Telford Lodge Care Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection took place on 3 and 4 January 2019 and was unannounced. The last comprehensive inspection took place in May 2018 and the service was rated 'inadequate' in the key questions 'Is the service Safe, Effective and Well Led?' and overall. The key questions 'Is the service Caring and Responsive?' were rated 'requires improvement'. We found eight breaches of regulations relating to person-centred care, safe care and treatment, premises and equipment, good governance, staffing, dignity and respect, safeguarding service uses from abuse and improper treatment and meeting nutritional and hydration needs. At this inspection we found the provider had not been able to make sustained and measurable improvements to fully meet the regulations and remained in breach of eight regulations.

Telford Lodge is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. At the time of the inspection, 36 people were using the service. They were mainly older people and people living with the experience of dementia. This is the only location for Telford Lodge Care Limited which is registered as a charity.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The last registered manager left the service in February 2018. At the time of the inspection, the provider was advertising for a new registered manager and the nominated individual was fulfilling the manager role.

The provider sent us an action plan indicating how they would meet the breaches of regulations and make improvements. However, the management of the home have not been able to meet their action plan according to the timescale they said they would make improvements in the service. As a result, people using the service continue to experience a sub-standard quality of care and support and were placed at risk of unsafe care and treatment.

During this inspection we found that staff were not being deployed to effectively meet the needs of the people using the service.

Incident forms did not have information about how these were investigated or what the outcome was. Care plans were also not being updated to reflect incidents. Risk management plans were not robust enough and lacked detailed and effective guidance to mitigate risks. They were also reactionary rather than preventative. This meant the provider was not assessing, monitoring and mitigating risks to people to help minimise their exposure to the risk of harm.

The environment was not always well maintained, and checks were not consistent. The home was not

dementia friendly with distinctive features to help people with dementia care needs orientate themselves. Signs for CCTV cameras did not make it clear they were recording both visually and with sound so people and visitors were aware of these.

The provider did not ensure medicines were always managed safely, and audits did not always identify discrepancies to help ensure people always received their medicines in a safe way. For example, there was a lack of guidance for staff in care plans relating to high risk medicines.

Safe recruitment practices for new staff to ensure they were suitable to care for people using the service were not always followed. The provider's audit had not identified this so they could make the necessary improvements.

Supervisions were not held in line with the provider's policy. We saw evidence of staff training but not of how it was being monitored so staff remained up to date with their training and the provider knew when training was due.

Where people lacked the mental capacity to consent to specific decisions, the provider did not always follow the principles of the Mental Capacity Act 2005 (MCA). Nor did care workers have a good understanding of the MCA.

There was a lack of evidence that records to monitor peoples' nutrition such as fluid intake and weight charts were not being monitored which meant the provider could not effectively monitor people's weight and nutritional status to identify any risks relating to nutrition so appropriate action could be taken in a timely manner to manage the risks and to meet people's needs.

The provider did not demonstrate they had a robust system to deal with complaints. There were no formal investigation records where there had been complaints and there was a lack of recorded outcomes and learning points.

The provider did not have effective systems in place to monitor, manage and improve service delivery and to improve the care and support provided to people.

We saw there were procedures for reporting and investigating allegations of abuse and whistle blowing. Staff we spoke with knew how to respond to safeguarding concerns.

Relatives were positive about the level of care provided.

People's needs had been assessed prior to moving to the service and care plans included people's background and some personal history.

The service liaised with other professionals and we saw evidence that people were supported to access healthcare services appropriately.

We found eight breaches of regulations in relation to person-centred care, dignity and respect, consent to care, safe care and treatment, premises and equipment, receiving and acting on complaints, good governance and fit and proper persons employed.

We are taking action against the provider for failing to meet regulations. Full information about CQC's regulatory responses to any concerns found during inspections is added to reports after any representations

and appeals have been concluded

The overall rating for this service is 'inadequate' and the service is therefore in 'special measures'. This is the second time the service has been rated inadequate.

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.

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.

The provider did not have appropriate arrangements to ensure the numbers of care workers deployed were adequate to meet peoples' needs and to ensure their safety.

Risk assessment processes were not always robust enough to minimise risks to people and others. Incident forms did not have investigation details with analysis and outcomes so appropriate plans could be put in place to prevent further incidents in the future.

Medicines management was inconsistent, and audits did not always identify discrepancies to make sure people received their medicines safely.

The provider did not ensure they followed safe recruitment procedures to ensure staff employed were suitable to work with people using the service.

Infection control procedures were not always followed.

Staff knew how to respond to safeguarding concerns to help keep people safe.

Is the service effective?

Inadequate

The service was not effective.

The environment was not always suitable to help meet people's needs and was not a dementia friendly environment.

People's dietary and health needs had been assessed and recorded but were not always updated which meant people could be put at risk of dehydration or malnutrition due to the lack of monitoring of people's intake and weight.

Care workers were supported to develop professionally through supervision and training but this was not consistent and it was not clear how it was monitored.

The provider did not always act in accordance with the requirements of the Mental Capacity Act (2005) to promote people's rights. Not all care workers we spoke with understood the principles of the Act.

People's needs were assessed prior to their move to the home which helped to ensure the provider only supported people whose needs they could meet.

Is the service caring?

Requires Improvement

The service was not always caring.

Although some individual care workers treated people with kindness, we saw that the provider did not always operate the service in a person centred manner, particularly around supporting people with their meals.

We observed some evidence that care workers supported people to have choice around day to day decisions.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always completed in a timely manner or with up to date information which meant staff lacked up to date guidance to enable them to deliver effective care to meet people's identified needs.

Activities for people were not always person centred or meaningful and did not always reflect their interests and preferences.

The service had a complaints procedure. However, there was little evidence that complaints were appropriately investigated because there were no investigation records and a lack of recorded outcomes and learning points.

People did not have their advanced wishes for end of life care recorded so staff were aware of these and were prepared to meet these if they developed.

Is the service well-led?

Inadequate

The service was not well led.

The provider had a number of audits and checks in place to monitor the quality of the care provided. However, these were

not effective in identifying the areas where improvements were required and the risks associated with the provision of a care service so appropriate corrective action could be taken. There was also a lack of robust management in the home which meant that the provider did not always meet their statutory obligations.

Telford Lodge Care Limited

Detailed findings

Background to this inspection

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

The inspection took place on 3 and 4 January 2019 and was unannounced. The inspection was carried out by two inspectors, a member of the medicines inspection team 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.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to the inspection we also looked at the information we held on the service including the provider's action plan from the last inspection, notifications of significant events and safeguarding alerts. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also contacted the local authority's safeguarding and placement teams to gather information about their views of the service.

During the inspection we spoke with ten people using the service, three relatives, four care workers, one senior care worker, one team leader, one catering worker, two healthcare professionals, the deputy manager, the nominated individual who is also managing the service, and the chair of the committee that runs the service. Our observations included using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us. We viewed the care records of nine people using the service and two staff files that included recruitment. We looked at training, supervision and appraisal records for all staff. We also looked at medicines management for people who used the service and records relating to the management of the service including service checks and audits.

Inadequate

Is the service safe?

Our findings

At the inspection on 9 May 2018, we identified a breach of regulation relating to safe care and treatment. This was because incidents were not always recorded or addressed appropriately, risk assessments did not always cover relevant risks and were not always robust enough, arrangements for managing medicines were inconsistent and unsafe and we observed some poor practice regarding infection control and environmental safety. Following the inspection, the provider sent us an action plan dated 31 August 2018 to tell us what they would do to address the identified breach. During the inspection on 4 January 2019, we found the provider had made some improvements but we found several areas that still required improvement and where they were not fully compliant with the regulation.

During the inspection we viewed the incident and accident forms completed since November 2018. There was a monthly log with outcomes and further actions required for November 2018 and an audit analysis for October 2018, but we did not see analysis for the previous months. After the inspection, the provider emailed us analysis data for May, June and July 2018. However, this still did not account for August, September and December 2018's analysis. There were no detailed investigations or outcomes and people's electronic Care File / Risk Assessments were not always updated to reflect the incident. For example, an incident on 04 November 2018 recorded two people arguing and trying to hit each other. The recorded outcome was, 'Made sure that [people] should not be together, when [person] want to go to room staff makes sure to supervise.' As the person did not have a one to one, they were unlikely to be constantly supervised when they went to their room. The incident form also indicated the incident had been recorded in the care plan but we did not see evidence of this.

Under Positive Behaviour in the Care File/ Risk Assessment, it was recorded the person was at 'Very High Risk' of becoming 'easily agitated and aggressive'. The trigger was '[Person] does not like being told what to do.' The interventions included staff to speak with the person calmly, explain why the person needs support with certain tasks and 'Team Leader to administer medication when showing challenging behaviour.' The plan lacked any strategy to manage the person's behaviour with other people to prevent escalation, did not, as indicated in the incident form, note the person was to be supervised and did not give details of when it was appropriate to administer medicine to help manage the person's behaviour.

We saw another incident form dated 4 November 2018, also for two people involved in an altercation with each other. The recorded outcome was, 'Staff to make sure that [person] should not seat with other resident as they take things from others and accelerate situation.' Again, we did not see evidence in the Care File/ Risk Assessment of this incident or how to manage this type of risk in future. In addition, isolating the person by having them sit alone, did not address the cause of the behaviour or manage it in a way that was sympathetic to the person's needs. Under Nutrition, the Care File indicated '[Person] likes eating their food at the same table with their friends in the dining room' so not sitting them with other people was not an appropriate option.

The incident forms for one person indicated they had falls on 11, 14 and 30 November and 2 December 2018. The outcome recorded on the forms was to supervise the person. The guidelines were not robust as there

was no detail and the risk management plan was not effective as the person had fallen four times in less than a month.

The provider had 'behaviour records' and we saw two incidents for one person on 4 and 5 November 2018. When we looked at the care records dealing with Positive Behaviour in the Care File/ Risk Assessment, it was recorded the person was at high risk of being 'physically and verbally aggressive and agitated'. The interventions were to 'speak to them and explain every time the steps of a task' and 'give them space and time to calm down.' The risk management plan was not detailed, effective and did not look at the possible causes and triggers so appropriate plans could be put in place to prevent further incidents in the future.

In the incident and accident folder we saw a body map dated 22 October 2018 for a person that indicated bruising. There was no incident form to explain what had happened and what measures were put in place to mitigate it happening again. There were no enquiries made to identify the cause so any suspicions of abuse could be ruled out. The manager said this was due to moving over from the paper to the electronic system.

We saw that the safeguarding alert forms were completed on the local authority's form instead of a local format which meant as the provider was responding to the local authority's criteria they had not recorded outcomes and learning for Telford Lodge to be used to prevent future alerts and improve service delivery.

We found that since the last inspection an electronic care record system had been implemented and individual risk assessments were completed on line. However, people's risk assessments were not individualised enough and risk management plans were not robust enough to mitigate identified risks. For example, one person had a risk assessment dated 12 December 2018 for wandering into other people's rooms. The management plan was to close doors and monitor the person. That did not take into account people who wanted their doors open or that the person was not on a one to one so could not be monitored all the time. The same person had a risk assessment for sharp objects which was to supervise the person while they were wandering and remove sharp objects.

Another person had two risk assessments for falls. One was dated the 11 August and the other 11 October 2018 which indicated they required one carer to support them but did not say with what or how that was preventing falls in all situations. The provider had not always identified the risks that were relevant to people's needs and their conditions. We did not find robust risk assessments or risk management plans for people who had diabetes, urinary catheters, epilepsy or behaviour that challenged. This meant it was not always clear what staff were required to do to mitigate the identified risks to people.

For one person we saw incidents of behaviour that challenge recorded on 26 September and 4 November 2018, but we did not see a risk management plan or guidance for staff on how to manage the person's behaviour.

For another person we saw a sign in the kitchen that the person required four spoonful's of thickener in fluid to the consistency of custard. However, use of a thickener was not recorded in the care plan. Initially kitchen staff told us the person did have thickener and after we queried it with the deputy manager, they confirmed they did not give the person thickener. The lack of clear guidance meant people may not have been receiving care that maintained and promoted their nutritional needs.

At the last inspection we raised concerns that a young child was visiting the home without a risk assessment or risk management plan in place. At this inspection, we saw a risk assessment had been undertaken but this addressed the risk to the child and had not considered the risks that this could pose from the aspect of a care service provision for older people, some of whom were living with dementia. Bringing a child into a care

service has some inherent risks not only to the child but to the service provision. For example, the child being caught up in an incident where a person behaved in a way that challenged the service. The manager told us they felt that the risk to people using the home was covered by other assessments such as risk assessments for falls but agreed to update their current risk assessment.

The provider undertook a risk assessment for the home in September 2018 and for each room in October 2018. They identified risks but actions taken were not recorded and there was no sign off from the manager. For example, in one room on 10 October 2018 risks recorded included sharp edges of table, sharp pins on the wall, drains with bottles, door is kept open with zimmer frame and the bin is open. Leaving the door open with a zimmer frame could pose a risk in the event of a fire. There was no action recorded and when we inspected we saw the same room still had the door being held open with the person's zimmer frame, indicating action had not been taken to mitigate identified risks.

The provider had some checks in place regarding the safety of the environment but these were not consistently carried out. Checks in place to keep people safe in the event of a fire included a fire risk assessment by an external company in October 2018 which recommended emergency evacuation chair training, which at the time of the inspection had not yet been undertaken. A fire drill was also completed in October 2018.

The fire register listed people but did not show how many staff were required to help each person evacuate. The daily fire door and exit checks were not being completed daily. For example, in November, checks were undertaken on 2, 8, 9,14, 16, 21, 22, 27, 28 November 2018. Maintenance checks were completed for water, electric systems, lifts and baths and there was an up to date gas safety certificate. We noted the home's water temperature recording form to monitor the temperature of hot water at taps said hot water must reach 50 degrees within one minute and seemed to be about the appropriate water temperature to prevent legionella. Whilst we noted that the water temperature was below 44 degrees centigrade at hot water outlets to which people had access, this could be misleading as the form was being used to monitor hot water to prevent scalding as opposed to managing the risk of Legionella. The Health and Safety guidelines 'Managing the risk of hot water and surfaces in health and social care' state water temperatures at outlets to which people had access to should be no more than 44 degrees.

On the first day of the inspection, a member of the CQC medicines team looked at medicines stock, storage, administration, records, policies and systems relating to the management of medicines at the service and found medicines were not always being managed safely.

We saw arrangements were in place for a local pharmacy to supply medicines. Medicines were stored securely. Staff checked and recorded room and refrigerator temperatures daily and these were within the required range. However, staff members did not always give medicines to people as prescribed. A single staff member undertook medicines support. We observed the staff gave medicines to people in the morning and afternoon. Medicines prescribed to be given in the morning at 8.30am were given up to 12.30pm. The staff recorded these on the Medicine Administration Record (MAR) as being given at 08.30am which meant the MARs were not accurate. The staff member who was supposed to have protected time for administering medicines was being interrupted to help with other tasks such as serving food and assisting people to go to the toilet, raising the risk of medicines errors.

We looked at MARs and care plans for six people. Some people were prescribed high risk medicines such as warfarin, insulin and anti-epileptics at the home. There was no guidance for staff in people's care plans on how to monitor or manage the side effects of such medicines. Lack of guidance for staff in care plans relating to high risk medicines was also highlighted during our previous inspection carried out in May 2018.

This meant people were at a risk of harm as staff may not have been able to identify side effects of high risk medicines. For example, one person was prescribed insulin which was administered by district nurses who visited the service. However, it was not listed in medicines in the person's care plan.

The staff informed us that people's medicines were regularly reviewed by their GP, but no record was kept of medicines reviews. This meant it was difficult to ascertain if people's medicines had been reviewed and whether their medicines were still suitable to treat them.

We did not find evidence that there was a system in place to receive and act on medicines alerts as outlined in the National Institute for Health and Care Excellence (NICE) guidance which states 'Organisations should ensure that national medicines safety guidance, such as patient safety alerts, are actioned within a specified or locally agreed timeframe'. This meant that should there be an alert that might have an impact on the service, there was a risk that staff would not be aware and act on the alert.

Senior care workers and team leaders who administered medicines at Telford Lodge had received relevant training and we were told subject to ongoing competency based assessments to help ensure people received their medicines safely. However, although staff confirmed they had undertaken competency assessments, at the time of the inspection we were only shown two out of four up to date competency assessments. This meant that the provider could not demonstrate at the time that all staff had completed a competency assessment to administer medicines.

The provider had an infection control policy reviewed in October 2018 in place to help protect people from the risk of infection and was completing infection control audits with actions required. Staff had completed online training on infection control and used personal protective equipment such as gloves and aprons as required. Care workers told us, "We have to always wear the gloves and change from one client to another client" and "Wash your hands and use gloves, apron and change gloves after every resident and keep washing your hands." However, we observed some poor practice when on the second morning of our inspection we saw one member of staff walking around with gloves after these had been used to handle a urine bottle. They were going from room to room and zone to zone instead of removing the gloves once the task was completed.

We saw there was a tick list daily cleaning log for each zone. However, when we checked the cleaning tick lists in individual toilets and bathrooms, we found they were not being completed daily. The men's bathroom in zone 5 last had a cleaning check recorded on 31 December 2018 and we saw someone's clothes were left in the bathroom. The Zone 5 ladies' bathroom had water leaking on the floor under the bath. We also saw electrical cables in the medicines cabinet. The first floor store room was open and we saw hoists that appeared dirty, were stored in this room. There was no cleaning schedule for the hoists or slings to monitor that these were being regularly cleaned. We also noted during our tour of the premises one person's bedroom and surrounding hall area smelled very strongly of urine and faeces. We saw that staff had entered the room and had left without acting to resolve the infection control issues.

This was a repeated breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment files of two staff members employed since the last inspection and found the provider had not carried out sufficient checks of their suitability to care for people using the service.

One care worker began work in 2018. There was no reference from their last employer who they were still employed with as a care worker at the time they submitted their application to work at Telford Lodge. Also,

why they left their last job was not indicated. A second member of staff who began work with the service in September 2018 had a personal reference and a reference from a job that was not listed on their application form's employment history. There was no reference from their last care job. A staff file audit was completed on 13 December 2018 and recorded that no issues were identified and that there were two references from previous employers, which were not in place, when we looked. As safe recruitment practises had not been followed we could not be confident that suitable staff were being recruited to care safely for people using the service.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection on 9 May 2018, we identified a breach of regulation relating to staffing. This was because we found the assessed needs of people using the service indicated a high level of supervision was required and this was not consistently provided to ensure the safety of people who used the service. Following the inspection, the provider sent us an action plan dated 31 August 2018 to tell us what they would do to address the identified breach.

During this inspection we saw the service was meeting the regulations but there remained areas that required the consideration of the provider. The rotas for December 2018 indicated the usual staff pattern to provide care for 36 people was to have three care workers on duty from 8am to 8pm with an additional three care workers in the morning and one additional care worker in the evening. In addition to the care workers, two team leaders were also on the rota each day. At night there were two care workers on each floor and one team leader covering the whole home. However, we were not assured staff were deployed in such a way so as to meet people's needs effectively. On the second day of the inspection, in the ground floor lounge we observed the team leader who was supposed to be doing medicines was sitting with people to support them to eat which meant people were delayed in receiving their medicines. We also saw they were helping other staff to provide personal care to people, which again led to delays to administer medicines.

A number of staff indicated to us during the inspection, there was not enough night staff, particularly as the two night staff on each floor were getting people up and providing personal care in the morning prior to their shift ending at 8am. We verified this on the second day of the inspection when we arrived at 6am and found eleven people already up and in the communal rooms.

At the last inspection we saw that there were periods of time when people were left alone in communal rooms. At this inspection a person using the service told us, "Enough staff, [but staff] don't care, it's just a job for them" and a relative said, "There always seem to be staff about. Now there is always somebody [staff] in the lounge." We saw that there was generally a staff member in the lounge, however sometimes this was domestic staff and not care workers. We also observed some care workers were in communal areas and not interacting with people but updating the care records. A healthcare professional told us, "I'm not sure if staffing levels are the best. Sometimes someone needs assistance and staff are with someone else."

People using the service generally said they felt safe. One person told us that there were not always enough staff around, but they did not necessarily feel unsafe. However, sometimes when someone using the service became aggressive, although enough staff responded to the incident, the aggression made the person feel unsafe. Another person, said that sometimes other people using the service came into their room during the night, possibly because they had 'confused the person's room with their own'. A third person told us that the home was safe enough and that they had enough freedom to go out to smoke. A fourth person felt it was safe at the home and they liked the fact the staff found time to walk with them locally as although they felt the area around the home was safe, they needed some support with walking in the community.

There were procedures for reporting and investigating allegations of abuse and whistle blowing. Care workers we spoke with could identify the types of abuse and knew how to respond to safeguarding concerns. Comments included, "We are going to tell [nominated individual] or social service", "We can tell the manager any safeguarding issues or go higher to CQC" and "I would report it to the manager and if they are not acting, take to safeguarding [team in local authority] and then CQC if I have any concern."

Some people were prescribed medicines to be taken on a PRN (as required) basis. At our previous inspection we found protocols for such medicines were not available. However, at this inspection we found PRN medicines were listed in people's care plans and protocols were in place to make sure these medicines were given consistently.

The manager and deputy manager said they used a dependency spreadsheet to calculate sufficient staff numbers and if a person using the service had an appointment, they added additional staff to the rota to support this.

Inadequate

Is the service effective?

Our findings

At the inspection on 9 May 2018, we identified a breach of regulation relating to premises and equipment. This was because we found the provider did not follow best practice guidance for dementia friendly environments, communal areas were not always clean and had hazards such as broken furniture and there were no signs to indicate CCTV cameras were recording both a visual picture and sound. Following the inspection, the provider sent us an action plan dated 31 August 2018 to tell us what they would do to address the identified breach. During the inspection on 4 January 2019, we found the provider had not improved sufficiently to meet the regulation.

We saw bedroom doors all had the sign of a bed and occupier's name and keyworker's name written on them. As noted at the May 2018 inspection this is not distinctive enough and is not clear enough signage, particularly for a person living with dementia, to orientate themselves. One of the main aims of a dementia friendly environment is to help people find their way around which in turn reduces disorientation, frustration and behaviour that challenges and improves well-being and independence. [Dementia Friendly Environment, Social Care Institute for Excellence]. The DHSC guidance 'Dementia Friendly Health and Social Care environments' states a dementia-friendly environment should: have clear reference points, serving as spatial anchor points, able to combine form, function and meaning; avoid long corridors, monotony, uniform architectural composition leading to repetitive environments; provide visual cues such as pictograms, resident/patient's name, portrait photograph and photographic labels; have arrows close to the relevant text to help make the connection between the two; introduce noticeable landmarks that might have special meaning to users and can be used as reference points (e.g. pictures of local area); and use personal items to identify personal or private space (e.g. on doors to bedrooms). During out inspection we saw the names of people using the service was in small print, bedroom doors were not personalised and there were no noticeable landmarks to use as reference points.

We saw examples during the inspection to indicate the environment was not meeting people's individual needs and that the provider had not ensured that the environment was safe or suitable. For example, in the upstairs zone 6 lounge, garden chairs, both metal and plastic, were being used in the lounges. An inspector sat down on a metal garden chair and found it to be hot because it had been sitting directly in front of the electric fire in the lounge.

There were not enough tables in the zone 6 lounge for people to sit at to have their meals or to place drinks on, in front of them. On the first day of the inspection at 10.20am in the upstairs lounge we observed a care worker bring in jugs of squash and place them in the corner of the room behind the television, so they were not accessible to people using the service. At 11.04 tea was served. There were only two tables in the lounge which were portable over seat tables and one of those had broken at 10.30am that morning. A care worker located another table from another lounge but there were still only two tables in the lounge that five people could use. Therefore, people had to hold their tea in their hand, place the cup on the floor or if they were unable to, it was placed on the table behind the television with the juice, which meant people could not access it when they wanted to.

On the second day of the inspection in the zone 6 lounge, two people were sharing a little table with their lunches on it. There was not enough room to comfortably put both lunches on it and because two people were sharing, the table had to be in the middle of the two people instead of in front of them. One of the people told us they were not happy with this arrangement and wanted their own table. At the same time, due to a lack of suitable tables in the lounge, a care worker was trying to balance a tray with food on the knees of a person using the service. This was not secure, as the care worker was trying to balance the tray with one hand and with their other hand support the person with having a drink. On the second day of the inspection, the provider ordered ten overbed and chair tables. However, prior to the inspection, they had not identified that there were not enough overbed and chair tables, or if they had noticed it, they had not taken action to resolve the issue

At 9:30am on the second day we saw the zone 3 lounge extractor fan in the window was missing it's cover and we could see exposed wires and the wall light by the first floor lounge was missing the cover and had an exposed bulb. In a corridor outside a lounge we saw the cover of a wall mounted battery powered hand gel dispenser was missing, leaving access to the gel and the batteries. In the zone 4 lounge there was water damage to the ceiling and to the pocket lights in ceiling which had not been made good. On the morning of the second day we saw the staff room door was unlocked with access to a toaster, kettle, washing up liquid. The hairdressing salon was also open. Dangers posed included a standing hairdryer with a broken stand being stabilised with a brick. In the men's bathroom in zone 5 there was no lock on the door to stop people from walking in on someone using the bathroom.

The service used audio-visual CCTV cameras. We saw one sign in reception that indicated the CCTV was audio-visual, otherwise notices we saw were security signs that indicated CCTV surveillance was being used but did not specify there was an audio as well as visual recording. As a result people and visitors might not be aware that they were being recorded visually and also their conversations were being recorded.

This was a repeated breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty to receive care and treatment when 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). We checked whether the service was working within the principles of the MCA.

We found that the service was not always working within the principles of the MCA. There was evidence that some people's relatives had signed to consent on behalf of the person using the service, but it was not clear that they had the legal authority to do so and in some cases this was happening even when the person had the mental capacity to make their own decisions. We saw one person had a best interests decision form completed for the use of a sensor mat but there was no mental capacity assessment to determine if the person was able to consent to the sensor mat or required a best interests decision.

The provider had a tracker to monitor any applications submitted to the local authority for DoLS authorisations and conditions and expiry dates of DoLS authorisations. At the time of the inspection more

than 20 DoLS applications were outstanding. We saw the provider last chased this up with the local authority in September 2018. DoLS authorisation for one person stated they required an advocate. An advocate visited on 31 January 2018 but there was no record of further involvement. We saw that a relative was involved in decision making including signing consent forms but there was no evidence that they had the legal authority to consent to care on behalf of the person using the service. In another person's MCA section of their care plan, the information was contradictory as it stated the person was able to retain and weigh up decisions but also stated they did not have the capacity to make decisions and had a DoLS authorisation. Therefore, the assessment carried out by the provider did not identify what aspects of the person's care they could consent to and did not provide clear guidance for staff.

We also found that when we spoke with care workers about their understanding of people consenting to their care, their responses were unclear, and most did not understand that people should be assumed to have capacity unless assessed otherwise. Comments from care workers included, "This type of people can't manage anything. Everything we have to provide for them. Some of them can manage. Most for the things we have to do it. When we work with them, we know what their choice is", "If someone can't take a decision, the next of kin can and if they don't have a next of kin we have to ask the team leader. Can't force them. If someone doesn't want to go to the GP, we can't force them. We have to tell the next of kin", "Some of them don't have capacity, so we have to know the care plan. If they don't have capacity we have to encourage them. I ask them if they want something and then I can get it for them" and "People who are not able to take their own decisions. Some of them you have to give them choices to make their own decisions. A lot of people can make their own decisions, even if they take a long time."

This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection on 9 May 2018, we identified a breach of regulation relating to staffing. This was because new care staff did not receive adequate training. They were not enrolled on the Skills for Care certificate and we saw that not all staff had up to date supervisions and appraisals and evidence of up to date training. Following the inspection, the provider sent us an action plan dated 31 August 2018 to tell us what they would do to address the identified breach. During the inspection on 4 January 2019, we found the provider had made some improvements but was not yet fully compliant with the regulation.

During the inspection care workers told us they had an induction and shadowed a more experienced care worker when they started working in the home. Training was completed predominantly on line and we saw a selection of staff training summaries. After the inspection, the provider sent us a training data base indicating training was generally up to date and when training was next due. During the inspection we saw one staff member had scored less than 50% in their online training for care planning, DoLS and moving and handling in April 2018. This meant they did not have a robust knowledge in those subject areas. The provider had not taken action to address the shortfalls in the person's knowledge to ensure the member of staff had the appropriate knowledge to care for people safely.

We saw since the last inspection, the provider had improved their supervision frequency and supervisions had been undertaken by the previous manager who joined in October 2018 but has since left the service. However, the record of staff supervisions and appraisals we viewed, recorded 27 out of 41 staff members had an appraisal in 2018 and only 18 had supervision in 2018. This was not in line with the provider's supervision policy which stated, 'The care service is committed to providing its care staff with formal supervision at least six times a year [the minimum would be four], the agenda covering all aspects of practice; philosophy of care on the service and career development needs.'

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

At the inspection on 9 May 2018, we identified a breach of regulation relating to meeting people's nutritional and hydration needs. This was because daily fluid charts were not always completed, monitored or acted upon. Following the inspection, the provider sent us an action plan dated 31 August 2018 to tell us what they would do to address the identified breach.

During the inspection on 4 January 2019, we found that people's fluid intake was recorded electronically. However, we saw that not everybody was reaching what the system calculated as their optimum levels of fluid intake. For example, one person had a fluid target set on October 2018 at 1975 ml fluid input per day. Records showed that the person was regularly not reaching 1000ml of fluid per day. On some days they only reached 500mls. This fell well below the optimal volume of fluid intake for a person and might put the person at risk of dehydration. There were no records of what action had been taken when people's daily intake fell short of the expected amount of fluid to be taken. When we discussed this with the management team, we were told that the optimum levels were arbitrary and not a required target. This meant we could not be sure people were receiving the amount of fluids they required. We discussed this with the deputy manager and they told us the system could produce a fluid intake chart and that they looked at it every day to monitor people's fluid intake.

Comments from relatives in feedback forms dated September 2018 included, 'The menu does not cater for Black people' and 'A good effort but could be increased range of international dishes (for African and Caribbean people for example).' One person using the service told us the food was poor with not enough variety. Another said the breakfast was okay but the kitchen didn't cook food they liked such as [cultural dish]. A third person also commented on the lack of cultural diversity. We observed during breakfast that people eating cornflakes had it served to them with warm milk which made the cereal soggy. We saw one person tell a member of staff they were unhappy about the texture of their cornflakes, noting that "corn flakes are flakes and not porridge." Staff removed the cereal but returned it with more warm milk, indicating a lack of knowledge by the care worker around the person's preferences.

The provider had a four week rolling menu of mainly traditional English food that was delivered frozen. Indian food options were also available on request. There was no separate menu or options for people with diabetes but sweeteners and low sugar options were used in deserts. One person's care plan indicated they were diabetic. On the first day of the inspection at lunchtime, we observed people eating fish in batter, chips with tomato ketchup and dessert was a sweetened yoghurt. On the daily food plan where people's meal preferences were recorded, each person had a code against their name to indicate specific needs such as whether they needed a diabetic, low fat or vegetarian meal as well as the consistency of the meal. Food menus were written up on a white board without any pictures and we did not see people being shown a picture of the food on offer, which may have been useful, particularly to those people who could not read the white board.

People's care plans included information about nutrition and people's food preferences. One relative was happy with the food served and said, "[Person] eats quite well and seems to have put on weight." Another relative was also very complimentary and said, "When lunch was served on Sunday [during their visit] there was such a choice."

At the inspection on 9 May 2018, we identified a breach of regulation relating to safeguarding service users from abuse and improper treatment. This was because staff were unnecessarily restricting people's movements and not adhering to the MCA principles when administering covert medicines. Following the

inspection, the provider sent us an action plan dated 31 August 2018 to tell us what they would do to address the identified breach. During the inspection on 4 January 2019, we did not see any people being restricted inappropriately.

People were supported to access healthcare services and care plans included information about people's healthcare needs. One relative said, "Excellent care here. [Manager] really fought their corner when they were in hospital", "[Person] always seems well looked after. Their needs are always met. If I mention to the staff [person] doesn't look well, they will phone me up and say [person] has an appointment with the doctor. Even on the weekend. When [person] appears to be ailing, they are straight there and down the hospital. It's a big weight off my mind."

The GP had a dedicated clinic once a week for people using the service. One healthcare professional told us, "Anything I asked for they were happy to help. Staff were able to answer questions" and another said, "The place has improved. Staff are more or less good in knowing about patients. Got me what I needed. Generally, I find they are quite responsive. No particular concerns."

Since the last inspection, no one new had been admitted to the service and therefore we were not able to see any completed new pre-assessment forms which will in future be completed electronically. At the previous inspection we saw that people's needs had been assessed prior to moving to the home and copies of the local authority assessment had been obtained to provide information about the person and their needs.

Requires Improvement

Is the service caring?

Our findings

At the inspection on 9 May 2018, we identified a breach of regulation relating to dignity and respect. This was because care workers were not always person centred in their approach to providing support to people and confidential files were easily accessible to others in the lounges. Following the inspection, the provider sent us an action plan dated 31 August 2018 to tell us what they would do to address the identified breach. During the inspection on 4 January 2019, we found the provider had not improved enough to meet the regulation.

While we were in the first floor lounge between 11am and 12pm, we observed a member of staff speaking with a person using the service. Another person told the care worker to 'shush' several times as it was disturbing them watching television. The care worker responded to the person saying they were only talking and continued to talk with the first resident. There was no attempt to resolve the situation or an explanation of why it could not be resolved.

We observed two mealtimes and saw that the care provided was not always person centred. As previously mentioned, there were not enough tables in the lounge for people to use during mealtimes. On the ground floor lounge at 12:55 on the second day of the inspection, we saw a care worker who was going to support a person to eat their lunch could not find a table to use in the lounge. This resulted in them having to balance the tray on their lap whilst helping the person to eat. Later they did find a trolley to put the tray on near the person. We observed they did not ask if the person was ready for their next spoonful of food but were directional in their support. The care worker repeatedly said, "Open your mouth" between each mouthful. The person kept trying to take the spoon from the care worker but the care worker avoided this and kept asking the person to open their mouth rather than promoting the person's independence and supporting them to help themselves to eat. The care worker then tried to get the person to drink while they were still chewing food, and as a result, food and drink were both coming out of the person's mouth and onto them and the floor. At 1:37pm, the care worker got up from supporting the person without an explanation and went to ask another person if they would like some juice.

We saw that one person in the lounge was not eating their food and no one was encouraging them to. At one point they began eating with their hands. No staff responded to this. Just before 2pm, we saw the person's plate with most of their meal was removed by a care worker without being eaten and no alternative offered.

During the same mealtime, a person indicated they needed their incontinence aid changed. Instead of responding to the person's need immediately, the care worker said they would bring the person's tea first and then support them with personal care which meant the person was required to sit and wait for their incontinence aid to be changed while the tea was being made. Then the tea was left while person's personal care needs were attended to. We saw a further example of an indiscreet conversation on the first day in the zone 5 lounge when a care worker audibly asked a person if they needed their pad changed in front of other people sitting in the lounge.

We observed the television and radio entertainment did not demonstrate consideration for the likes or dislikes of the people listening to it. Lounges mainly had BBC news on and during chair exercises on the first day of the inspection, the radio was playing modern music for a younger audience, rather than more age appropriate music.

The above five paragraphs show a repeated breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Notwithstanding the above, most people and relatives expressed satisfaction with the individual way their care was being provided. One person felt that the staff were good and that they had a good relationship with a number of people. Relatives were very positive and said, "They are always kind. If [person] gets panicky, staff will always sit with them and talk to them to calm them down. I have seen others agitated and a member of staff will sit with them for a considerable amount of time" and "They were so caring. They are always so welcoming and fabulous. [Person] is in the best place for them. Definitely their care needs are being met one hundred percent. I really feel that they care."

People's cultural and religious needs were included in their care plans. We saw evidence of a care worker speaking kindly to people and care workers speaking with some people in their first language. We noted one of the team leaders used the respected 'Ra' for people with an African identity and "Aunty" for Asian individuals and people's names for European residents. We observed people responded very positively to this form of address.

People were supported to celebrate important occasions in their lives. One person's birthday was acknowledged in the dining room with a present. Staff told us they celebrated events such as Christmas and Diwali. One care worker said, "We check the care plans. Some of them are from my culture and at festival times we can tell them today is Diwali festival and we have to do this."

The electronic system did not record if people were involved in planning and making decisions about their care. Care workers told us they asked people what they would like in terms of food and personal care. One care worker told us, "We ask people every time what they want. If they refuse care in the morning, we have to ask them when we come in the afternoon." We saw records that were titled 'weekly key working sessions'. These were from September to December 2018 and only eleven people had a key working session once during this time which meant not all people were being given a regular opportunity to discuss their care or any concerns they might have.

Requires Improvement

Is the service responsive?

Our findings

At the inspection on 9 May 2018, we identified a breach of regulation relating to person centred care. This was because care plans had not been written to reflect changes in people's needs and there was a lack of social and leisure activities which reflected people's needs and interests. Following the inspection, the provider sent us an action plan dated 31 August 2018 to tell us what they would do to address the identified breach. During the inspection on 4 January 2019, we found the provider had not improved sufficiently to meet the regulation.

During this inspection, we received information indicating that night staff were getting people up very early in the morning. On the second day of the inspection we arrived at the service at 6am. On the ground floor lounge we saw five people sitting in chairs. One person was asleep in their chair and staff said they had been in the chair in the lounge all night. In the zone 6 lounge on the first floor, there were also six people sitting in chairs in the lounge, one of whom was sleeping in their chair. Care workers told us everybody had chosen to get up themselves, as early as 5am. We were told only one of the eleven people wanted a shower and the rest had a wash.

We looked at the people's care records and could not always see any instructions about the time for people to go to bed or to get up. In the Care File there was a section in Night Care to record when people wished to go to bed but this was left blank and there was no record of when people might like to get up in the morning. One staff member told us, "[Night staff] ask people if they want to get up. If they are sleeping we try to wake them up and say this is morning time, so we tell them it is morning. If they say okay, [they want to get up] we go ahead [with personal care]" and "Night staff get as many [people] as they can up. Not all [people]. Night staff gives showers." Another member of staff said "Night staff are waking people up to shower them. People are getting up really early to wash."

One person's daily records on 4 January 2019 stated they had been sleeping in the lounge in an armchair but there was no record in the night-time care plan around sleeping in a chair in the lounge. Their Night Care assessment stated they did not have a certain bedtime and did not often sleep in their room but there was no information on where they did sleep. The care plan indicated the person should have 30 minute checks and this was not reflected in the daily records.

In terms of being involved with planning their care, one person did not know what a care plan was and felt they had not had any conversations about their care. They went on to say they felt the staff were not really trained for dementia. A second person said they did not think they had a care plan. Their on-line care plan said they were unable to sign it. Relatives were more positive about their involvement in care plans and told us, "I haven't been invited to a care plan reviews but if I mention anything it seems to be logged" and "We have a complete copy of [person's] review and we're involved in everything." A third relative stated they were very happy with the service, that they had been actively involved in the care plan and had been asked for input regularly.

On person said they didn't know if there were any activities but said they would like to go swimming. A

second person also said there were no activities taking place and they too would like to go swimming. One of the care workers was also the activity co-ordinator. We saw posters and photographs of past activities and were told five people went to the science museum in November and to see the Christmas lights in central London in December 2018. There was a monthly film club, but it was not clear if people using the service were choosing the films. The activity co-ordinator had a Level 2 award from the National Activity Providers Association (NAPA) but was not able to explain to us why some activities were more useful than other leisure activities, for example to help improve or maintain people's motor skills. There was no planner to show people what the daily activities were. Games and craft activities were put away in cupboards, so people could not access them outside of the designated activity times and some of the equipment, for example the dominos were inappropriate as they had children's characters on them indicating they were for children and not adults. The activities we observed during the whole two days of the inspection were chair exercises and a game of skittles, which meant most people using the service did not have a meaningful activity to take part in.

Care files had a section for people's end of life wishes but we did not see one that was completed. They all recorded that people were unsure and there was no record of the conversations staff had with people to explore this area. This demonstrated that staff lacked the confidence and knowledge to address these matters with people and their relatives. One person's care plan stated they had not made any advance decision or a decision about whether or not they wanted to be resuscitated if they stopped breathing. Another person's end of life care plan recorded it needed to be discussed with relatives and under last wishes the care plan recorded the person is unsure of their wishes. We saw in one care plan that although the person had the capacity to make decisions for themselves, their end of life care stated it needed to be discussed with the next of kin. Another person's end of life care plan also stated they were unsure of their wishes. A DOLS care plan stated there was no advance decision to be resuscitated but we saw the person had a resuscitation order for Do not attempt cardio-pulmonary resuscitation (DNACPR) in transport in place from November 2017 but the end of life and last wishes sections made no mention of DNACPR. A fourth person's end of life care record stated the need to speak with their social worker.

Care staff we spoke with were unsure about end of life care. One care worker said they completed training but did not give a further explanation of how they implemented it. A second care worker told us, "We don't have training but we do care for people. The nurse comes and tells us what to do. We call the doctor when they are going" and a third care worker said they had completed on line training and knew people had end of life care plans but did not know what was in them. The above showed that staff lacked confidence and were not adequately supported to discuss end of life care issues with people or their relatives, so these needs could be appropriately assessed and planned for.

This was a repeated breach of Regulation 9 of the Health and social care Act 2008 (Regulated Activity) Regulations 2014.

The provider had a complaints procedure dated May 2018. There was a complaints box in the reception area with blank pieces of paper to write complaints on. The reception had a keycode and was not accessible to people using the service and therefore they could not access the reception area to get a blank piece of paper to write their complaint, if they had one. The complaints procedure and form were also not available in other formats such as an easy read format. One person said they did not know who to complain to and were worried about complaining in case something negative happened. Another person using the service said they had no complaints but if they had they did not know who to go to.

We saw evidence that since the last inspection, the provider had responded to complainants by email, but there were no clear investigation records with the outcomes of the investigations and learning points, where

these might have been necessary. Therefore, it was not clear what action had been taken as a result of the complaint to identify, where appropriate, areas to improve service delivery as part of meeting individual needs.

This was a breach of Regulation 16 of the Health and social care Act 2008 (Regulated Activity) Regulations 2014.

We received mixed feedback from people about whether they knew how to make a complaint. One person said they did not know who to complain to and then said they wouldn't complain. Another person said they would complain and knew how to. They said they "would report problems to different people depending on what the problem was and its seriousness".

Inadequate

Is the service well-led?

Our findings

At the inspection on 9 May 2018, we identified a breach of regulation relating to good governance. This was because the provider's quality assurance arrangements were ineffective and we had identified multiple breaches of regulations including breaches of some regulations we had identified at the previous inspection. Following the inspection of May 2018, the provider sent us an action plan dated 31 August 2018 to tell us what they would do to address the identified breaches. During the inspection on 4 January 2019, we found the provider was not compliant with the regulation.

The provider did not have effective quality assurance systems to monitor the service delivery. Audits were in place but we did not see evidence that these were completed consistently each month or were utilised to improve service delivery. The last Management Audit – Care Overview completed was dated 10 October 2018. Where 'corrective action' had been written there were no target dates completed. The questions on the audit covered all people using the service but clearly each person's file was not looked at and this was confirmed by the deputy manager. The audit was not effective as it did not identify issues noted in the inspection. For example, it asked, 'Do care plans contain personalised information of each individuals wishes and preferences?' The answer was 'yes' but none of the nine care plans we looked at had details for end of life wishes. Another question asked, 'Are there any individuals in the care environment with challenging behaviour?' The answer was 'yes' and the 'corrective action: safeguarding has been alerted'. There was no preventative action and it lacked a management overview of how challenging behaviour was managed. A third question was, 'Are regular meetings held to allow individuals to be involved in service affecting decisions?' The answer was 'yes' but we only saw evidence of one meeting for people using the service in 2018.

In the Management Audit – Health and Safety dated 10 October 2018, it asked, 'Can staff demonstrate knowledge of the position of firefighting equipment?' The comment was, 'evac+chair need training' but there was no target date for completion. We saw, 'Are all staff trained in the basic level of manual handling?' answered as 'yes' but also saw one staff member's training summary indicated they had scored 40% in their manual handling training. This meant the member of staff had a less than adequate knowledge of moving and handling but there was no follow up to this. We did not see completed audits for November and December 2018. Our findings showed that the provider's audits and checks lacked detail, depth and had not identified the issues relating to the quality of the service raised during the inspection.

The Management Audit for maintenance and grounds dated 12 September 2018 asked, 'Are hydraulic lifts functional?' The answer was 'Partially. Two hoists require a service' but there was no target date for when the repairs would be completed by. We also saw a Management Audit –Medication dated 12 October 2018 and an audit for infection control dated 12 September 2018. These did not identify areas of concerns seen during the inspection around the failure to manage medicines in a safe way and staff not always following good practice in the relation to the control spread of infection.

Poor care practices were allowed to continue because there appeared to be a lack of leadership in the home and the staff did not receive the training and support needed to improve.

There was no evidence to indicate people's health needs were monitored robustly, for example where they had needs in relation to weight, fluid intake and diabetes. Although the deputy manager told us they ran a report of various monitoring records such as weight, and looked at it daily, we did not see any evidence of actions taken or how people's wellbeing was improved.

The above was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the management team had a check list with actions based on the last CQC inspection and that there were weekly meetings with the chair of the home's committee and, in the absence of a registered manager, the deputy manager. Since the last inspection, the provider had also implemented an on-line care system and provided staff with hand held devices for recording care.

Relatives said they could raise concerns with staff. One relative said, "I can talk to [deputy manager] or the team leaders. Team leaders are excellent. Trying their hardest to get back on track although personally I don't know if they were off track [a reference to the last CQC report]."

We saw feedback forms from nine relatives dated September 2018 with generally good feedback including, 'The staff seem very gentle, welcoming and well meaning', [Person's] care is excellent' and 'Staff very friendly with residents.' Less positive comments were around the lack of choice in the menu. There was no summary or action plan to demonstrate lessons had been learned and service delivery had improved. Five people using the service also completed feedback forms and overall were satisfied with the service.

We saw signature sheets for team meetings held in September and November 2018 but no minutes or actions from the meetings. Therefore, staff who did not attend the meeting were not given the opportunity to read the minutes and keep themselves updated. We saw a residents and family meeting was held on 8 September 2018.

When we asked care workers if they felt supported in their role, they told us, "The service is great because staff are very good. Now I am happy. I don't know who the manager is", "I can talk to manager. [Deputy] is acting manager. They understand more than [nominated individual]", "We need proper managers. [Previously, one manager] was always here and both on call, so support was always there" and "[Nominated individual] comes about once a month and in the evening and stays in the office. [Previous manager] is good. [Deputy manager] is very good and helpful."

The nominated individual, who was fulfilling the manager's role, was undertaking a Health and Social Care level 5 management course and a leadership programme with the local CCG. They were also attending provider forums hosted by the local authority to help improve their knowledge and skills.

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 11 HSCA RA Regulations 2014 Need for consent The provider did not always seek consent for care and treatment from the relevant person and did not demonstrate they always acted in accordance with the Mental Capacity Act 2005. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not operate an effective system for handling and responding to complaints. Regulation 16 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not make sure that recruitment procedures were operated effectively to ensure the information specified in Schedule 3 was obtained in relation to each person employed. Regulation 19(3) (a) Schedule 3