Greensleeves Homes Trust

# Croxley House

## 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

About the service: Croxley House is a residential care home that provides personal and nursing care for up to 33 people most of whom may be living with dementia, or who are elderly and frail. At the time of our inspection, 30 people were living in the home.

People's experience of using this service:
People told us that staff were kind and caring, however we observed occasions when staff did not always show people the respect that they deserved. People received the medicines they needed, however we observed a medicines error which was not reported.

People were cared for by staff who had undergone good pre-employment checks and had access to training, although there were insufficient staffing to help ensure people received the attention they required and that staff had to spend with people. When people had accidents and incidents these were recorded.

Risks to people had been identified, although we found many people had had unwitnessed falls and we observed people walking around without staff, when they were at high risk. The environment in which people lived required improvement to ensure its appropriateness and cleanliness. This included its suitability for people living with dementia.

People's consent was not sought in line with the Mental Capacity Act 2005 (MCA) as decision-specific mental capacity assessments had not been completed. Although regular audits of the service were carried out, shortfalls identified, such as the failure to follow the principles of the MCA had not been identified.

People received sufficient nutrition and hydration and where staff were concerned about people's eating or health, they involved appropriate healthcare professionals. Some people were seen to retain a sense of independence and make their own choices about how they wished to spend their time. However, there were mixed views on the activities offered to people.

People's care needs were clearly recorded in their care plans. These included their likes, dislikes and background information on people. People could express their views and opinions about the service through regular residents' meetings and surveys.

During our inspection we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also made two recommendations to the registered provider. You can see what action we told the provider to take at the back of the full version of the report which is on the CQC website at www.cqc.org.uk

Rating at last inspection:  We last inspected Croxley House on 26 April 2016 when we rated the service as Good. The report was published on 17 June 2016.

Why we inspected: This was a routine, scheduled comprehensive inspection which we carried out in line with our inspection methodology.

Follow up: We will ask the registered provider to draw up an action plan telling us how they propose to rectify the shortfalls we have identified. We will review this action plan when we carry out our next inspection to check that actions have been addressed as stated. We will next inspect the service in line with our inspection timescales methodology.

## 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

Details are in our Safe findings below.

**Is the service effective?**

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

**Is the service caring?**

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

**Is the service responsive?**

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

**Is the service well-led?**

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

# Croxley House

**Detailed findings**

## Background to this inspection

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

Inspection team:
The inspection was carried out by two inspectors 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.

Service and service type:
Croxley House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection. Croxley House accommodates 33 people in one building.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
We carried out this inspection, which was unannounced on 19 March 2019.

What we did:
Before this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. This enabled us to ensure we were addressing potential areas of concern at our inspection.

As part of our inspection we spoke with eight people, three relatives and seven staff. We also spoke with the registered manager and deputy manager as well as one visiting healthcare professional.

We reviewed a range of documents about people's care and how the service was managed. We looked at 10 care plans, medicine administration records, risk assessments, complaints records, policies and procedures and internal audits that had been completed. We asked the registered manager to send us information following our inspection for further analysis.

Requires Improvement

# Is the service safe?

## Our findings

At our last inspection, we rated the service as Good in safe. However, we found at this inspection this rating had not been sustained.

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

We found some aspects of the service were not always safe. Regulations may or may not have been met.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

● Information in relation to ensuring people could be safely evacuated in the event of an emergency such as a fire was not up to date. We found one person's personal evacuation information (PEEP) was missing from the fire folder. A staff member told us, "I update the information once a month." This meant that should there be need for an evacuation in the intervening period the information held by the service would not be accurate.

● However, staff did know the plans for an evacuation. One staff member described the process to us and was able to tell us where the meeting place was outside.

● Staff also carried out regular checks on equipment and services within the service such as electrical testing, gas safety, emergency lighting and fire extinguisher checks and monthly water temperature checks.

● Although risks to people had been identified and guidance was in place, we observed staff not always following people's care plans. For example, one person's care plan stated, '[name] now uses a zimmer frame for walking and transfers with the assistance of 1 x care staff'. However, this person had been able to walk from their room to a small lounge area unaccompanied by staff and without their mobility aid. We accompanied the person back to their room and found them very unsteady on their feet. We noted this person had had four unwitnessed falls in a six-month period.

● Another person's support was recorded as, 'should have one stick (to walk with) and one carer' and yet, we saw the person walking around without either.

● One person told us, "I did feel very safe, but recently I've got these walkers coming into my room in the evening and at night and I do find it worrying. I fell asleep in my chair and when I got up there was someone in my bed. I called the staff and they did come quickly." They told us they now kept their door locked at night, but did not like having to do so.

●The environment in which people lived required improvement. We found two people's windows on the ground floor of the service did not have window restrictors. Meaning people could climb out of a window.

●One person's window was being propped open with a video case. They told us they had to do this as the window would not stay open without it.

Preventing and controlling infection

●One person's carpet smelled strongly of urine and there was a large dirty patch on the carpet. We spoke with the registered manager about this at the end of our inspection who told us they would arrange for the carpet to be cleaned the following day. Following our inspection, the registered manager gave us evidence to show this person's carpet had also been cleaned previously.

● There was a room, openly accessible to all, labelled 'bathroom/toilet' on the first floor. However, we found it was the staff locker room. There was no soap in the soap dispenser which meant staff were not able to wash their hands properly when coming onto their shift. Following our inspection, the registered manager informed us that the dispenser had become clogged but that there was also a pump soap on top of the locker which staff could use. They also informed us that they have since placed a lock on the outside of the door to prevent people, other than staff, using this room.
● We saw people's continence pads exposed out of the packaging which was not good practice and left them exposed to airborne infections.
● The kitchen floor was dirty and we noticed the chef's shoes were blackened with dirt. Low level fixtures and fittings, windows and window frames were also dirty and a commode in one room smelled of urine and did not look clean.
● Chairs in the communal lounge area were stained and the ceiling fan was black with dirt.
● We checked the laundry room and observed a staff member taking clean washing out of the machine. We saw them drop a couple of items on the floor and promptly pick them up and put them back in the pile of clean washing.
● The sink in the laundry room was dirty and there was a lack of 'clean' and 'dirty' areas where staff could easily separate out people's laundry.

The lack of ensuring people are free from risk, good medicine management practices and poor infection control was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● People received the medicines they required and medicines were stored securely and appropriately as staff ensured that the medicines trolley was locked when not in use.
● People's medicine administration records (MARs) contained recent photographs for identification purposes, information relating to allergies and double signatures for handwritten entries.
● There were no gaps on people's MARs which indicated to us that people had not missed any medicines. A relative told us they felt their family member got the medicines they needed.
● Where people were on 'as required' medicines these were supported by protocols which gave guidance to staff on what to look out for to indicate a person was in pain.
● However, we witnessed poor practice in relation to medicine administration during the morning. We saw a staff member retrieve a tablet that had been dropped on the floor and give it back to a person. At the end of our inspection we asked the registered manager what action they would expect a staff member to take should they drop a tablet. They told us, "I would expect them to phone the GP, report it, put the tablet in a pot ready for returning or destroying." However, this had not happened and the registered manager told us they had not been made aware of this incident. Following our inspection, we were told by the registered provider that supervision had taken place with the staff member concerned and refresher medicines training set up. Until training had been completed, the staff member was to be supervised by the registered manager when administering medicines.

Staffing and recruitment
● People and visitors gave us mixed feedback on staffing levels. The registered manager told us that each day they, the deputy manager, one senior and four care staff would be on duty. This increased to five care staff late afternoon/early evening. One person told us, "There is never enough staff. I used to sit in the lounge a lot more but I was always worried about people falling over (because there were no staff in there)." Another person said, "I do notice that sometimes they are short staff and they tend not to have agency anymore."

● Staff told us they felt they needed more staff. A staff member told us, "About once a week, we have less than five in the afternoon. We are not able to interact with people as much." Another staff member told us, "I don't think there are enough staff. Often I find I am the only one around so I have to get help to move people." A third commented, "If I was honest I would say that it lacks a carer in the morning. Night staff do get people up but with an extra carer we would have time to spend with people."
● We also received similar comments from others. A professional told us, "You can see there are times when they are short staffed. You can't always find someone quickly." A relative said, "There are not always enough staff around."
● We observed a visitor arrive at the service during the morning and they stood waiting for some time to be assisted by staff. We heard them say to a person, "I think I am being helped. I have been waiting a long time."
● During our inspection we observed people who should not be walking unaided moving around the service without staff presence.
● There was also a period when two staff were on their break and two were providing personal care to people. This meant there were no care staff on the floor to monitor people.
● We heard one person asking what activities were taking place in the afternoon and for the television to be turned on. They were told by a staff member they were busy and as such the person had to wait.
● We reviewed information relating to accidents and incidents and found that between June 2018 and December 2018, 54 unwitnessed falls had occurred. Most of these were during the night shift when only two waking care staff were on duty. The falls related to 11 people at the service, most of whom who had had three or more falls each in this period.

The lack of sufficiently deployed staff to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff underwent a robust recruitment process before commencing work. This included providing evidence of their right to work in the UK, references from previous employers, employment history and their fitness to work. Prospective staff also underwent a Disclosure and Barring Service check which helped ensure that they were suitable to work in this type of setting.

Systems and processes to safeguard people from the risk of abuse
● A staff member told us, "I would report any concerns to [registered manager] or the local authority. All staff have had training."
● People had information available to them which related to how they could express any concerns if they felt unsafe or worried. A relative told us they felt their family member was safe as it was a, "Secure environment."

Requires Improvement

# Is the service effective?

## Our findings

At our last inspection we rated the service Good in this domain. We found at this inspection however that the service had not sustained that rating.

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and we found it was not.

- There was a lack of decision-specific mental capacity assessments for people. For example, one person who staff told us lacked capacity had bed rails in place. We found no evidence that this person's capacity had been assessed or a best interest's discussion had taken place to decide whether the use of bed rails was the least restrictive option for this person.
- Other people did not have capacity assessments for the locked front door, sensor mats or 24-hour care, which meant it was not clear whether or not staff had considered if they were restricting people.
- One person was being given their medicines covertly (without their knowledge). Although we read guidance was in place from the pharmacy on how the medicine could be given, there was no decision-specific capacity assessment in place, or best interests decision.
- Information in people's care plans was contradictory. We read one person was recorded as, '[Name] has mental capacity to make decisions'. However, later, their records stated that the person was unlikely to regain their capacity.
- Another person had a mental capacity assessment for their medicines, however it was not clear from the document whether they had capacity or not.
- One person had been deemed to have capacity on their mental capacity assessment and yet, a DoLS application had been submitted for them.
- The registered manager was not following their own internal policy which stated, 'assessment, therefore, has to focus on a person's ability to take a particular decision not about their general mental capacity'.

The lack of compliance with the principles of the Mental Capacity Act was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● There was a lack of suitable signposting in the service for people living with dementia. Some people liked to walk around but we found people's bedrooms did not have any individualised identification features to help them navigate back to their own room. As such people were going into rooms that were not theirs.
● We observed the clock in the lounge was set at the wrong time. A staff member told us it needed a new battery. One person told us they had told staff twice about this, but nothing had been done.
● In the communal lounge we observed the chairs pushed up against each other giving people a lack of personal space, as well as a lack of side tables which people could use to place a drink for example. A staff member told us, "We are held back by the building. I don't like the chairs being flush with each other."
● Following our inspection, the registered provider told us they were looking at ways of improving the environment for people, such as purchasing memory boxes to be displayed outside of people's rooms.

We recommend the registered provider ensures the environment in which people live is suitable for their needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People were assessed before moving into the service. This helped ensure that staff were able to provide the most appropriate care for people.
● The registered manager told us they kept up to date with latest practices through head office updates and CQCs website.

Staff support: induction, training, skills and experience
● Staff undertook training in topics such as food hygiene, health and safety, manual handling, dementia awareness and first aid. One staff member told us, "The training is outstanding."
● A staff member told us, "We have a new system – My Learning Cloud – where we can keep more of a check on training. I think the training is effective."
● Staff had the opportunity to undertake training relevant to their role or position within the service. For example, management training.
● Staff were provided with support from their line manager as regular one to one supervision took place. This gave staff the opportunity to talk about their role, any concerns they had, or training needs.

Supporting people to eat and drink enough to maintain a balanced diet
● We received mixed views from people on the quality of the food and the dining experience was one that could be improved. One person told us, "The food is diabolical." Another person told us, "The food is okay. I have a good appetite." A third said, "The food here is varied." Another said, "Yes, very nice lunch." A relative told us, "The food always looks decent."
● At lunch time we observed people sitting in the dining room and being served by a dining assistant. Some staff sat at tables with people eating their lunch, although we did not hear them make much conversation with people. There were also times when staff were just standing around, rather than engaging with people to make the lunch time experience more of an event.
● Other people were being supported by staff to eat and we saw this was done at a pace which suited the person. We also saw people with plate guards which meant they could eat independently.
● Although there was a choice of main meal, we heard from the chef that people on a pureed diet did not get this choice. Instead, they made the decision on the meal they pureed.
● One person told us, "The food is rubbish. Today they (staff) handed out a lot of veg on trays. They don't

normally do that – it's only because you're here."
● We reviewed people's care plans in relation to their weights and saw that people's weights were generally steady. When people were at risk of malnutrition or dehydration, staff had made appropriate referrals such as to the dietician.

We recommend the registered provider ensures that people are supported to have food of their liking.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff worked with healthcare professionals to help ensure the most effective care was provided to people.
● We observed two healthcare professionals meet at the service to discuss someone's health needs. Staff sat with them listening to advice and guidance.
● There was evidence of people receiving input from the GP, chiropodist, dentist and optician. Some people had received speech and language reviews where staff had concerns about the person's swallowing.
● A relative told us, "They will call the ambulance if she is unwell."

Requires Improvement

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were not always shown dignity and respect by staff. Regulations may or may not have been met.

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- People were not always shown dignity or respect by staff and people's individual decisions were not always respected. One person was recorded in their care plan as wishing female care staff only during personal care. Despite this, from their daily notes we recorded nine occasions over a period of 11 weeks when personal care was provided by a male member of staff.
- People's individual choices were not always respected. One person asked for a glass of wine at lunch time. We heard them say, "It's fizzy, I don't like fizzy wine." When we looked at the bottle we found that staff had given the person a non-alcoholic fizzy drink. We asked a staff member if there was a reason this person could not have alcohol and they told us there was not. The registered manager told us following our inspection that they have purchased wine for this person to have with their meals.
- The chef told us that people were shown visual choices of the main meal each day, however we did not see this happen, apart from with the deserts. We heard two people say, "We don't know what it is" when they were asked by staff what they would like from the menu.
- One person had some cards to look at from their birthday. We saw a staff member place the cards on the person's lap, however a few minutes later they slipped off onto the floor. Instead of staff picking them up and sitting to read them with the person, a staff member gathered up the cards and placed them on the mantlepiece out of reach of the person.
- People's 'en-suite' doors had been removed and instead a plastic shower curtain had been put in place. This meant a lack of privacy for people if they wished to use the toilet. One person told us, "It's absolutely ridiculous not having a door. If someone knocks and I'm using the loo, I don't have time to answer before they are in and opening the curtain."
- People's clothes were not always given care when they were laundered. We saw that white and coloured items were placed in the washing machine together. A staff member told us, "A lot of us used to separate out the washing, but I don't know why it doesn't happen anymore." This had resulted in people's laundry looking grey and discoloured. The registered manager told us at the end of our inspection, "It frustrates me. I have addressed this with staff and I ordered a lot of new towels." We noted also, that the registered manager had raised this with staff during their February staff meeting.
- We noted staff had not taken the time to iron the table cloths in the dining room. So, although tables looked nicely set table cloths were creased.
- Although there were lots of clocks around the service, only one was correct. Others were either not working or set incorrectly.

The lack of dignity and respect shown to people was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity

● We did receive positive feedback however about staff from people. One person told us, "The staff are very kind to us. I have a keyworker who comes and chats with me." Another person told us about one staff member, "She really does do a good job. We have a laugh."

● A healthcare professional told us, "Staff are caring. I have never witnessed anything bad or untoward." A relative said, "I am happy with the level of care." They added, "I am very happy – lovely staff."

● One person said, "They (staff) are all very nice as a rule." A second person told us, "I like it here. The staff are kind. They look after me."

● There were some nice examples of kind, attentive care from staff. A staff member stooped down beside one person, rubbed their hands and checked that the person was okay. A relative told us, "Mum has settled in well. It's very homely."

● Another staff member held the hands of a person when they accompanied them into the lounge.

● A staff member told us, "They become your extended family and I treat them like my family."

● During lunch we observed some staff being very attentive to people whilst supporting them to eat. One staff member sat beside a person helping them with their meal. They took it at the pace which suited the person; making sure they had finished their mouthful before giving them another. As the staff member offered the person a forkful they said, "Here we go my love. Are you enjoying it?"

● We observed some people maintaining a sense of independence as they went outside when they wished, made their own way in and out of the communal areas and were given the opportunity to make choices.

● A staff member told us, "We have to respect their individual differences."

Requires Improvement

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met through good organisation and delivery and further social interaction for people would help ensure people received responsive care.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support

- There were mixed views on social stimulation and activities for people. People who were more capable told us there was little that stimulated them, but they did like sitting in the garden. One person said, "I feel very safe here, but there's nothing to do for me." Another told us, "I'm bored. There's nothing to do and nobody to talk with."
- One person told us, "No activities. We go to Southend once a year. We just sit around."
- During a quiz activity in the morning, we heard one person say, "We don't seem to do anything now."
- Staff told us they felt there was a lack of social stimulation for people, especially those who spent the majority of their time in their room. One staff member said, "There isn't enough for people with dementia to interact with." Another staff member told us, "Activities. There's nothing done with the ones with dementia. It would be lovely to have two (activities) coordinators." A third told us, "They're (people) bored. It's heart breaking. We only have time to do the personal care."
- We did not see staff spend time with people who spent the majority of time in their room.
- We observed staff carried out task led care, not always involving people in decisions and not always supporting people to follow interests or social activities
- However, we observed people walking independently in the grounds of the service. One person told us they liked walking and did, "Several laps" each day.
- We also received some positive comments. One relative told us, "There is a variety going on." ● A local church held services regularly at the home and we read in people's care plans that they were encouraged to attend. One person played the piano during the service.
- We also heard that there were occasional trips out and observed some music being played and a quiz during the morning. Although both lasted a very short time some people did engage with them.
- People's care plans were easy to navigate. They were clear and detailed and included individualised care plans for people. This included where people suffered from health needs such as depression or anxiety.

We recommend the registered provider ensures people have the opportunity to participate in individualised, meaningful activities to prevent a risk of social isolation.

- Some people preferred snacking throughout the day and having finger foods and staff encouraged them to eat in this way to help ensure they maintained a good weight.
- People had life histories in their care plans which included information about their likes, dislikes, favourite television programmes, music choices and hobbies. These gave a good baseline for discussion by staff.
- There was the opportunity for people to express any end of life wishes they had and for these to be

recorded, however we noted in the care plans we reviewed that most people had chosen not to, 'talk about it'. One person had recorded they would like, 'occasional music' played.
● A professional told us, "I have found when people are in their latter stages, the care and attention is really good. They (staff) have good personal skills."

Improving care quality in response to complaints or concerns
● A relative told us they would know how to make a complaint and who to address it to. There was a complaints policy available for people.
● We read some compliments received by service which noted, 'you were all so warm and welcoming. I immediately felt at ease" and, "Thank you for looking after and caring for [name] in his last few months."

Requires Improvement

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- We asked staff about the culture within the staff team and received a mixed response, with some telling us the staff team was not cohesive and, "It's quite a mixture," and yet others told us, "We work together. The care staff are second to none."
- We also noted the registered manager had a, 'do not disturb' sign on her door all day which did not give the impression that the registered manager had an 'open door' policy for staff and people.
- Deployment of care staff was not organised in a way which meant staff were always available to assist people. For example, during lunch time some staff stood around not assisting or engaging with people and for a proportion of the day we noted senior staff were in handover, rather than on the floor. In addition, the activities lead was often the only member of staff in and around the lounge area.
- There was a lack of robust management oversight in that some of the shortfalls identified by us, which were already known by the registered manager, had not been addressed by either the registered manager or registered provider. There was no formal assessment for staffing levels and no evidence of assessing or responding to some of issues relating to the building. For example, the registered manager told us, "There used to be doors on the en-suites, but they had to be removed as it was difficult with the bedroom door so near." Although this may have been the case, the registered manager had not considered obtaining people's views as to whether they would be happy to have the door replaced with a curtain. Following our inspection, the registered manager told us they were investigating alternative arrangements to the curtains.
- We spoke with the registered provider to ask what action had been taken following our inspection. They sent us an action plan detailing how they planned to address the shortfalls. For example, they were considering sliding doors on en-suites, rather than curtains and the activities programme was being reviewed and reorganised. They had also purchased new laundry baskets to help ensure staff separated out the washing. Although it appeared they had quickly responded to our feedback many shortfalls should have been identified and addressed sooner by the registered manager. This would have helped to ensure people lived in an environment suitable for their needs and they received a good level of respectful care.

- Although regular audits were carried out across the service, such as infection control and care plan audits, these had not always identified shortfalls. For example, the lack of decision-specific capacity assessments and the poor environment and cleanliness. The registered manager did however, send us a new infection control audit template they planned to introduce. We were also told by the registered provider that a carpet audit had been introduced.

● We did see an external medicines audit had not identified any shortfalls. However, a provider's internal audit had made a recommendation that people's MAR charts were stored inside medicines trollies when medicines were being administered. Despite, the registered manager stating in their action plan that this was being done from early March 2019, we noted the practice of MAR charts being left on top of the trollies still taking place during our inspection.
● The registered manager told us that a purpose-built unit was being constructed next door to the service. They said, "People living with dementia will move to that unit and those who require residential care will remain here. This building will be refurbished." However, the new unit was not going to open until March 2020 which meant in the meantime, people were living in an environment that was not necessarily fit for purpose.

The shortfalls in governance of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We did receive positive feedback from people, staff and professionals on the management of the service. One person told us, "The manager does run the place extremely well. The deputy is good." A professional said, "The manager is good. We have regular meetings. The relationship is a lot better. We have regular contact." Staff told us, "[Registered manager] takes no nonsense," "I would say it's (the service) well managed," "I feel supported by the managers." A relative told us, "I get on well with [registered manager]. She is approachable."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People had the opportunity to feedback suggestions or concerns through residents' meetings. One person told us, "We do have resident's meetings and you can bring anything up."
● We reviewed the minutes of the most recent meetings and saw they were well attended. We read that people had fed back on the food and we noted at the next meeting people had reported a, "Slight improvement."
● One person had commented that they felt there was, "Not enough to do in the afternoon" and people were invited to make suggestions of activities they would like.
● Salient points were recorded at each meeting and we read these were carried forward as action points. One person had asked for a hook to be attached to an exit door and we saw this had been done.
● In addition, an annual survey was carried out. The registered manager had yet to develop an action plan in response to the latest survey however, we noted that people and families had responded positively to the kindness of staff, staff taking time to talk to them and that the home was a secure place to live. Less positive feedback related to the quality of the food, being able to take part in hobbies, having the choice of when to get up or go to bed and the staffing levels.
● We heard that staff were currently fund raising to purchase an interactive light table for people living with dementia. They told us this was something people had requested.
● Staff also had the opportunity to be involved in the running of the service. One staff member told us, "If I put my views across she (the manager) would listen to my point of view."
● Staff had the opportunity to meet through staff meetings.

Working in partnership with others
● We spoke with the registered manager about external agencies and relationships they had developed with them. They told us they worked closely with the district nursing team and GP. They said they had received training through Skills for Care on communication and leadership and were a member of NAPA (activities for people living with dementia).

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 will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>The registered provider had not ensured people were always shown respect. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The registered provider had not ensured they were following the principles of the Mental Capacity Act 2005. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The registered provider had not ensured people were kept free from harm, or that people lived in an environment that was clean and well maintained. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The registered provider had not always ensured good governance within the service. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The registered provider had not ensured there |

were a sufficient number of staff to meet people's needs.