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Salisbury Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 9 and 12 April 2018 and was unannounced.

At our last inspection in August 2017, we found the provider to be in continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regulations in relation to person centred care, governance and safe care and treatment. Following the inspection, we took enforcement action and placed conditions on the registered provider's registration to submit monthly reports to us setting out how they would assess, monitor and take action to improve the quality and safety of the care and support provided to people living at Salisbury residential home. We also met with the provider to discuss what they would do to improve the key questions to at least good.

Salisbury Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Salisbury residential home accommodates 31 people in one adapted building. At the time of this inspection there were 27 people living in the service.

There was not a registered manager in post. 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. One of the partners in the provider partnership had applied to become the registered manager, but this had not yet been completed. There was an acting manager in post, who came to the service in November 2017 to support the service with on-going improvements.

At this inspection on 9 and 12 April 2018, we found continued breaches of regulation in relation to safe care and treatment, governance, and person centred care. We also found new breaches of regulations in relation to nutrition and hydration and staffing.

Risk assessments in relation to moving and handling were not always accurate, and did not contain relevant information to support staff to move people safely. Behavioural risks assessments were not sufficiently detailed to ensure staff had guidance on what action to take when people were distressed. There were no risk assessments in relation to choking or the use of bed rails. We found that some improvements had been made in relation to the monitoring of risk in relation to people's weights, their risk of developing pressure ulcers, and monitoring of falls.

Quality monitoring systems and audits had failed to identify the shortfalls we found during this inspection. Whilst there were quality assurance mechanisms in place, these had proved ineffective at identifying areas for improvement, and not all aspects of the service were being effectively monitored. This placed people at risk of harm.

People's health and safety were at risk because the provider had failed to identify where safety was being compromised in relation to environmental risks. Alterations made to the passenger lift had not been risk assessed or checked by a competent person to ensure they were safe. There were exposed hot water pipes in people's rooms and communal toilets within the service which posed a risk of burns if people were to touch or fall against them. We found two stand aid slings which were available for use, but were not safe to use due to wear and tear. The provider, acting manager and care staff did not always recognise risks in the environment, such as items which could cause potential harm.

The provider was using a dependency tool to identify the number of staff required according to people's needs. However, this had been ineffective in identifying the number of staff required to meet peoples social, emotional and physical needs. The provider had accepted a high number of new admissions in February 2018, which did not demonstrate a responsible approach to ensuring new admissions were carefully considered in line with on-going improvements the service was required to make.

Staff received training relevant to their role, however, refresher training was overdue in some areas for several staff. Competency checks on staff performance were not being routinely carried out to ensure staff were applying their learning effectively; the acting manager told us they had begun this process with two staff members.

People's capacity to make decisions was assessed and Deprivation of Liberty Safeguards (DoLS) applications had been made where appropriate. However, some mental capacity assessments did not always reflect what the decision being made was, and why a test of capacity was needed.

People received their medicines safely, however, improvements were required in some areas to ensure documentation was accurate, and staff had up to date information about people's medicines. There were areas of the service where external medicines were not secured. The service had not considered the risks around the potential for people accessing them and placing themselves at risk of accidental harm.

The provider needed to consider more fully how to maximise the suitability of the premises for the benefit of people living with dementia, and we have made a recommendation about this.

The provision of activity was improving, but was still not meeting individual and specialist needs. The activity co-ordinator had ideas on how to progress the current programme in place.

The service needed to develop their practice in supporting people in relation to their end of life care. Care plans made reference to people's end of life wishes, but some contained only minimal information. The service did not follow best practice guidance to create care plans that set out people's wishes and needs in sufficient detail.

Food and fluid charts were not always completed fully or totalled to ensure people were receiving adequate nutrition and hydration. The dining experience was not conducive to an enjoyable mealtime and opportunity for social interactions, and we have made a recommendation about improving the dining experience for people.

Appropriate recruitment checks had been carried out on new staff, to ensure they were of good character and suitable to work with people in the service. This included obtaining references and ensuring DBS (disclosure and barring checks) were carried out.

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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Not all risks were identified in relation to people's health and safety.

Risks in relation to people's care were not always accurate or sufficiently detailed.

Due to the complex and unpredictable needs of people living in the service, staffing levels were not always adequate.

Systems were in place to manage people's medicines safely. However, some improvements were needed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Deprivation of Liberty Safeguards had been applied for when people who lacked capacity to consent, had their liberty restricted. The service was following the principles of the Mental Capacity Act 2005.

Staff were trained in subjects relevant to the people they were caring for. However, some staff were overdue refresher sessions.

People were supported to maintain good health and had access to healthcare support in a timely manner.

People told us the food was satisfactory and that they had a choice but people's nutritional information was not always recorded accurately.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Due to some of the wider failings within the service people did not always benefit from a caring culture.

People's privacy and dignity was not always considered.

Staff were observed to be kind and caring in their interactions with people.

Relatives and visitors could visit at any time and there were no restrictions.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Some areas of people's care had not been properly assessed or included within their care plans.

People's preferences with regards to how they would like to be cared for at the end of their life were not always sufficiently detailed.

There was a complaints process in place.

Is the service well-led?

Inadequate

The service was not well-led.

The service had been rated 'Requires Improvement' at three consecutive Inspections.

The governance systems in place were ineffective in identifying and addressing the concerns we had about the service.

The provider has consistently failed to take effective action to mitigate the risk of harm.

The provider had failed to adhere to their regulatory responsibilities and ensure compliance with the fundamental standards and regulations.

Salisbury 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9 and 12 April 2018 and was unannounced. The inspection team consisted of three inspectors (one of whom specialised in medicines), and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of our inspection planning we reviewed all the information we held about the service. This included previous inspection reports and any notifications sent to us by the service including safeguarding incidents or serious injuries. This helped us determine if there were any particular areas to look at during the inspection. We spoke with the local authority safeguarding team prior to the inspection.

At the time of inspection there were 28 people living at the service. To help us assess how people's care needs were being met we reviewed six people's care records and other information, including risk assessments and medicines records. We reviewed three staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

During the inspection we spoke with four people who lived at the service, four relatives, two health professionals, the acting manager, deputy manager, care co-ordinator, and four members of care and catering staff.

Inadequate

Is the service safe?

Our findings

At our last inspection on 16 and 17 August 2017, we found that risks were not always managed safely. We rated this key question as 'Requires Improvement', and found the provider to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection of 9 and 12 April 2018, we found that people were still at risk of harm due to environmental risks. We also found that not all risks in relation to people's care had been assessed fully, and in some cases were inaccurate. This meant that the provider remained in breach of Regulation 12, and we have rated this key question as 'Inadequate'.

The risks of scalding/burns from the un-protected hot water pipes to people using the service was identified during the last inspection in August 2017, however, action had not been taken to protect people. We found un-protected hot water pipes in communal bathrooms and in some people's rooms, which could present a serious risk of scolding and/or burns, in particular those at risk of falls because they could fall against them.

The deputy manager had notified us that the lift had broken down on 25 March 2018. When we inspected the service on 9 and 12 April 2018, we found the lift doors had been removed, and access to the lift shaft had not been secured safely. On the ground floor, panels of wood (which were splintered on the edges) had been fixed to the wall. People could have crawled between or over this and into the lift shaft. Upstairs, we found a panel of wood had been secured to the wall half way up, which meant people could have climbed over this. Furthermore, where the service had temporarily removed the doors to the passenger lift, there was not an associated risk assessment. They had also not consulted with the fire service as to the potential adverse impact this alteration might have in the event of a fire. We were so concerned about people's safety that we asked the acting manager to take immediate action to ensure this was made safe during our inspection.

We found some wardrobes in people's rooms were not secured to the walls, which posed an accident and injury risk. We asked the acting manager to take action to secure the wardrobes and to check all wardrobes in the service to ensure they were secured to the wall.

During our last inspection in August 2017, we found that there were no risk assessments in place for people at risk of choking. At this inspection we found the provider had not taken action to ensure these were implemented. There were eight people at risk of choking. The provider had failed to identify and act on this risk to ensure the safety of people.

Three people were using bed rails. There were no risk assessments in relation to the risks associated with the use of bed rails, such as entrapment or injury.

At our last inspection in August 2017, we found that some people experienced behaviours which could challenge staff and other people living in the service. For these people there were no risk assessments in place to guide staff in how to reduce the risk. At this inspection, we found that although more detail had been added into people's care plans, risk assessments in relation to behavioural risks were still not

sufficiently detailed. For example, one person was known to experience low moods, and could be physically and verbally abusive to staff. Their risk assessment did not contain strategies staff should use when they became aggressive to support them. There was no detail around which professionals or agencies should be contacted to support them in these situations. Another person's care plan and risk assessment did not provide information on particular behaviours they presented with, which put staff and others at risk of harm.

People had risk assessments in place to help staff support people with their mobility, however, we found these were not always updated with accurate information. For example, we observed that one person was being transferred with the use of a hoist. Their care plan said that they were able to walk and did not use any aids. Their care plan had not been updated to include the use of a hoist. Another person's care plan stated that they were able to walk a few steps using a walking frame, but needed care staff to support them. Staff members told us that the person was currently being hoisted as their mobility had declined. This had been the case for one week, but records had not been updated to reflect the change. Additionally where hoists were being used to move people, the colour of sling loops were not always stated, which is important to aid correct positioning.

We found two stand aid hoist slings on the ground floor which were available for staff to use. We found them to have worn velcro and frayed loops which would indicate they were unsafe to use. A staff member was responsible for checking the condition of these slings. They had checked the two slings on 25 March 2018, and found them to be in 'Good' condition. We were told by the health and safety lead in the service that all slings had been serviced by an accredited LOLER (Lifting Operations and Lifting Equipment Regulations) company. However, they could not source the documentation to evidence this, and told us they would arrange to have this done as a priority.

Information about people's diabetes and how this should be managed was not available to staff to inform them of what monitoring was required. Where reference was made to people having diabetes, there was no information on what their target blood sugar levels should be, what action they should take if they became too high or low, or the associated symptoms of this. One person's care plan said they needed weekly blood sugar readings but we were informed this was stopped over two weeks ago.

At our last inspection in August 2017, we found that some people required their weight to be monitored on a weekly or fortnightly basis. However, we found this was not happening which meant the risks to these people was not being adequately managed. At this inspection we found that people's weight was regularly monitored in line with their assessed needs. However, where people had lost weight we noted that food charts were not always completed consistently or accurately to ensure effective monitoring of their intake.

For people at risk of developing pressure ulcers, screening tools were used to assess the level of risk, and were regularly updated. Pressure relieving equipment, such as cushions and mattresses, were provided where necessary to reduce the risk of developing pressure ulcers.

We saw there were systems in place to assess and ensure the safety of the service in areas such as fire and legionella. There were personal evacuation plans (PEEPs) in place detailing how each person would need to be supported in the event of an emergency. However, we found some were confusing. For example, one PEEP's said the person used a hoist and/or a standing hoist. We spoke to the acting manager about making sure these were accurate and more detailed.

We found that larger pieces of equipment, such as hoists had been serviced and checked so they were fit for purpose and safe to use.

Records showed people received their medicines as prescribed. However, information about people's known allergies and medicine sensitivities in notes and on medicine charts was sometimes inconsistent which could have led to error particularly when new medicines were prescribed. The provider told us that they had informed the pharmacy (who prepare the medicine administration records) of known allergies which should be added.

When people were prescribed medicines on a when-required basis, there was written information to assist staff to give people these medicines appropriately. However, for medicines prescribed to assist with people's psychological agitation there was insufficient detail about ways that staff could attempt to avoid having to give people these medicines. For people with more complex pain-relief strategies, written information was not clear about the use of more than one pain-relief medicine prescribed on this basis. For medicines prescribed for external use such as creams and ointments, there was sometimes insufficient written information or body charts to show staff where on the person's body they should be applied.

For people with limited mental capacity to make decisions about their care and who would refuse their medicines, the service had consulted with professionals about how to give people their medicines crushed and hidden in food or drink (covertly). However, we noted that when changes were made to medicines or new medicines were prescribed, the guidance had not been reviewed and updated specifically for these medicines.

We noted that some equipment used in the area medicines were prepared was unclean and without due consideration for hygiene. There were areas of the home where external medicines were not secured. For example, creams stored on top of people's wardrobes. The service had not considered the risks around the potential for people accessing them and placing themselves at risk of accidental harm.

At the last inspection in August 2017, we observed that at times, if people became agitated that staff had to remain with people constantly to ensure their safety. This temporarily impacted on staffing availability. We found during this inspection that this was still the case.

We received mixed feedback from people in relation to the staffing levels in the service. One person told us, "Occasionally there are problems with there being enough staff, such as when things are hectic. If I need help in the lounge, quite often no one is around and I have to shout for help as there is no buzzer nearby. I don't know how those with dementia manage." Another said, "Nine times out of ten they get to me quite soon after I ring my bell." A relative told us, "When the bell rings, they say they'll be back. Once I was here when they put [relative] on the commode and left them for an hour. [Relative] was in agony and I couldn't leave. They [staff] did apologise."

Staff were seen to be available in the communal areas for the majority of the day, however, we did not consider that the complexity of people's needs had been fully considered, nor the increased physical needs of people coming into the service. The acting manager told us that there were four members of care staff and one head of shift on each afternoon shift. The head of shift was responsible for administering the medicines. The acting manager said there were six people using the service who required the assistance of two care staff to mobilise or for personal care. This meant that if two people required support at any one time there would be no care staff available to provide support to anyone else using the service, unless the head of shift stopped administering the medicines.

Some people were living with advanced dementia which meant that at times they required more support from staff. For example, we observed one person continually walking around the service. At one point they kept standing in front of the television which irritated those who were trying to watch a film. They then

knocked a glass of water over. No staff were present at the time and people were becoming more and more irritated by the person's presence. On another occasion we saw that one person was being supported by a carer to eat, but continually kept trying to stand up and was becoming angry and raised their fist. They were at high risk of falling so the staff member had to remain with them. Staff members told us, "Sometimes there are sufficient staff and we can answer call bells quickly, but when residents become upset and need more support there is not enough of us." Another said, "We have many more residents now whose needs are more complex, like hoisting, so takes more time."

We were informed that the provider had admitted eight people to the home in the month of February 2018. This did not demonstrate a responsible approach to ensuring new admissions were carefully considered in line with on-going improvements the service was required to make. The provider was using a dependency tool to identify the number of staff required according to people's needs. However, this had been ineffective in identifying the number of staff required to meet peoples social, emotional, and physical needs.

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

The service had not developed their practice sufficiently to ensure that lessons were learned and improvements made when things had gone wrong. Following our previous inspection in August 2017, the provider had not ensured that improvements we identified were addressed promptly, and were again in breach of regulations. This did not give us confidence that the provider was learning from and developing systems and processes which supported improvement.

Staff received safeguarding of adults training, however, the training matrix showed that nine staff were overdue refresher training in this area. Staff were however, able to explain what types of abuse they could come across and who they needed to contact with any concerns. One staff member said, "I have reported concerns to the head of shift. One person came in with bad bruising and I immediately reported it. I later found out they had fallen which caused the bruises, but I'm glad I raised it."

People we spoke with told us they felt safe living at the service. One person said, "I know I'm safe here because the carers are so kind. It's not the first home I've been in and this is better than the last." Another said, "I feel secure here because the staff are so good to me."

People were protected by procedures for the recruitment of new staff. Checks had been carried out with the Disclosure and Barring Service (DBS).

We found that the accommodation was clean and had a fresh atmosphere. Cleaning schedules were in place which gave details of which cleaning products should be used in different areas. Staff had access to personal protective equipment, for example, gloves and aprons.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in August 2017, we could not always be sure that relevant referrals had been made to other professionals, or were being followed, as documentation was not available to demonstrate this. This meant that there was a risk that people may not receive the care they require in a timely manner. This constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014, and we rated this key question as 'Requires Improvement'.

At this inspection we found that referrals to other professionals were being made in a timely manner, and a log was in place to show which professionals the person had seen. However, we found other areas of people's care documentation still required improvement which meant the service continued to be in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Assessments of people's needs were completed before they moved into the service. This was done to assess if the service could meet their needs, and so that the resulting care plans were able to reflect people's needs holistically. The issue was that people's records were not always accurate or sufficiently detailed.

We also had concerns that 8 new people were admitted in the month of February 2018, and were not assured that full consideration had been given to the complexity of new people coming in, alongside those who were already living in the service. This did not demonstrate a robust admission and risk assessment process.

Nutritional and hydration needs were not always recorded accurately or consistently. For example, one person was losing weight, and their care plan said they liked to eat little and often, and that food and fluid intake should be logged. The service had implemented a 'snacks list' whereby people who were losing weight were added to the list and offered more frequent snacks during the day. We found that this person had not been added to the list despite their weight loss. We checked their food charts to see if they were being offered extra snacks during the day and found that these were not being completed consistently by staff to show that mid-day, afternoon, and night snacks were being offered. The food charts showed that when offered a meal the person would eat very little of it, and therefore regular snacks were important to try and increase their calorie intake. Similarly, their fluid charts were not consistently completed to show that regular fluids were being offered. Fluid charts showed that some days the person had as little as 200 – 400mls of fluid. There was no detail about what action should be taken if their fluid intake was low, and it was not clear if this was being monitored.

Another person's records showed they had lost weight when they were last weighed. They were on the 'snack list' however, the food charts did not show that snacks were consistently being offered by staff throughout the day. Other areas of the food chart were just left blank, therefore it was not clear if the person was offered food by staff or if they had declined this.

This was a breach of Regulation 14 of the Health and Social Care Act (Regulated Activities) 2014.

We observed the lunchtime meal. We noted the tables were not laid, the tablecloths were old, and there were no centrepieces in place on any of the tables to make the environment a more pleasant one to eat in. The atmosphere in the dining room was muted and there was limited social interaction between people and staff. Seven people sat in the dining area. We observed on one table that people were only offered lemon juice. One person tried it and said, "There's no taste to it". One person asked for a milkshake, and the staff member brought back a chocolate one without asking the person first what flavour they preferred. One person said they didn't like their meal, and the staff member asked if they wanted the second option. They did not show the person the other meal option or make any attempt to offer the person something off of the menu. The person walked away from the table not having eaten any food.

The mealtime experience was practical and lacked atmosphere where people could socialise and enjoy this time. We discussed our findings with the acting manager, and on day two of our inspection we found the tables were laid with pretty table cloths and nautical themed centrepieces. However, this was in response to our feedback and the service had not identified independently that improvements were needed in the dining experience.

We recommend that the service explores current guidance from a reputable source (such as the Social Care Institute for Excellence) to ensure that mealtime experiences are an opportunity to support and promote independence, in addition to creating a positive mealtime experience, particularly for those with specialist needs including dementia.

Staff told us they received the training they needed to support people. One staff member said, "Ive had all my training, safeguarding, moving and handling and first aid. Some are overdue, but I think courses are planned by [acting manager]." One person told us, "The carers do know exactly what my needs are, which is good." Another said, "The carers are good in every way and they support me in pairs."

Staff received training in medicines, first aid, dementia, safeguarding adults, Mental Capacity Act 2005, infection control, and moving and assisting. However, we saw from the training matrix that several staff were overdue refresher training in areas such as prevention of pressure ulcers, first aid and health and safety. The matrix also showed that nine staff were overdue refresher training in safeguarding adults, six of whom were six months overdue. We saw that the acting manager had listed new training sessions for 2018 in some areas of training which were overdue, however this did not include safeguarding.

New staff were provided with an induction period when starting work at the service. A recently recruited member of staff told us the induction included some training (dementia, moving and assisting and first aid) and shadowing of more experienced staff. They were recently new to the caring profession and had not completed or been enrolled onto Care Certificate training. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It's made up of standards that should be covered if staff are 'new to care' and should form part of a robust induction programme.

It is expected that providers should follow the Care Certificate standards to make sure new staff are supported, skilled and assessed as competent to carry our their role.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff authorised to handle and give people their medicines had received training but some had not recently had their competence assessed to ensure they managed people's medicines safely. Following the inspection we received information which showed that this had been followed up and staff assessments for

competency had been completed.

The acting manager told us they had begun observing staff to ensure they were competent to apply the learning gained, and checked staff knowledge in health and safety, moving and assisting, MCA and dementia. However, they had only completed two so far. They told us they were prioritising this work.

Supervisions and appraisals provide staff with the opportunity to discuss how they are working, receive feedback on their practice and identify any training needs. One staff member said, "We [staff] have supervision more frequently now, and my work is checked which is good." Another said, "I have had recent supervision." We saw from records that during supervisions relevant items were discussed such as training, well-being, whistle-blowing (reporting of poor practice) and safeguarding.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty.

The service had made appropriate applications under DoLS to ensure people's human rights were protected. Care plans included information on why the DoLS was applied for, and if it had been authorised. However, we did not always see that the purpose of the DoLS was fully explained within all people's care plans. We also found one capacity assessment which said the person lacked capacity, but it was not clear as to what decision was being made in respect of this.

People's records made reference to their capacity to consent to the different areas of their care, and if there were legal representatives in place. Care plans included a section on who was involved in creating the care plan, and to what extent people were involved. In one case we saw that an Independent Mental Capacity Advocate (IMCA) was listed. IMCA's are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.

We observed staff gained consent before assisting people with any tasks. One staff member said, "I always ask residents first, I tell them what im going to be doing, and ask them if that is okay." Another said, "We [staff] always assume the person has capacity. Encourage them to make choices day to day."

People were supported to live healthier lives by receiving on-going healthcare support. Records confirmed that people had received the help they needed to see their doctor and other healthcare professionals such as community nurses, falls teams, speech and language therapists and GP's. Healthcare professionals we spoke with told us that they were prompt to seek advice and listened to their recommendations.

The provider had not considered how to maximise the suitability of the premises for the benefit of people living with dementia. Walls were painted a similar colour with little contrast. There was limited signage available to help people to orientate themselves and did not follow best practice and up-to-date guidance to support people living with dementia. There were few clear signs, symbols or colours to help people to recognise their own bedroom. For example, some bedroom doors had names and pictures on, but not all.

Some decoration in the service was tired and in need of improvement. There was a lack of sensory stimuli, for example, orientation boards and information for people in an easy to understand format. In addition, there were no memory boxes and objects of reference to help aid reminiscence or provide a stimulating environment.

We recommend that the service explores current guidance from a reputable source (such as the Social Care Institute for Excellence) to further improve the design and decoration of the service, and consider best practice for people living with dementia.

The service had worked together with other organisations, which included the local medicines optimisation team who regularly visited the service to review people's current medicines and ensure they were prescribed the most effective medicines.The service had also worked with a local quality team following the last inspection to support improvement in the service.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in August 2017, we rated this key question as 'Requires Improvement'. This was because we did not always receive positive feedback from people about the staff approach. We were also not assured that people were involved in their care planning, as people had not always signed them to demonstrate that they had been fully involved in creating them and that their views about their care were known.

At this inspection we found that due to the wider failings in the service, people living at the service did not always benefit from a caring culture. The concerns we raised during our last inspection in August 2017, had not been adequately addressed by the provider to ensure people were safe and the overall quality of care people received in the service was of a high standard. We have therefore rated this key question as 'Requires Improvement'.

We observed that people's privacy and dignity was not always considered fully. For example, we found that some communal toilets and bathrooms did not have a locking mechanism in place to ensure people's privacy. We observed that when people were being hoisted in communal areas, there were no privacy screens available to place around the person whilst they were being moved, and therefore allow for a better level of privacy.

People who were sat in the lounge area did not always have access to a call bell to summon help from staff. This meant if staff were not in the vicinity they would have to shout out for help which we felt was not dignified especially if the person wanted to use the toilet. One relative told us, "In the lounges there is no buzzer nearby and on some occasions I've had to go and get help for someone because there isn't a carer in the room. A resident was sick and I found myself dealing with it and shouted for help."

People told us that staff were kind and caring. One person said, "The carers are lovely, dedicated, caring and loving, and considering the payment they get, wow. I wouldn't get out of bed for it. They know me well and I can have a laugh with them and tease them. I said to one, 'If I was forty years younger and with my own teeth you'd have to watch out!'. It's all done in fun and innocence." Another said, "The staff are so lovely and caring and they are very good to me. We chat about what's going on in their families and things about me. It makes me feel valued. They are respectful and want the best for me." A relative said, "Most are very nice, but a few are forceful and just want to get to the next resident. I don't feel we really get acknowledged." A second relative said, "There are some wonderful carers here who really want to help him. We laugh and joke together. They don't just care about him, it's about me as well. That is so nice for me."

Resident meetings are an opportunity to gain people's views about the care they receive. The service advised us that no meetings had taken place in the service since August 2017. Although annual surveys had been sent out to people for feedback, having meetings enables people to give verbal feedback and answer any questions they may have face to face. A relative said, "There are no residents or relatives meetings, and there should be. There's no newsletter either." Another said, "I never get asked how I feel things are for my [relative]." Following the inspection, the provider told us that us that there was a newsletter available for

March 2018, and they planned to implement these every three months to ensure information is shared with people and their families. They had also planned resident meetings.

We observed that staff supported people effectively and patiently. One person living with dementia had their coat on, ready to leave the building, and appeared anxious. A staff member went over and spoke to them and said, "[Name] why don't you come with me? We can go into the dining room and you can hold my hand if you like." Another staff member when supporting a person to stand said, "We are here to help. You won't fall, you can trust us. Let's do this together. We know you can stand. It will be the right thing for you."

Most of the staff we spoke with clearly knew people well but some care records did not always reflect people's life histories, past employment, family lives and relationships. This could make it difficult for new staff to get to know people and support them to initiate meaningful conversations. People's care plans had not always been signed to demonstrate people's consent to their care. We found three care plans which had not been signed.

People's ability to retain a level of independence was not always reflected in their care plans. For example, one person 's care plan said that they needed support from care staff to maintain their personal hygiene when required. Staff we spoke with said that sometimes they could attend to their personal care independently. However, their care plan made no reference to this. People's preference as to their preferred gender of carer was noted.

We saw that people's communication needs had been assessed. Some people's care records contained good information in respect of this area and we saw that staff adopted this when speaking with people. However, other people's care records required more comprehensive information on how to meet these needs.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in August 2017, we found the provider to be in breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) 2014 and we rated this key question as 'Requires Improvement'.

At this inspection in April 2018, we found that key information was missing from people's care plans and the information around people's care was not always current. This meant staff would not have essential up to date knowledge of the care people required. This meant the provider remained in breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) 2014 and we have rated this key question as 'Requires Improvement'.

People were at risk of receiving inconsistent support that did not meet their needs. Each person living at the service had an individual care plan; however, the quality of these was variable. In some cases, the information was not specific. Information relating to certain conditions, such as diabetes, was referred to in several areas of people's care plans. For example, in two care plans reference to their diabetes was logged in 'nutrition and hydration' and 'personal health' sections. It would be beneficial if staff were easily able to access information about existing health conditions in one, prominent position along with guidance to staff about the condition, how people could be supported and what to expect if they became unwell. This would mean that staff could access the information in a timely manner if needed by a doctor or paramedic for example. It would also mean that staff would have a clearer understanding of how they could help and support people. The care plans and records demonstrated that this aspect of people's care had not been planned to meet their individual needs.

In another case we were informed that one person became more agitated in the afternoon due to symptoms associated with sundowning. (Sundowning is a symptom of Alzheimer's disease and other forms of dementia, where confusion and agitation may get worse in the late afternoon and evening). The person's care plan made no reference to this and was important for staff to know so they could anticipate times of the day where the person would benefit from extra support. We saw the person wandering around for much of the day, but there was not any stimulation for them, such as sensory activities or objects to interact with. Staff just directed them back to the lounge or dining area. The person's care plan said that the person could become verbally and physically aggressive, and said the risk assessment described how to support them. When we looked at the risk assessment it said staff should 'quickly intervene and find a meaningful activity to do'. It did not describe what activity the person would find meaningful, or what might distract the person and help to relax them.

One person's care plan stated that they were registered blind. Another section of their care said they liked to watch the television. There was nothing noted in relation to how impaired the person's vision was. There was no information around how the television should be positioned, or how close staff should stand when trying to communicate in the most effective way. When we spoke with staff they told us the person could see shapes and the outline of people, but this was not recorded in their care plan. Additionally, one area of the care plan said, "I am able to express and say my needs when I am well", but another area of the care plan

stated they were "Non-verbal" and unable to express their wishes. This meant there was a risk staff may not try and communicate with the person and ascertain their views in relation to their day to day care and decisions which needed to be made.

The service needed to develop their practice in supporting people in relation to their end of life care. Planning ahead for when people may no longer be able to communicate their views regarding end of life wishes is sometimes called 'advance care planning'. This involves thinking and talking about how people choose to be cared for in the final months of their life.

The end of life care plans in place were not always holistic, and did not always reflect the scope of people's individual wishes and needs. For example, if they preferred to go into hospital or remain in the service, which people they wanted to be with them (and those they did not) and how they wished to spend their last days. There was no additional information on how staff could provide comfort during these last days such as music the person liked or calming aromas. The provider told us that there was often a delay in receiving information from family members to add into the care plans, and this impacted on the level of information available.

The service had not referred to publically available best practice guidance such as the Gold Standards Framework and National Institute for Health and Care Excellence (NICE) guidance when planning people's care. Some care plans made reference to people's end of life wishes, but contained only minimal information, such as preferred funeral provider and to contact their next of kin. The acting manager provided evidence that end of life training had been planned, but there was no specific approach or model of end of life care in place, such as the Six Steps end of life programme which is a nationally recognised programme for supporting people and their families about making advanced decisions about the care they want at the end of their lives and their wishes after death.

There was an activity co-ordinator working in the service five days per week for six hours per day and there was an external musical entertainer who visited twice a week. We asked people if they felt there was enough to do and we received mixed feedback. One person said, "I don't join in things. I just like my sixties music and listen to it in my room. Yes I do get bored, but look around, you can see there is no one for me to talk to. There's an imbalance here, too many people with dementia." Another said, "In the summer they take us to the beach and it gives me a feeling of independence. We go on the train that takes us around the town. They encourage me to take part in things but honestly I'm happy on my own. I do knitting and when the weather's nice, I like getting out in the garden." A relative said, "[Relative] joins in with the music and gets up and dances. There seem to be different things on offer. [Relative] loves the garden and they have hoop games in the better weather." Another said, "There's not much for [relative] to do. The Activities' Coordinator brought them in a wordsearch and they helped [relative] with, but I'm not sure how regular that is. As a result [relative] is bored."

The activity co-ordinator told us that they felt the provision of activity had improved, and had lots of ideas on how to progress the current programme. During the day we observed four people throwing and catching a beach ball. This was followed up with the same four people doing an activity where they shook percussion instruments to music. In the afternoon we observed the activity co-ordinator visited a person in their room, and they sang together while they held their hand. The person gained obvious pleasure from this, smiling as they sang.

In the afternoon the musical entertainer came in to sing which people appeared to enjoy. However, for those people living with dementia, more personalised activities were required in order to meet their specialist needs. We observed that these people tended to sit quietly or walk around the building with little

engagement with anyone. This was an area that the activity co-ordinator told us they were working on.

The provider had systems in place for managing complaints. We saw that these were logged, but did not always describe the nature of the complaint. We also noted that a recent complaint about missing money had not been logged. We did however see that this had been responded to in a timely manner. One person said, "Yes I can complain if I need to, whether anything would get done though I couldn't tell you." A relative said, "[Acting manager] seems okay, but they need to get things done. [Relative] was without their TV for three weeks. That is their main source of interest."

Inadequate

Is the service well-led?

Our findings

At our last inspection in August 2017, we found shortfalls in the service which indicated that the auditing and monitoring systems had failed to identify the issues we found during our inspection, and had not recognised where people were at risk of harm. We found repeated breaches and new breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which demonstrated that the audit and governance systems in place were not effective, and we rated this key question as 'Inadequate'.

The August 2017 inspection was also the third consecutive comprehensive inspection which had resulted in an overall rating of 'Requires Improvement'. Following this inspection we took enforcement action to impose conditions on the providers registration. We asked the provider to identify the root causes of the shortfalls in the oversight and governance of the service and what action was being taken to mitigate these from reoccurring. We decided to impose these conditions on the providers registration because people could have been exposed to the risk of harm.

We found that the provider had implemented additional quality audits as a means of improving and identifying shortfalls. However, these had not been effective and had not identified the issues we found during the inspection. Additionally, this inspection in April 2018, identified that the provider remained in breach of three regulations of the Health and Social Care Act 2008, in relation to safe care and treatment, person-centred care, and governance. We also found two new breaches in relation to nutrition and hydration and staffing.

The provider's inspection history demonstrates a failure over a period of three years to achieve compliance with the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which means we have not seen evidence of adequate leadership and governance in place to ensure improvements are made and sustained.

The provider therefore remains in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and we have again rated this key question as 'Inadequate'.

At this inspection in April 2018, the provider was not present as they were on a period of leave, but there was an acting manager and deputy manager in place to run the day to day management of the service. There was also a care co-ordinator in post.

At this inspection concerns were identified again with the accuracy and completeness of people's care records. This was because some of the information about people's needs and risks were inaccurate or not complete. People's care plans did not cover all of their needs and risks and staff lacked adequate guidance on how to care for people safely or in the way they preferred. The provider's care plan audits had not addressed this. This meant there was a risk that people would not receive the care and support they needed.

We found that some improvements had been made in relation to the assessment and monitoring of some risks relating to people's care. However, we found that the provider had not taken action to address other

shortfalls identified at the last inspection in August 2017, which placed people at continued risk of harm. For example, the implementation of choking risk assessments. We also found environmental risks which had not been identified by the provider. We concluded that risks associated with people's environment were not safely managed, and the provider was not aware of guidelines relating to health and safety requirements.

A lack of risk assessments had been completed in some areas. For example, no assessment of risk had been completed in respect of exposed hot pipework within the service, placing people at risk of burns. Wardrobes were not secure posing an accident and injury risk. This demonstrated a lack of knowledge in relation to key guidance, such as Health and Safety within care homes published by the Health and Safety Executive in 2014.

The provider had a 'room check' audit for health and safety hazards, which included checking the floors, lights, call bell, and furniture. This was last completed in December 2017. The health and safety lead was unable to produce documentation for a specific health and safety audit or risk assessment which would take into account risks relating to the building and premises.

Monitoring systems had failed to ensure the support people received was of a consistently high standard. For example, the acting manager told us they carried out a daily 'walk around' to check standards. However, these had not picked up on the issues we found with regard to environmental risks and issues found with the dining experience. On day two of our inspection, new tablecloths had been provided, and a 'welcome to our home' sign had been put in the entrance area, along with wall stencils giving a more welcoming and homely feel to the building. However, this was only in response to our feedback, and the provider had not thought to do this independently so people lived in a more visually pleasing environment.

Where audits had been conducted by the manager or provider, they were not always robust at identifying issues or driving improvement. One care plan audit consisted of a tick list, covering all areas in people's care plans. The audit carried out in March 2018 identified no concerns in relation to people's moving and handling assessments. We found inaccuracies within these. There was a second audit which had been implemented, and was more detailed. This audit randomly checked two care plans each month for quality. The one completed in March 2018 identified that two care plans did need updating. However, no one had identified that choking and bed rail risk assessments were still not in place, despite having the templates for these ready to be implemented.

These examples clearly demonstrate that the service was not well led. The provider had not done all that was reasonably practicable to improve the service so that risks to people's health, safety and welfare were minimised.

We asked people if they had noticed any changes in the service. One person said, "I know there have been changes here and I feel it's getting better. Everything seems better organised and there's more activities going on." Another said, "I'd recommend the place in every way except for the mix of residents. They need to get that in better balance." A relative said, "If you want a home for someone with dementia, here you are. They get all the attention. Don't send a relative here if they have limited mobility."

Accidents and incidents were now being monitored more closely, and a monthly report was produced which enabled the provider to have more effective oversight and to monitor themes and trends.

The service had worked in partnership with other organisations, such as the community nursing team, mental health teams, and GP's.

Annual surveys were sent out to people and relatives to get their views. We found the majority of feedback was positive. However, one relative said, "The turnover of staff and management over the past couple of years does provide an unsettling time for residents and families."