to show this had

Is the service effective?

been formally assessed and agreed to be in the best interests of the person. We also found a number of people refused to be supported with their personal care. The length of time of some refusals indicated there was a potential to cause harm to people's wellbeing. There had been no discussion with relevant healthcare professionals or family members about how this should be managed in the person's best interests. In addition, the front door to the service was being locked with a key so people could not leave if they chose. Staff told us the door had been locked to prevent people from leaving the building unsupervised as there had been an incident where this had happened. These practices suggested further learning was needed to ensure staff understood their responsibilities in relation to this. The manager told us she had identified there were more DoLS applications that needed to be submitted.

Most people and relatives were positive in their comments about the food provided although they told us choices were limited. Comments about the food included, "The food is good…... you don't get a choice at lunchtime. For supper you get a choice. Breakfast is just juice, cereal, toast. I have never seen a fried breakfast here," "Excellent food here, you get a choice sometimes," and "The food looks more than acceptable. [Person] has put weight on so she is clearly eating. The menu used to be up on the dining room notice board, it's not there now. I haven't seen a choice offered. There are sandwiches and cakes at tea time, nothing else." The cook told us they had a two week menu that was repeated until the new season which meant the choices were limited. The manager told us, " We offer bacon or egg sandwiches every morning and cooked breakfasts every weekend mornings." However, our discussions with people suggested they were not always fully aware of the choices available to them.

We spent a period of time observing the lounge and dining room to see how people were supported during meal times. This was a positive experience for some but not for others. Most people ate in the dining room and were able to eat their meals independently. There was a choice of main meal but there was no choice of pudding. In the lounge one person said they did not like the look of their meal. They pushed the meal to one side but because there was no staff member in the lounge, they had to wait around fifteen minutes to tell a staff member they did not want it. The staff member asked the person if they were going to have some of the meal to which the person responded, "That really looks quite nasty I don't like the look of it. I don't want that thank you." The staff member offered them a sandwich instead and this was provided promptly with some biscuits. The person did not eat much of this and appeared unsettled. We noticed there were noise distractions over the mealtime which did not make it a relaxing experience. For example, a staff member was vacuuming the floor, the television was on in the lounge with the sound very low and music was playing.

We looked at the care records for the person who did not eat much at lunchtime. This identified the person had lost weight on the last four occasions when weighed, which suggested the person had not eaten enough calories to maintain their weight. We were told this person's loss of weight had been discussed with the GP but professional visit records in place did not confirm this. The care plan stated that snacks should be provided throughout the day but we did not see snacks were regularly offered. There was an instruction to use fresh cream and butter where possible in the food to help increase the amount of calories consumed. One of the cooks we spoke with told us they used extra cream and butter in the food they prepared but told us this was not necessarily recorded anywhere. This meant we could not confirm this was being done consistently by both cooks all of the time.

The manager told us she had introduced food and fluid charts for those people who were at risk of not eating or drinking enough. This was so that the amount of food and fluids people consumed could be monitored and any actions necessary taken. When we looked at the food and fluid charts, these had not been completed sufficiently or consistently to be sure people had eaten and drank enough to maintain their health. For example, sometimes staff had indicated people had eaten a quarter of their meal but it was not clear what the full meal consisted of. If it was a sandwich, we could not tell if it was one round of bread or more. A fluid chart we looked at showed after 9.30am one person had not been given any further drinks for the rest of the day. On another day there were no drinks indicated after 12.30pm. On a food chart for the same person one of their meals was not indicated at all for two days. It was not evident that the information recorded on the food and fluid charts was being monitored and used to manage risks associated with people's nutritional health. A relative we spoke with felt the nutritional needs of their relative were being met well, suggesting that some people's nutritional needs were managed appropriately. They told

Requires improvement

Is the service effective?

us “One day when [person] was dehydrated they encouraged her to drink a lot because they didn’t want her to go into hospital. She has put on weight since she has been here. She is eating well.”

Staff told us ‘handover’ meetings held at the beginning of each shift enabled them to communicate any areas of concern so these could be followed up if needed. People’s changing care needs were also discussed at this time so that staff would have up to date information. We observed one of the ‘handover’ meetings and saw concerns about people were communicated to ensure they could be monitored. For example, a discussion was held about a person who had not eaten well.

People told us they saw health professionals such as the doctor or district nurse when needed. . People commented, “They have a doctor here, he saw me a week ago,” and “They called the doctor a few weeks ago. He came the same day.” Some people’s healthcare was being supported by visiting district nurses. However, records we viewed did not always confirm health professional visits had taken place to demonstrate people were being supported with their healthcare needs. For example, the manager told us the GP had been contacted when they had concerns about people’s nutrition. She confirmed this was not recorded in the professional notes. We also found that chiropody visits were arranged but sometimes people refused support. When this happened it was not clear this was followed up to ensure the person’s foot care needs were met. We noted this had been raised as a concern by a relative who felt their relative’s foot care was not being managed appropriately.

Requires improvement

Is the service caring?

Our findings

During our inspection on 17 December 2014 we found suitable arrangements were not in place to ensure people's privacy, dignity and independence were respected and promoted. This was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

The provider sent us an action plan outlining how they would make improvements. This included providing staff with training and introducing staff supervision meetings to discuss this issue.During this inspection we found staff training and staff supervisions had been implemented.However we found this had not resulted in the necessary improvements being made and maintained.

On the first day of our inspection we arrived unannounced. Some of the people sitting in the lounge were inappropriately dressed and their personal care was in need of attention. For example, most of the people had no tights, socks or slippers on. Some people's hair was unkempt and in need of combing. It was clear these people had not been appropriately supported with their personal care. This was confirmed by the fact that when we visited the second day 'announced' most of these same people were wearing tights, socks and slippers.

Care plans indicated where people needed support with personal care including to dress, but staff told us people sometimes refused this support. Where we had identified this from records, we could not see appropriate actions were being taken to ensure the person's personal care needs were met. For example, the daily shower/bathing records for one person indicated they had not received a bath, shower or strip wash for 12 days. Staff were documenting this on a daily basis but we could not see that actions had been taken to address this concern.

Some of the en-suite toilets in people's rooms had no doors or screens to promote their dignity should others enter their rooms. This was found to be the case when we last visited the service in December 2014. The provider's action plan stated these would be replaced on a gradual basis. The manager told us these had only been replaced for people who had requested them. However doors on toilets are considered essential to promote people's dignity and it was a concern this had not been recognised.

People told us items went missing from their bedrooms and they sometimes found items in their bedrooms that did not belong to them. We identified that one person had been wearing another person's underwear. The manager told us she had attempted to address this through changing the process to manage the laundry. A visitor told us, "A lady does come in and eat [person's] fruit." We looked at the care file of a person that staff told us went into other people's bedrooms. There were numerous references to them going into other people's rooms and being found in other people's beds. A staff member told us, "They get lost and go into any bedroom to find their own." When we entered one bedroom we saw faeces smeared on the bed quilt and on the wash stool in the en-suite toilet. There was also a strong unpleasant odour in the room. This had been there for a prolonged period during the day as we had periodically checked to see if this had been cleaned . Staff told us there was one person who was likely to have done this, because they went into other people's rooms all the time. We saw from records this person had done this before. There were no clear management plans to help ensure people's personal rooms and possessions were protected and people's privacy and dignity maintained.

We found this was a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014 Dignity and respect.

People and relatives were positive in their comments about the staff. They told us, "They are very friendly. I think they could do with a few more. Very helpful and very caring," and "They are very good and gentle." People told us they felt at ease with staff when they provided their personal care. They told us, "They are very good. It's always a lady showering me. We have a laugh with it; she has to do it all," and "I think they are very good. The blokes wash me, the women the same. I don't mind who does it, they have a job to do."

We observed the communal areas of the service to see how people were cared for by staff. We saw staff were friendly in their approach but communication with people was mostly when they offered support or were completing a care task. Some staff did not always take the time to engage and communicate with people when they had the opportunity. Staff did not always know about people's health needs and

Requires improvement

Is the service caring?

daily routines or about their past histories so they could hold interesting conversations with them. This meant people received limited stimulation and interaction, which they may have enjoyed.

People were able to make some decisions about their care and how they spent their time such as where they sat, what they ate, and what activities they participated in. However, when group social activities were provided they were in the main lounge where most people sat. This meant if people did not wish to participate or watch these, they had to move to the smaller lounge. We saw one person who was independent chose to do this and staff encouraged them back into the large lounge when they had finished. We did not see other people asked if they wanted to stay in the lounge whilst the activity was underway.

People had personalised their bedrooms with items to make them more homely in accordance with their wishes. We saw one bedroom had been decorated by a relative which showed they had been involved in decisions about their relative's room. However, we noticed that clocks and watches were not being maintained to ensure they showed the correct time to promote people's independence and orientation to time. For example, in one bedroom the clock had stopped and showed a date in April, some three months past. We noticed another person's watch was still showing an hour behind, it clearly had not been altered when the clocks had changed.

Staff told us they involved people in decisions about their care. They told us, "When we wash them we ask them if they want to do it themselves, ask them what they want to wear and whether they want a bath or shower. When the families come in we ask them to check the care plan and try to speak to residents as much as we can. Care plans are reviewed every month. When I do mine I ask families to come in or ask them when they visit." The staff member told us that when they had made changes to a care plan they had asked the person to sign it to confirm they agreed to it. We saw some signatures on care plans to confirm this.

Requires improvement

Is the service responsive?

Our findings

During our inspection on 17 December 2014 we found suitable arrangements were not in place to ensure there was accurate records about people's needs so that people were protected against unsafe or inappropriate care. This was a breach of Regulation 20 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010 Records.

The provider sent us an action plan outlining how they would make improvements. This included implementing new care plans for each person and ensuring they were audited monthly to check that they accurately reflected people's changing care needs.

During this inspection we saw new care plans had been introduced which were more detailed and accurate than they had been before. However, in some cases we found care plans were not being consistently updated to ensure they continued to contain accurate information about people and how they needed to be supported. For example, we saw when a person had sustained a fracture, a new short term care plan had been devised for the management of this. However the manual handling care plan and the care plan regarding their risk of falls had not been updated to reflect the change in this person's health and mobility. This is despite the person no longer being independent and needed the support of equipment to move around. We also saw this person's history profile was blank and the 'care planning process' record had not been completed to show the person's involvement in their care. These omissions had not been identified as part of any audit processes carried out.

Care plans contained limited information about people's past interests and hobbies. This meant staff could not rely on information in care plans when planning activities and social stimulation of interest to people. The manager told us that a priest visited once a month to hold a service for people. We saw one person in particular liked to participate in the service and were told others also joined in. When we spoke with two people about their past work history and interests they were able to share this with us in a very short time. When we asked staff about these people they did not know this information. This brought into question the amount of time staff had to spend with people, to learn about their past lives, hobbies and interests and engage with them. One staff member told us, "We never go out with the residents because we don't have enough staff now."

They went on to say they used to have extra staff come in so they could take people out but this no longer happened. We saw in the 'resident meeting' notes that the manager was attempting to organise an outside visit but this was reliant on getting sufficient staff to volunteer to support people.

Care plans contained information about people's food preferences. In some cases staff knew these and ensured people were provided with drinks and meals in accordance with these preferences. For example one person's care plan included specific details of what they liked to eat and where. We saw the person in the lounge with tea and biscuits in accordance with their preference. However, we saw a nutritional care plan for another person that stated they did not like carrots. When we checked the food charts we saw they had been given carrots and on this day the person had not eaten all of their meal. This showed there was an inconsistency in ensuring people needs and preferences were addressed.

Despite finding care records were not always being updated, they had improved in relation to what we had found during our last inspection. However we still found information in people's care plans was not sufficiently detailed and was sometimes not being used to ensure people received person centred care in accordance with their needs.

On the first day of our inspection when we arrived at 7.30am most people were up and dressed. The night staff confirmed this was usual practice and they aimed to get most people up before the day staff came on duty. We were told that some people routinely liked to get up early and they were supported with personal care and dressed. However this was not the case for everyone. When we spoke with one person they told us the expectation was they got up when staff went into their room to support them. This practice did not promote person centred care as people were not being supported in accordance with their choice.

People told us they were not involved in planning their care or how they would like to spend their time. They told us, "No, they have never sat with me and discussed my care. I like gardening. They have never mentioned hobbies to me. You are virtually in your bedroom all the time, there are no activities," and "I love playing chess, I have never been asked to play it here." A relative told us they had

Requires improvement

Is the service responsive?

complained on more than one occasion about not being involved in the planning of their relative's care. They felt the lack of communication by the staff and management team was an issue.

There were limited social activities and consideration was not always given to people's preferences. When there were 15 people sitting in the lounge, a member of staff played a board game with one person. In the afternoon there was a pamper session in the smaller lounge where one staff member gave three people a manicure. On another occasion there was a game of skittles which people participated in. We observed a staff member assisting a person in to the front lounge where they put some music on. They stated, "Is that nice for you [person]" and walked out. They did not offer the person a choice; the music was pop music and not age appropriate. The same situation was observed in the other lounge where a staff member put on music without consulting any of the people sitting there to make sure it was to their liking. One person sitting next to the speaker commented that it was "far too loud". The staff member then turned it off rather than asking if the person wanted it turned down.

One person told us they did not want to be at the service and staff told us this was something the person repeated all the time. We saw this person was anxious and unsettled. Staff told us the person's behaviour could become challenging to themselves or others but they had not been given any specific instruction on how to manage this person's anxiety or behaviour when it escalated. When we looked at this person's care plan we could not see any specific information about the person's behaviour to guide staff on how to support the person's mental health needs. This meant staff may not know how to engage with the person to understand how the person was feeling so they could support their needs. There were no arrangements in place to monitor the person to help identify and address their anxiety in a timely way so this did not escalate further.

We found the lack of person centred care was a breach of Regulation 9 (1) HSCA (Regulated Activities) Regulations 2014 (Part 3)

People were provided with information about how to make a complaint when they moved into the service. The provider's complaints procedure was on the notice board in the reception area. People told us they knew how to make a complaint if they needed to. People told us, "I only complain about not being let out, not complained otherwise," and "I complained about my missing clothes. They were taken when I was outside with my support worker." A relative we spoke with told us they had "continually raised the issue of communication" because they were not kept informed of what was happening with their relative. Another told us, "[Person] used to read, their glasses went missing six months ago. I raised it with the previous manager at Christmas time…. I have raised it with carers three times since. They said they would arrange an optician but nothing has happened." We were also told about other complaints during our visit including one about the bath on the ground floor. We did not see that all complaints we were told about had been identified and recorded. Complaints records we looked at showed there had been two complaints received since our last inspection of the service in December 2014. Both of the complaints received were linked to people's personal care needs not being met including people wearing stained clothing. During our inspection we identified that people's personal care needs were not always being met which suggested lessons were not being learned from complaints received.

Inadequate

Is the service well-led?

Our findings

We carried out a comprehensive inspection of this service due to breaches in our regulations being identified during our inspection in December 2014. We met with the provider and they tasked the new manager in post to make these improvements. We carried out this inspection to ensure sufficient action had been taken to make these improvements.

We found systems and processes to assess and monitor the ongoing quality and safety of people were not effective. The processes in place to determine if there were sufficient numbers of suitably trained staff to support people were not being used effectively. As a consequence we found many examples of when staff were not available at the times people needed them in order to meet their needs and preferences.

The system for identifying risks and risk assessment processes were not sufficient. Risk assessments did not always give staff clear direction on how to manage risks. This included risks of people falling and risks associated with people refusing care, medicines and personal support. This meant people's care, safety and wellbeing was not being consistently maintained. Staff did not always know how to support people where they had behaviours that were challenging to themselves and others and new care plans that had been developed since the last inspection did not support staff to manage these. We saw an example of when a person became very anxious and did not receive support from staff to manage this. The manager gave assurances that staff would be supported with the relevant training to help them develop their skills in managing people's behaviours and they would review information in care plans to help support staff with this.

Systems to oversee the management of the risks associated with people not eating and drinking enough were not sufficient. For example, staff were required to complete food and fluid charts as well as weight charts to monitor people's weight. We found food and fluid charts were not consistently being completed. Where charts showed that people had not eaten or had much to drink we could not determine whether this was being identified by staff and acted upon. Weight charts sometimes conflicted with information in care plans so it was not clear which record was accurate. Staff told us the advice of health professionals was sought if they were concerned about people's care. However, records were not always being maintained to show advice had been sought and what advice had been given to ensure this was followed by staff. These issues had not been identified by the provider or manager.

The process to identify where people were being deprived of their liberty (such as not being able to leave the building) was not effective. This meant referrals that should have been made to the Local Authority were not being identified and made to seek approval of best interest decisions where there were restrictions being placed on people's care.

Accident and incident records we looked at showed there were numerous incidents that had not been reported to us as required. This meant when these incidents had occurred, we had not been able to check that appropriate actions had been taken to safeguard the person and reduce the risk of the same thing happening again. There had been incidents where people had been challenging towards one another which had resulted in them becoming anxious and upset and sometimes sustaining injuries. Staff did not understand the process for reporting injuries or incidents in the absence of the manager. They knew they had to complete an incident form and to pass this to the manager. Staff did not know what then happened with the information to ensure it was appropriately reported and acted upon. One member of staff told us when the manager was away they left them "in a pile" for when the manager returned.

There had been a serious incident at the service that had not been reported to safeguarding in the absence of the manager. This meant the action that needed to be taken to manage the risks associated with the people involved was delayed putting others at risk. Prior to our inspection we had identified there had been seven safeguarding referrals. Three of these fell into the category of neglect. These had been substantiated after being investigated by the local authority which demonstrated people's needs had not been met and their health and safety maintained. The provider had not ensured processes were in place that made sure there was consistent good management and leadership at the service.

The manager had taken action to improve communication systems but it was evident further improvements were needed to ensure people felt listened to and their concerns taken seriously.

Inadequate

Is the service well-led?

Meetings had been organised with people and relatives to give them an opportunity to provide their opinions and put forward their suggestions about the service. Some had attended the meetings but some said they did not know about them. A relative told us they had seen a notice on the wall about a meeting otherwise they would not have known about it. Notes of the 'resident' meetings showed a range of issues had been discussed such as the ongoing maintenance of the home, the implementation of the quality assurance survey and plans to arrange trips out. It was not always clear from the notes that issues raised had been effectively addressed. For example in March 2015 an issue was raised about maintenance tasks not being completed in a timely way. The manager had stated they were advertising for a new maintenance person. The notes of the meeting held in June 2015 did not report on any progress with this. During our inspection we were aware there was a person providing maintenance support but their hours were limited, which had restricted progress on the maintenance work required at the service.

The provider had not ensured systems and audit processes in place were sufficient to ensure when people had concerns, these were identified. We found complaints were not always being recorded and we cound not identify that lessons were learnt from these. We could not be sure verbal complaints made were being taken seriously and acted upon.

We found there were many aspects of the service that did not promote a positive culture which involved people in their care, and made sure people received care that was personalised and specific to their needs. Although care plans contained some personalised information about people, this information was not always being used to support people in maintaining their preferences and wishes. People had limited opportunities to pursue their hobbies and interests.

Environmental checks were not always sufficient to ensure people's safety and privacy and dignity was maintained. We found call bells missing in bedrooms, faeces smeared on a bed and chair and no doors on some of the toilet ensuites, despite this issue being raised at the time of our last inspection.

Staff told us they had staff meetings where they could discuss their work and offer their opinions on the service but one had not taken place recently.

The manager had arranged for quality satisfaction surveys to be sent to people and relatives to gain their views about the service and identify any areas for improvement. Some people told us they had received a survey and others did not. Comments included, "I did get a survey form; I gave it to my daughter," and "Never seen a survey form". Although people's opinions were sought through quality satisfaction surveys, some people did not feel their views were listened to. Comments included, "No they don't act on opinions. They need to improve communication," and "I don't think they listen to me." Another person said "I think they do listen, I can't be specific."

The provider told us that they regularly visited the service to support the manager and to monitor the quality and safety of the service provided. This included approving finance to allow the necessary improvements of the premises to take place. However it was of concern that they had not identified the quality and safety issues in relation to people's care.

The provider had not ensured the management of the service was consistently effective so that people's needs were met. This has been identified through the last three inspections to the service where we have found repeated non-compliance in meeting regulations. In September 2014 we found systems to assess and monitor the care and services were not effective in protecting people's health, welfare and safety. In December 2014 we found sufficient improvements had not been made. At this inspection we acknowledged action was taken by the provider to employ a new manager but found progress had been slow in ensuring people received safe care that met their needs. We recognised that the manager had made some improvements, however, they told us that this was focussed on office based duties. As a result of this, their time had been limited to observe and monitor the care people received.

The provider did not have systems and processes to ensure that they were meeting the requirements of the Health and Social Care Act 2008. This was a breach of Regulation 17 HSCA 2008 (Regulated Activities) regulations 2014 (Part 3) Good Governance

A requirement of the service's registration is that they have a registered manager. The manager in post was not registered at the time of our inspection. They had been in post since 24 November 2014 and told us they were in the process of registering with us. Since being in post, the

Inadequate

Is the service well-led?

manager had taken the time to get to know people and relatives and this was confirmed by people we spoke with. One person told us, "I know the manager. Very pleasant, more organised than the last one but less hands on. Very office bound, you don't see her," and "[Manager] is wonderful."

People we spoke with gave varying account of their views of the service. Comments included, "I would recommend the home due to number one, the staff," and "It's not bad here. I haven't had a bad time here, it's just the way the staff treat you, do this, do that." A relative that we spoke with told us, "It is good, it is one of the reasons I brought [person] here."

A relative spoke positively about the provider. They told us, "Very approachable and very understanding and he does go out of his way to help you."

Most staff spoke positively about working at the home. They told us, "The team here is amazing." "I think [manager] is quite a good manager. She is receptive to what you have to say."

We noted that since the last inspection new flooring had been fitted to replace carpets that had caused some of the unpleasant odours at the service. There had also been action taken to remove broken furniture in people's rooms, although there were still some items of furniture requiring repair or attention. This included the repair of the bath on the ground floor which the manager told us was planned. We were told improvements to the garden were on-going. The manager acknowledged that improvements were needed to the garden so that people could enjoy the benefits of this and was working closely with provider so that arrangements could be made for this to happen.

The manager told us when they started work at the service they had focused their time implementing new systems to improve the care and services people received. They acknowledged that this had meant they had spent a lot of time in the office as opposed to working alongside staff. They told us they planned to increase the amount of time they spent with staff in order to identify if there were any potential areas where further training was needed so that people's needs were met effectively.

The provider told us they had recently agreed administrative support for the manager, for 16 hours per week, and they were hoping this would help the manager to carry out the necessary improvements. Through our discussions with the manager we saw they were committed to making the improvements needed but needed more time and support to do this.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 (Part 3) Staffing** Sufficient numbers of suitably qualified, skilled and experienced persons were not always available to support people's needs and keep them safe at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 HSCA (Regulated Activities) Regulations 2014 (Part 3) Safeguarding service users from abuse and improper treatment.** Systems and process for protecting people from abuse and improper treatment were not effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014 (Part 3) Dignity and respect.** Suitable arrangements were not in place to support people in maintaining their privacy, dignity and independence.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 (1) HSCA (Regulated Activities) Regulations 2014 (Part 3)** Suitable arrangements were not in place to ensure people received care in accordance with their needs and preferences to maintain their health and wellbeing.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes to monitor and improve the quality and safety of services provided, and to manage risks related to the health, safety and welfare of people, were not effective. This included records not always being sufficiently detailed and accurate to support safe and appropriate care.

The enforcement action we took:
We are currently taking enforcement action . We will report on this once it is concluded.