Mr & Mrs R Cowen

Stonehaven Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 7 April 2016 and was unannounced. The home provides accommodation for up to 27 people, including some people living with dementia care needs. There were 14 people living at the home when we visited. The home was based on two floors connected by a passenger lift; there was a choice of communal spaces where people were able to socialise; most bedrooms had en-suite facilities.

There was a registered manager in place. 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.

At the last inspection in August 2015, we asked the provider to take action to make improvements in relation to person-centred care; the need for consent; safe care and treatment; quality assurance and staffing. We took enforcement action and imposed a condition on the provider's registration to prevent them from admitting new service users without prior written permission from CQC. We rated the service as inadequate and placed it in Special Measures

At this inspection we found some improvements had been made and the service has been taken out of Special Measures. However, the provider was still not meeting all fundamental standards of safety and quality.

We found continuing concerns with infection control arrangements. The laundry and main bathroom were not clean and some people's bedrooms smelt strongly of urine.

People told us they felt safe and staff had received training in safeguarding adults from abuse. However, the local safeguarding authority did not have confidence in the provider's ability to conduct effective and prompt investigations.

Most staff treated people with consideration, kindness and patience, interacted positively with people and supported them to build caring relationships. However, one staff member did not treat people in a considerate or compassionate way.

Medicines were managed safely and people received them as prescribed, although action was not taken when storage temperatures dropped to unsafe levels. Measures had been put in place to reduce the risk of people developing pressure injuries, but special pressure-relieving mattresses were not set correctly according to people's weights, so may not have been effective.

The provider had not taken action to ensure that legislation designed to protect people's rights and freedoms was followed. However, staff sought verbal consent from people before providing care and support.

Activity provision for people had not improved. This was very limited and did not always meet people's social needs. Records of activities people took part in were not accurate. One person's personal care needs were not being met and people were not always supported appropriately when they became anxious or upset.

Other people received personalised care from staff who understood and met their needs. Most people were supported to make choices about their daily routines. They had access to healthcare services, although staff did not follow-up on the need for one person to be re-seen by a doctor when their arm was swollen.

The provider operated a comprehensive quality assurance system, but this was not always effective. The systems and processes had not ensured that all fundamental standards of quality and care were met.

Individual risks to people were managed effectively and people were supported to move safely. Emergency procedures were in place and staff had been trained to administer first aid.

People said the quality of the food had improved with the recruitment of a new chef, although a choice of drinks was not offered at lunchtime and visual prompts were not used to help people choose their meals.

People had mixed views about how well the home was run. There was a high turnover of staff and people were not cared for by a stable staff team. With the exception of mealtimes, which were disorganised, staff worked well together, understood their roles and felt supported by managers.

Staff were suitably trained and said they felt supported in their roles. Induction procedures were comprehensive and staff were encouraged to gain vocational qualifications. There were sufficient staff to meet people's needs and recruitment procedures helped ensure only suitable staff were employed.

People's privacy and dignity were protected and they or their families (where appropriate) were involved in planning the care and support they received. There was an appropriate complaints policy in place and the provider sought and acted on feedback from people.

The provider notified CQC of all significant events and had displayed the ratings from the last inspection in the reception area of the home. The registered manager was working with other professionals to help improve and develop the service.

We identified breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Infection control arrangements were not adequate as some areas of the home were not clean and some bedrooms smelt of urine.

Care staff knew how to identify, prevent and report abuse, although the safeguarding authority did not have confidence in the provider's ability to investigate allegations of abuse promptly.

Individual risks to people were managed effectively. However, special mattresses were not all set correctly.

Suitable arrangements were in place to manage medicines safely, but action had not been taken when the fridge storage temperatures were unsafe.

They were enough staff to meet people's needs and recruitment practices were safe. Appropriate emergency arrangements were in place and information was available to support people if they had to be evacuated.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not follow legislation designed to protect people's rights and freedom.

People had access to healthcare services and staff said relationships with professionals had improved.

People's nutritional and hydration needs were met and they said the quality of meals had improved.

Some bedrooms were personalised, although the environment was not supportive of people living with dementia.

Staff were suitably trained and supported in their roles.

Is the service caring?

Requires Improvement

The service was not always caring.

One staff member did not treat people with consideration and respect, although others interacted positively with people.

People were supported to build caring relationships.

People's privacy was protected and they were involved in planning their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Activity provision did not meet people's social needs. One person's continence needs were not being met and people were not always supported appropriately when they became anxious.

Other people received personal care from staff who understood and met their needs.

An appropriate complaints policy was in place and people knew how to raise a complaint.

The provider sought and acted on feedback from people and visitors.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance systems had not been effective in ensuring the provider met all fundamental standards of quality and safety.

People had mixed views about how well the home was run and there was a high turnover of staff.

Staff felt supported by managers, understood their roles and worked together as a team.

The provider notified CQC of significant events; and visitors were welcomed at any time.

The provider had a clear set of values, which they endeavoured to communicate to staff.

The registered manager was working with a consultant and the

Clinical Commissioning Group to improve and develop the service.

Stonehaven Residential 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 took place on 7 April 2016 and was unannounced. It was conducted by two inspectors and a specialist advisor in the care of older people.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed previous inspection reports and notifications we had been sent by the provider. A notification is information about important events which the service is required to send us by law.

We spoke with five people living at the home and four visiting family members. We also spoke with the registered manager, the deputy care manager, four care staff, a member of kitchen staff, a cleaner and a staff member responsible for arranging social activities. We also obtained feedback from the local authority's safeguarding and commissioning teams.

We looked at care plans and associated records for seven people and records relating to the management of the service. These included staff duty records, staff training and recruitment files, records of complaints, accidents and incidents, and quality assurance records. We also observed care and support being delivered in communal areas.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, on 11 and 17 August 2015, we identified that staff were not following infection control guidance; people had experienced mistreatment by staff; there were not enough staff deployed; and the risks of people developing pressure injuries were not being managed effectively.

At this inspection we identified continuing concerns with infection control arrangements. Providers are required to take account of the Department of Health's publication, 'Code of Practice on the prevention and control of infections'. This provides guidance about measures that need to be taken to reduce the risk of infection, including the need to maintain a clean environment that facilitates the prevention and control of infections. The guidance had not been followed as some areas of the home were not clean. For example, the carpets in five people's bedrooms smelt of urine, very strongly in two cases. Staff told us they were cleaned often, but the malodours could not be removed. The mattress in one person's room was badly worn and the water-resistant covering was no longer intact. We drew this to the attention of the registered manager, who arranged for it to be replaced immediately. Another person, who was frequently incontinent at night, was using a mattress that was not sufficiently waterproof; it smelt of urine and had brown stains on both sides.

There was a four-inch hole in the plasterboard wall of the main downstairs toilet that created an infection trap and light pulls in toilets and bathrooms were ingrained with dirt. The area behind the washing machines in the laundry room was not clean. Part of the flooring was ripped, which meant it could not be cleaned effectively and created an infection trap. A red bag containing potentially infectious linen had been placed on the floor of the laundry, rather than in the laundry trolley provided. Waste bins in the laundry and the sluice rooms were not pedal-operated, as recommended by the guidance, but had swing tops which were not hygienic.

The main bathroom that was used to bathe people was not clean. The floor was dirty. The top edge of the bath had been deeply scored by the bath hoist which caught on it when used. There were dark stains on the base of the bath from contact with the bath hoist, the frame of which was rusty. The seat of the bath hoist was also cracked and dirty. Two first aid boxes which were stored on a shelf in the bathroom were very dirty, covered in dust and contained dressings with a 'use by' date of 2006. The bathroom was not a pleasant or hygienic environment for people to bathe in.

The continued failure to maintain a clean, hygienic environment in order to prevent and control the risk and spread of infection was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The most recent inspection of the home's kitchens by officers from the local authority's Environmental Health Unit, in October 2015, identified serious concerns with food hygiene arrangements. They awarded a rating of one star out of a maximum of five stars. The registered manager told us they had made the necessary improvements and were waiting for a re-assessment of their arrangements by the local authority.

The provider had a suitable infection control policy in place; they had conducted infection control risk

assessments and an annual statement of infection control. This detailed outbreaks of infection, staff training and audits of infection control that had been completed. Staff had received training in infection control and completed cleaning check sheets stating that cleaning had been undertaken in accordance with cleaning schedules, although this had not been effective in maintaining a clean and hygienic environment. Personal protective equipment (PPE) was available in key places around the home and we saw staff using it appropriately.

When asked if they felt safe, one person said "safe? Yes for sure". Another person responded to the same question by saying, "Yes I feel safe, they always check on us at night". Visitors also said they felt their relatives were safe. One visitor said of the staff, "They always tell us what has happened and call us if there are any problems". People appeared relaxed around care staff.

Staff had received training in safeguarding adults. They knew how to identify and report abuse, and how to contact external organisations for support if needed. The registered manager was aware of what action they should take if they had any concerns or if concerns were passed to them. They had reported some incidents to the local safeguarding authority in accordance with multi-agency protocols. However, staff from the local safeguarding authority told us they did not have confidence in the provider's procedures and their ability to conduct thorough and prompt investigations. In a letter to the provider, in March 2016, they expressed concerns about the length of time taken to resolve allegations of abuse relating to a person who had lived at the home, which they subsequently found to be 'substantiated'. They also identified a further incident that had not been reported to them as required. We discussed this with the registered manager who told us they disagreed with the authority's findings.

Medicines were not always stored safely in line with manufactures' guidance. The home had a special medicines fridge in which to store prescribed medicines that needed to be kept at low temperatures. Staff monitored the temperature of the fridge, but had not taken action when the temperature had fallen below zero degrees Celsius. Temperatures below two degrees Celsius can change the nature of medicines and reduce their effectiveness. Staff were unaware of safe storage temperatures; the provider's medicines policy did not provide guidance about this or action staff should take if temperatures were found to be outside a safe range. We raised this with the registered manager, who took action to make staff aware of the correct operating temperature for the fridge.

People were supported to receive their medicines when needed. All medicines were stored securely and appropriate arrangements were in place for obtaining, recording, administering and disposing of prescribed medicines. For most 'as required' medicines there were individual guidelines for staff about when these should be administered.

We heard staff asking people if they had any pain before administering 'as required' medicines. People who could verbalise their need for pain relief said they could ask for, and get, medicines such as a paracetamol for a headache if required. This was confirmed by a visitor who said their relative had been given paracetamol at night for a headache. However, the pain assessment tool being used for people who were unable to verbalise their need for pain relief was not suitable for people living with dementia. We discussed this with the registered manager, who showed us an alternative assessment tool that was more appropriate and which they said they would implement.

There were effective processes for the ordering of medicines and checking these into the home to ensure the medicines provided for people were correct. There was a weekly audit of all boxed medicines which helped ensure medicines were always in stock. A system was in place to enable urgent supplies of medicines to be obtained when the local pharmacy was closed. A weekly medicines audit was also completed to identify any

discrepancies in the number of medicines held. A full medicines audit was also completed monthly. The format of the audit was comprehensive and covered all areas of medicines management but had not identified concerns with the temperature of the medicines fridge. When administering medicines, staff checked the previous records to ensure these had been completed correctly.

Medicines were administered by staff who had undertaken relevant training and been assessed as competent to administer medicines. We observed staff administered medicines competently; they explained what the medicines were for and did not hurry people. The staff member administering medicines noted a person was having trouble swallowing tablets and was heard to say, "[Person's name], I'll ask the doctor for liquid, would you rather have liquid [than a tablet]?" However, the staff member administering medicines was frequently interrupted which placed them at risk of making errors.

The management of pressure injuries had improved. The risk of people developing these had been assessed and measures put in place to reduce the risk. These included the use of special pressure-relieving mattresses for some people. However, we found two of these were not set correctly, according to the person's weight, so may not have worked effectively. The registered manager told us staff should check the settings daily, but this was not easy for staff to do as information about people's weights was not accessible to staff when they were in people's bedrooms. The registered manager said they would explore ways for staff to monitor the settings more effectively.

Other individual risks to people were managed effectively. For example, people were supported to move safely. When using equipment, such as hoists, staff worked in pairs, checked people were ready to move, reminded them to lift their feet up and talked to the person throughout the process to reassure them. Staff checked the temperature of bath water before supporting people to use it.

There were arrangements in place to keep people safe in an emergency; staff understood these and knew where to access the information. A fire safety risk assessment was in place; fire safety equipment was checked regularly and staff had been trained to administer first aid. Personal evacuation plans were available for all people; they included details of the support each person would need if they had to be evacuated and were kept in an accessible place.

People and relatives felt there were sufficient staff to meet their needs. When asked if they felt there were enough staff, one person said, "Yes, there is always someone about." Another person said that staff came promptly when they used their call bell. The provider used a dependency tool to calculate the number of staff required. This considered the complexity of people's needs and the experience of staff. Whilst there were sufficient staff to meet people's needs, we noted there were only four staff trained to administer medicines. Staff were available for each medicine round, but there were times when no trained staff member was available to administer 'as required' medicines, such as paracetamol in between medicine rounds, including at night. The deputy care manager told us they lived nearby and could be called in to administer additional medicines if needed. The registered manager said they were recruiting two new senior care staff members to make staffing arrangements more robust.

Clear recruitment procedures were in place to help ensure staff were suitable to work at the home. These included reference checks from previous employers and a criminal record check with the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions. Staff confirmed this process was followed before they started working at the home. One new staff member had had an initial DBS check and was waiting for the full check to be completed. Suitable arrangements were in place for them to be supervised at all times in the interim, whenever they had contact with people.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, on 11 and 17 August 2015, we identified the provider was not following the principles of the Mental Capacity Act 2005 (MCA). At this inspection we found improvements had not been made and people's rights continued to be compromised.

The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. Some of the people using the service had cognitive impairment. The provider used MCA assessment forms to identify which decisions the person was able to make. The MCA is clear that mental capacity assessments should be decision specific. However the structure of the form, which involved a tick box approach to a range of 12 issues, was not decision specific, which meant people's capacity may not have been assessed correctly.

Where people were assessed as unable to make one of the decisions listed on the form, best interest decisions were not always recorded. Where decisions had been made on behalf of people, there was no record to show that family members or professionals had been consulted. These included decisions relating to the use of bed rails; the administration of medicines and the delivery of personal care. The decisions made did not show that less restrictive options had been considered, for example by lowering the person's bed rather than using bed rails to keep them safe. One person had been assessed as able to make food choices with support. However, this contradicted their care plan which instructed staff to make best interest decisions about menu choices on behalf of the person. The MCA was therefore not being followed and people's rights continued to be compromised.

The continued failure to follow the Mental Capacity Act, 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people had capacity to make decisions, we saw they had signed consent forms indicating their agreement to the care and support they were receiving. The staff told us they had received training in the MCA through a commercial company and via on line training and understood the need to seek consent from people before providing care and support. A family member told us, "If [my relative] won't agree to something, they leave them and try again later. They'd never force them to do anything they didn't want to do." A member of the care staff confirmed this and said "We have all had training in mental capacity and we know it's all about them making their own decisions for as long as they are mentally able to; so, they might be able to choose what to wear but not to agree to having bed rails or looking after their money".

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The provider had appropriate policies and procedures in place in relation to DoLS. A DoLS authorisation was in place for one person and applications had been made for nine

other people. Staff knew about this and the support people needed as a consequence.

People were seen regularly by doctors, nurses, dentists, and chiropodists, but were not always supported to access healthcare services when needed. One person had fallen and hurt their arm in November 2015. Staff called a doctor to examine the person, who concluded there was 'no fracture seen'. In March 2016, staff noticed the person's arm was still swollen and a doctor was asked to visit again; however, on arrival they did not examine the person's arm because the person had 'a funny turn'. Staff did not make any further requests for a doctor to re-visit. During our inspection, four weeks after the visit, the person had still not been re-seen by a doctor and their relative told us the person's arm was "still really swollen". We brought this to the attention of the registered manager who said they would make another request for the doctor to visit.

The registered manager told us relations with the community nursing team had improved since our last inspection and they were recording the outcome of nurses' visits on a new form to help improve communication.

People told us the quality of the food had improved. A new chef had been employed who was in the process of reviewing the menus, which they said needed to be more "balanced". One person said "The food is all good, we get a choice and tea and coffee as well". Another person said "The meals have improved 100%." They told us the chef usually came round and asked everyone what they wanted from two menu options. Staff did not use visual prompts to help people choose their meals, such as pictures of the meals or by showing people the options at the point of service, although the registered manager said the chef had access to pictures and should use them. The times meals were served was displayed in a large notice, although the menu was not on display. The tables in the dining room were laid for lunch at 11:00am which might have been confusing for people living with dementia.

At our previous inspection we noted that people were only offered water to drink with their meals; at this inspection we saw all but one person were given orange squash with their meals but none was offered a choice of drinks. People were given appropriate support to eat. For example, at breakfast staff noted that one person was not eating, so sat with them to prompt and encourage them to eat. Staff had ceased recording the amount people ate and drank as they said no one was at high risk of malnutrition or dehydration.

When asked about special diets, the chef said one person was on a soft diet and one person was on a low fat diet. They were unaware that one person was diabetic or that another person was receiving medicines that were affected by certain foods and drinks. They showed us food preference lists for these people, which did not mention their special dietary needs. We raised this with the registered manager who agreed to address it.

Some bedrooms had been personalised with items and pictures important to the person. Most bedroom doors had signs of the person's name and bathroom doors had large signs to help people find them. Age appropriate music and TV channels were being shown. However, the décor of the home did not support people living with dementia to be able to navigate their way around the building. All corridors, doors and door frames were painted in similar colours. This made it difficult for some people to find and distinguish their rooms easily and we heard people asking the way to their rooms or to the bathroom.

Our previous inspection identified that people were not cared for by staff who were suitably supported in their role. At this inspection staff felt they received appropriate support and guidance. New staff received induction training, which followed the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. They worked

alongside a more experienced member of staff until they had been assessed as competent to work unsupervised. A relatively new carer told us "I had one or two week's induction when I worked with another carer. While I am very experienced as a carer, every home has its differences to get used to." We viewed a care certificate workbook for a new member of care staff and saw it was comprehensive, relevant to the care and support people required and had been completed to a high standard. It provided the staff member with the necessary knowledge to enable them to care for people effectively.

People and family members were satisfied with the ability of staff to meet people's needs. One family member said, "Things have improved, they've got pretty good staff there now and the atmosphere seems calmer." Care staff felt they were well-trained. One staff member told us about the "lengthy training" they had received. In addition they said, "I think I have had everything going, but when I have asked to do other things, [the registered manager] is really supportive and encouraging; it's really good for training here." Another staff member said, "We have all the mandatory training and even had a company from the mainland to train us to do care plans that was good". Staff training was refreshed regularly and staff were also supported to gain vocational qualifications in health and social care. Most staff demonstrated an ability to put the training into practice. They communicated effectively with people and understood most people's care needs.

Staff felt supported by management and received a range of supervisions. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. One staff member said, "I think we get good support here and [the managers] make sure of that. If we need any advice or support we get it."

Requires Improvement

Is the service caring?

Our findings

At our last inspection, on 11 and 17 August 2015, we identified that people were not always treated with consideration. At this inspection we found most staff treated people well. However, one staff member did not treat people with dignity, respect or consideration.

At 11:50am staff began assisting people through to the dining room for lunch. When a staff member was taking a person into the dining room, another staff member shouted across the room "She has to go to the toilet, it would break her routine." This was clearly heard by everyone in the room. Once seated in the dining room, people had to wait until 12.30pm for their meal to be served. Towards the end of this time people started shouting for their food. We heard comments like "When's it coming?" and "Why don't they hurry up?" The staff member responded by saying, "Don't keep shouting [person's name], the cook will bring it in when it's ready". Another person began moving their crockery and place mat around and was asked abruptly by the staff member, "What are you doing [person's name]; take your hands away". The staff member then scolded a person for trying to support another person at their table. The interaction had a negative impact on the person, who folded their arms and looked straight ahead in silence.

During an activity during the afternoon, a person asked, "Will someone get me out of here?" The staff member responded by saying, "No you have got to stay, we are playing Bingo now". This was repeated three times and while the person remained seated they did not join in with the activity. Another person also asked to leave the room and was told, "Stop pushing your chair back or you will fall and crack your head". This was said in an abrupt manner and was repeated several times. A further person repeatedly asked the staff member questions. This seemed to be a source of irritation, so they asked another member of staff to "take her in the other room she keeps interrupting". The person heard this, as did other people in the dining area and the adjoining sitting room.

The failure by the provider to ensure that staff treated people with consideration, dignity and respect at all times was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other staff interacted positively with people. One person said of the staff, "They are all very good to us, very friendly." Another person told us staff were "very nice, very friendly". A family member described the atmosphere at the home as "calm, relaxed and loving and said their relative had been "cared for and loved".

One person became anxious whenever staff left them and we saw staff responded to them in a kind and patient way. When medicines were being given, staff checked people were happy to receive them and explained what they were for. One person had fallen deeply asleep in a chair. When two staff members came to wake them for lunch, they were gentle and kind in a way that ensured the person was not startled. The person struggled to get up, but the staff members remained patient; they did not rush the person and gave supportive advice about how to stand safely.

Staff protected people's privacy and dignity when supporting them to move. For example, they used

blankets to cover people's legs when using the hoist, in case their clothing rode up. Prior to supporting a person to eat, the staff member showed respect by introducing themselves to the person. When attending people's rooms, staff knocked, waited for a response, and introduced themselves before entering, usually asking "Is it OK if I come in?" Confidential care records were kept securely and only accessed by staff authorised to view them. Most staff spoke quietly to people when offering to support them to use the bathroom before or after meals.

Staff supported people to form positive caring relationships. Written feedback from a family member included: "]My relative] was not able to communicate in her last weeks; thank you so much for spending the time to find out special ways that she could do so." Two people had formed close relationships while living in the home. Staff were aware of this and made arrangements for them to sit together at meal times. People were also supported to follow their faith. A minister of religion visited the home to administer Holy Communion to one person and another attended a local church weekly.

When people moved to the home, they (and their families where appropriate) were involved in assessing, planning and agreeing the care and support they received. Reviews of care plans included details of family members who had been consulted in addition to the person. Family members said they were always kept up to date with any changes to the health of their relatives.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, on 11 and 17 August 2015, we identified that appropriate strategies were not always used to support people when they became anxious; some care plans lacked key information; and activity provision was not always suited to people with cognitive impairment. At this inspection, we found care planning processes had improved but activity provision had not.

One person told us, "We played hangman yesterday and have bingo today. Otherwise there is not always much to do." Another person confirmed this and said, "I just sit here and mumble and grumble; there is no one to talk to." Although there were references to people's interests and preferred activities in their care plans, this had not led to specific activities being organised to meet people's interests. Activity provision was limited to nine hours per week when the activity coordinator was working, so did not meet the needs of all the people on a regular basis. The registered manager told us care staff should run activities when the activity coordinator was not working. However, these were not recorded and staff said they had little time available to do this.

A game of bingo was held in the afternoon. Whilst some people engaged with this, others did not enjoy it and asked to leave. The staff member running the session had their back to some people, two of whom did not engage in the activity. They seemed unaware that the activity was not meeting everyone's needs and did not change their approach or the activity itself when this became evident.

We observed a positive reminiscence interaction between a staff member and three people which lasted for about five minutes. Staff had supported another person to use a laptop computer, which the person told us they used to play card games. However, for most of the time people sat in their lounge chairs watching the television or sleeping.

A form was used to record activities people had undertaken, but this was not accurate. For example, the form for the day of our inspection showed everyone had taken part in the bingo, when only six people had. Forms for other days also showed everyone had taken part in every activity, which the registered managed accepted was not correct. The provider was unable to demonstrate that people's social and activity needs were being met.

People were not always given appropriate support when they became anxious or agitated.
One person had a 'behaviour care plan' in place. This included specialist advice about the support the person needed when they became agitated or upset. However, care records showed this advice was not followed on two occasions in March 2016 when they had become anxious. Instead, staff had responded by administering sedatives.

The provider's policy required staff to use 'behaviour charts' to record people's behaviour when sedatives needed to be given. These were designed to help staff identify triggers that caused people to become agitated and the effectiveness of staff responses. However, when completed, the behaviour charts did not always contain information about the time the incident occurred or the possible triggers. This meant staff

were not able to identify patterns and adapt their approach to support the person more effectively.

One person had been assessed as living with 'severe dementia' and we observed them acting in an aggressive way towards a visiting relative, who they hit twice. Staff had not recorded these incidents in the person's care records or behaviour chart, and had not considered appropriate strategies to support the person when they acted in this way.

Care records for this person also showed they were frequently incontinent at night. When we visited their room, we found it smelt strongly of urine. However, they had not been referred to a continence specialist for assessment or advice. Senior staff told us this was because the person "won't wear [continence] pads". This pre-judged the outcome of the assessment and meant healthcare professionals were not able to investigate potential causes of the person's incontinence or appropriate support. Comments in the handover book repeatedly mention the need for the person to be offered a bath following incidents of incontinence. However, bathing records showed they had not received one. A senior staff member told us, "I tried to once and got punched [by the person]." A close friend of the person confirmed the person was not supported to bathe as staff were "not able to manage [the person]", but said staff encouraged them to receive a body wash whenever possible. The person's continence needs were not being supported appropriately.

The failure to ensure people's needs were met in a personalised way was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other people said they received personalised care from staff who understood and met their needs. Care plans contained detailed information about people's needs and how they wished to receive care and support. This included the GP 'encounter sheets' which provided a complete record of the person's health needs. The plans were updated on a monthly basis, or sooner if people's needs changed. In addition, a full review of the person's care and support needs was conducted every six months. Family members were invited to these reviews and we saw their comments and views were recorded.

A senior staff member told us they were planning to create a 'dementia corner' in the lounge, with a café theme where appropriate activities could be run. They had also joined a networking organisation that provided information about creating suitable activities and environments for people living with dementia. This had led to them providing dolls for people to interact with, which a family member told us had "worked well and given people something to concentrate on".

Most staff supported people to make day to day choices. For example, people told us they could choose when they got up, when they went to bed, what they ate and where they spent their day. One person said, "I get up at about 8.15 and have breakfast in my room then come downstairs." Staff used a 'handover book' to pass on important information about people between shifts. This was used to alert other staff to changes in people's needs and confirmed that people had chosen to go to bed late or get up later than usual. However, one staff member did not give a person any choice about where they had their lunch. When asked to go through to the dining room they asked, "Can't I have [my meal] here?" The staff member replied, "No; we will take you through." The person challenged this and asked, "Must I go?", to which the staff member responded, "Well if you don't eat you will be very hungry by tea time".

When we spoke with staff, they demonstrated a good awareness of most people's individual support needs and how they preferred to receive care and support. For example, they knew how often people liked to bathe, what support they needed to wash and dress; they knew what medicines people were taking, why they were taking them and how they liked to receive them. One person had had difficulties managing their finances, so staff had supported them to attend an appointment at their bank; they had also worked with

the person's social worker to try and resolve the issues. Another person was less anxious and restless than they were at our last inspection. Staff had supported them to regain their mobility; they were engaging well with the staff and appeared contented.

The service had an appropriate complaints policy in place, which was advertised in the reception area of the home. Records showed no formal complaints had been received since the last inspection. The registered manager told us they resolved all minor concerns as and when they arose. People and visitors knew how to make a complaint and said they would talk to a senior staff member.

The provider sought and acted on feedback from people during occasional 'residents meetings' and through the use of questionnaire surveys. The latest survey was completed in January 2016 and showed most people were satisfied with the service provided. A family member had requested more opportunities for relatives to interact with staff. To meet this, the registered manager told us they were planning a social evening for all family members to attend.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, on 11 and 17 August 2015, we identified that the culture of the service was not supportive of staff; staff were not organised; and quality assurance systems were not effective. We took enforcement action and imposed a condition on the provider's registration to prevent them from admitting new service users without prior written permission from CQC. At this inspection we found some improvements had been made, but identified continuing breaches of regulations relating to infection control and the need for consent. We also identified an additional breach of regulation relating to treating people with dignity and respect. The provider's quality assurance systems had, therefore, not been effective.

The provider operated a comprehensive quality assurance system which included a range of high level audits which focused on checking that appropriate systems were in place rather than how effective the systems were in practice. For example, the infection control audit had not picked up the cleanliness concerns or the strong smell of urine in some rooms. The only question on the audit tool relating to people's rooms asked whether they were visibly clean, not whether any malodours were present. The audit confirmed that cleaning check sheets had been completed, but did not assess whether the cleaning had been completed to a suitable standard. It had therefore not been effective. Other audits included medicines, the environment and care plans. The medicines audit comprised daily, weekly and monthly checks and had been effective in ensuring medicines were administered safely. However, it had not identified that the temperature of the medicines fridge had exceeded safe limits. The audit of care plans confirmed that monthly and six monthly reviews of people's care had been completed, but did not assess whether the individual reviews had been completed effectively. For example, the audit had not identified that a person needed to be referred to the continence service or that the Mental Capacity Act was not being followed.

The continued failure to operate effective systems and processes to ensure compliance with regulations was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had mixed views about how well the home was run. One person felt the home was "not run very well" as they often had to wait for staff support at mealtimes and said they rarely saw the registered manager. Other people were more complimentary about the leadership of the service. One person said the managers were "all very good". A family member said the provider had a "great team". Visitors were positive about the home and said they were confident if they raised concerns with managers they would be "sorted out".

The provider's PIR confirmed there was still a high turnover of staff at the home. It stated that 19 members of staff were employed; 20 members of staff had left the service in the previous year and nine new staff members had been employed. Although this is partly explained by a reduction in the number of people living at the home, and therefore the need for fewer staff, it still represented a high turnover. This meant people were not cared for by a stable staff team who could build long-term relationships with them. The registered manager told us recruiting high quality staff was "the biggest challenge". They said a senior staff member had just left without notice, but they were in the process of recruiting a second deputy care manager to enhance the leadership of the service.

Staff described the management as "supportive". One staff member said, "[The registered manager] is great; she is very supportive and helpful. One of the managers is always around so there is always someone to talk to about any issues we need to." Another staff member told us, "I think they are good managers and it is a well led home". Staff meetings and management team meetings were held regularly. The registered manager used the meetings to seek feedback from staff and suggestions for improvement. They were members of the national and local residential homes associations, which hold meetings and circulate information about current best practice in the sector. These links also helped them keep up to date with developments in the sector.

The home had a calmer and more relaxed atmosphere than at our last inspection. With the exception of mealtimes, which were disorganised, staff worked well together and understood their roles. A staff member told us, "We all get on really well here, it is a good home, so that if one of us needs some help they get it from the others and they know when they need some help they will get it too, so it's a good team. I have worked here for three years and the team now is the best ever and really want to be here and look after the residents".

The provider notified CQC of all significant events and the previous CQC inspection rating was displayed prominently in the reception area. Relatives could visit at any time and were made welcome. There was a duty of candour policy in place which required staff to be open with people and relatives when accidents occurred; relatives told us they were informed about any incidents promptly.

The registered manager had a clear set of values for the service. These were that "each member of staff should think the service is good enough for their own mother and they should treat residents how they would like to be treated themselves". They said they spent time observing care being delivered and "stressing the need to treat people with dignity and respect". However, these values were not understood and demonstrated by all staff. We brought this to the attention of the registered manager who undertook to continue promoting and communicating them to staff.

The registered manager told us of plans to improve and develop the service. They had worked with a social care specialist to identify and implement improvements and had engaged with the Clinical Commissioning Group (CCG) to help improve working practices. They were aware that some refurbishments were needed to the premises, such as new carpets in some rooms. However, they said they could not afford to do this until the number of people being accommodated, and therefore their budget, increased.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that the needs of all service users were being met in an appropriate way that met their needs and reflected their preferences. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure that all staff treated service users with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that care and treatment of service users was only provided with the consent of the relevant person. Regulation 11(1)(2)&(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to sure that care and treatment was provided in a safe way to service users by assessing the risk of, and preventing, detecting and controlling the spread of infections. Regulation 12(1)&12(2)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure that systems and processes were established and operated effectively to ensure compliance with the regulations. Regulation 17(1) and 17(2).