Lifestyle (Abbey Care) Limited

# Lifestyle (Abbey Care) Limited Elizabeth - Swale

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

We carried out this inspection on the 28 November 2016. The inspection was unannounced, which meant the staff and registered provider did not know we would be visiting.

During an inspection in February 2015, we rated the home, 'Requires improvement' because we identified multiple breaches of the regulation. Within this rating, we found the 'Safe' domain was 'Inadequate. These breaches of the regulation related to the delivery of safe care and treatment, safeguarding people from abuse; premises and equipment; consent to care or treatment; and maintaining people's dignity.

We completed a focused inspection in August 2015 to look at what changes the registered provider had made since inspection in February 2015. We found that improvements had been made and the breaches of regulation had been addressed. The domain of 'Safe' was now rated as 'Requires improvement,' and the domain of 'Caring' had improved and was therefore rated as 'Good.' However, we needed to see that the improvements were sustained.

We completed this inspection to review the action the registered provider had taken since the last inspection and to see if the improvements identified during inspection in August 2015 had been sustained.

Lifestyle (Abbey Care) Limited - Elizabeth Swale is a residential care home, located on the Abbey Care Village site in Scorton.  The service provides residential care for up to 54 people living with a dementia and does not provide nursing care. The home is divided into Elizabeth House, which is a two storey unit that can accommodate up to 30 people. The other unit is Swale House, which is located on the third floor of another home on the site and can accommodate 24 people. Swale House is currently being refurbished and is empty. At the time of inspection there were 27 people living at the service.

There has been a registered manager in place since March 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection, we found that people's prescribed medicines were not safely managed. People did not receive their prescribed medicines when they needed them and medicine administration records were not accurately completed. We found people were at risk of harm because of the way medicines were managed.

There was a lack of information in people's risk assessments and care plans. This meant they did not accurately reflect people's risks and the care and support they needed from staff to keep people safe. We found that these risk assessments and care plans contained conflicting information, were not updated when people's needs changed which meant that the information in them was not always accurate.

From our observations, we found that some people who used the service required two to one support. We

looked at staffing levels to determine whether there was sufficient staff on duty to care for people safely. We requested information from the registered manager/provider about how they determined staffing levels; however we did not receive this information.

During inspection, we noted there was one senior carer and three care staff on duty throughout the day and two care staff during the night. When we arrived for inspection at 06:00, we could see that one person had experienced a fall, but had been left unattended whilst staff contacted 111 emergency services for assistance and checked the other people using the service to ensure they did not need assistance. This meant there were not enough staff on duty to provide safe care and support to people.

The dependency level record produced by the registered manager on 12 November 2016 showed 13 people were rated as having a high dependency; 15 people rated at a medium dependency and one person was rated as low dependency. Although the level of need had been assessed this did not translate into a change in staffing numbers, as the rotas showed no variation in staff on duty. On the day of the visit the number of people who lived at the home was 27 but this impact of this change was minimal. The registered manager worked in a supernumerary capacity and the deputy manager during the week who told us they would assist if needed but this was dependent upon their workload. We found from the review the dependency levels, discussions we staff and people and our observations there were insufficient staff on duty to meet the care and support needs of people. There were insufficient staff on duty overnight to ensure people could be safely evacuated from the home in the event of a fire.The registered provider accepted our concerns that there were insufficient staff to meet people's needs and since the inspection they have being in the process of recruiting more staff. However the updated dependency tool they have provided still indicates that only two staff are needed overnight.

We found that although refurbishment work had been completed, this had not involved ensuring the lighting and heating were adequate. The registered provider was asked to ensure the lighting levels complied with health and safety guidance.

We found that regular checks of the hot water temperatures were completed. These checks revealed water was routinely between 38°c to 39°c, which is below the recommended temperature of 43 degrees Celsius (°c). The registered provider failed to notice that water temperatures were below recommended levels and failed to take action to increase water temperatures to safe levels. This meant people experience unsafe bathing temperatures and put them at risk of harm.

We observed staff washing plates and cutlery in the sink in the dining room. Although a thermostatic valve was in place, we found the hot water was below safe water temperatures. A domestic dish washer was in place, however could not accommodate all of the dishes. When we spoke with staff, they failed to recognise the risks posed to infection prevention and control because of unsafe water temperatures. Following inspection, the registered manager took action to obtain an industrial dishwasher.

A third of the people chose to sit in the lounge in their overcoats; staff told us this was because the people believed they were going to work, but individuals told us it was because they were cold. No ambient room thermometers were in place so staff could not check the temperature of the home so could not be assured the recommended temperature of 21°c was met. We found during the morning that the ambient room temperature in the communal areas was 19°c.

There was evidence to show that the registered provider was working within the principles of the Mental Capacity Act 2005 (MCA). However we found that staff could not always effectively demonstrate how best

interest decisions were made and followed. This meant we could not be sure if staff fully understood the requirements of MCA.

Deprivation of Liberty Safeguards (DoLS) authorisations had started to be obtained; of the 12 authorisations sent, only five had been completed. We found that the conditions imposed were not always met and there was no system in place to monitor how staff were meeting conditions and that renewals were requested in a timely manner. Staff were unaware that people had the right to contest the DoLS authorisation and they were entitled to legal aid should they wish to make representations to the Court of Protection about their detention.

Staff were unaware that some of the people who used the service had been detained under a section of the Mental Health Act 1983 (amended 2007) and were now residing at the home under a community treatment order (CTO). This meant, staff had failed to obtain information about the conditions these people had to abide by or that the person had a right to appeal to the Mental Health Tribunal about their detention and were entitled to legal aid.

We asked the registered manager if anyone needed the support of an advocate. They told us that no-one currently required this type of support.

People were protected from the risks of harm or abuse because there were effective systems in place to manage any safeguarding concerns. Staff understood their responsibilities in respect of protecting people from the risk of harm. No safeguarding alerts had been raised in the last two years, which is considered unusual for this type of service, as people living with dementia can become agitated, which can lead to them coming into conflict with staff and other people. Recent accident and incident records showed people could become agitated and confrontational, which would suggest alerts may have been needed.

New staff had been employed following the home's recruitment and selection policies and this ensured that only people considered suitable to work with vulnerable people worked at the service.

We found that one staff member had transferred from a sister home but the registered manager had not checked their recruitment file. This file showed the person had previously been a registered nurse but was suspended from practice; the previous home had not followed this matter up. In failing to check this recruitment file, the registered manager had failed to notice that the sister home had not completed robust recruitment procedures and had failed to investigate this matter to determine whether this staff member had been fit and safe to work at the service.

Staff were receiving support through supervision and received relevant training but the registered manager needed to ensure discussions focused on relevant practice such as staffing levels and training was effectively implemented.

An activities coordinator was in post three days per week. We found that a limited range of activities were provided at the service. During our inspection, we did not observe any activities taking place. Relatives and visitors spoken with during inspection told us that they never saw the activities coordinator and did not see people engaged in one to one or group activities.

Quality assurance audits undertaken by the registered manager were designed to identify whether systems at the home were protecting people's safety and well-being. When quality audits identified that improvements needed to be made, there was a record of when actions had been completed. However the audits were not effective as they failed to pick up the issues which we identified during inspection.

The registered provider was not submitting statutory notifications in respect of the outcome of DoLS applications or events that affected the service such as a broken lift. We also observed that the registered provider was not displaying the latest CQC rating in the home. We are taking action outside of this inspection to ensure the registered provider meets these legal requirements.

People told us that they were very happy with the food provided. We observed that people's nutritional needs had been assessed and required fortified foods. The meals were provided by the sister home and at their inspection we found the catering budget for 57 people was £600 a week. We queried with the registered manager how sufficient fortified food was provided on this budget. The nominated individual informed us that since our inspection of the sister home the budget had been increased. Staff also informed us that in recent weeks the quantity and quality of food had improved.

People's care records were person centred but needed to be improved so they consistently and accurately identified people's needs and wishes. Person centred planning [PCP] provides a way of helping a person plan all aspects of their life and support, focusing on what's important to the person. From speaking with staff, we could see they had an in-depth knowledge of people's needs.

Accidents and incidents were now monitored each month to see if any trends or patterns were identified. The registered manager used this information to ensure appropriate equipment and support was in place. They bought sensor mats, high/low beds and referred people to physiotherapists, GP, falls teams and instigated enhanced observations-all our accidents forms have action plans attached to them.

People who lived at the service and their relatives told us that staff were very caring and that they respected people's privacy and dignity. We saw that there were positive relationships between people who lived at the home, their relatives and staff; staff had a good understanding of people's individual care and support needs.

The registered manager had systems in place for monitoring and overseeing the operation of the home, however these needed to be improved.

Meetings were taking place for people who used the service, relatives and staff. The relatives we spoke with felt the registered manager was approachable and had made positive changes to the home. They found that concerns were now being addressed and felt improvements had been made at the home.

People were supported to access healthcare professionals and services. People told us they could access their GP if they felt unwell and records showed when health professionals were involved in people's care.

The premises were clean, hygienic and well maintained and there was plenty of personal protection equipment [PPE] available. We saw there was appropriate signage, decoration and prompts to assist people finding their way around.

We saw certificates for safety checks and maintenance which had taken place within the last twelve months such as fire equipment, electrical safety and water temperature checks. We found that since the last inspection the maintenance person had been enabled by the registered provider to complete all of the repairs and could now take action in a timely manner to fix any problems.

We identified that work was needed to ensure four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was rectified. You can see what action we told the registered provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

We looked at how medicines were handled and found that the arrangements were not always safe.

Assessments were undertaken to identify risks to people using the service and others, but these were not always accurate or up to date.

Staff had been recruited following the home's policies and procedures, but the registered manager needed to review the files of people who transferred from the sister home.

There were insufficient numbers of staff deployed to ensure people received safe and effective support.

Action was needed to improve the lighting, ambient room temperatures and hot water temperature.

Staff had received training on safeguarding adults from abuse and understood their responsibility to report any incidents of abuse.

The premises were clean and equipment checks were regularly completed.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff were assessing people's capacity to make decisions but were not making formal best interest decisions.

Improvements were needed around ensuring DoLS authorisations were monitored and staff were aware of conditions from these or for community treatment orders.

People's physical and mental health care needs were assessed but care records did not always reflect changes.

Staff undertook training that gave them the skills and knowledge

they required to carry out their roles.

People's nutritional needs were assessed and the meals provided met people's individual dietary needs.

Staff consulted health and social care professionals and they told us their advice was followed by staff.

## Is the service caring?

**Good**

The service was caring.

We observed positive relationships between people who lived at the home, relatives and staff. Staff were kind, considerate and patient.

People's individual care and support needs were understood by staff, and people were encouraged to be as independent as possible, with support from staff.

We saw that people's privacy and dignity was respected.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

People's care plans recorded information about their individual care and support needs and their life history. However, these were at times contradictory and were not up dated as people's needs changed.

Very limited activities were provided and this meant people were regularly sat with nothing to occupy them.

People were encouraged to give feedback about the service they received.

There was a complaints procedure in place and people told us they were confident any complaints would be listened to.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

Quality audits were being carried out to monitor that the service was providing safe and effective care, however they had not captured the concerns we had with medicines.

Notifications were not always being submitted to CQC as

required by legislation.

There were opportunities for people's family and friends to express their views about the quality of the service provided.

# Lifestyle (Abbey Care) Limited Elizabeth - Swale

**Detailed findings**

## Background to this inspection

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

This inspection took place on the 28 November 2016 and was unannounced. This meant the registered provider and staff did not know we were visiting.

The inspection team consisted of two adult social care inspectors and a pharmacy inspector.

Before our inspection, we reviewed the information we held about the home. We looked at statutory notifications that had been submitted by the home. Statutory notifications include information about important events which the registered provider is required to send us by law. We reviewed the feedback we had received from the local commissioners and placing authorities. This information was reviewed and used to assist us with our inspection.

The provider was not asked to complete 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.

During the visits we spoke with nine people who used the service, six relatives, staff from a voluntary befriending group, a community nurse, the nominated individual, registered manager, deputy manager and six staff members. We undertook general observations and reviewed relevant records. These included five people's care records, the medicine records for 14 people, six staff files and other relevant information such as policies and procedures.

Requires Improvement

# Is the service safe?

## Our findings

At the inspection in August 2016 we found that the breaches in regulations relating to safe care and treatment; safeguarding people from abuse, infection control and the maintenance of the building had been rectified.

At this inspection we found the management of medicines were not always safe and the records relating to medication were not completed correctly.

Medicine stocks were not properly recorded when medicines were received into the home or when medicines were carried forward from the previous month. This is necessary so accurate records of medication are available and care workers can monitor when further medication would need to be ordered. We also found gaps in the medicine records which we looked at because staff had not signed for the administration of medicines. It was therefore, not always possible to confirm if care staff gave people their medicines as prescribed.

We also saw that some topical creams were applied by care staff. Although the home had a policy, stating clear information on where to apply and the frequency of application we saw this was incomplete and the recording of the application of these topical creams was poor. This meant we could not be sure if people were receiving their topical creams as prescribed. We spoke with one carer about people's topical creams and they told us that they had applied topical creams that morning, but had not made a record of the application.

When we checked a sample of medicines alongside the records for seven people, we found that twelve medicines including oral medicines, inhalers and nutritional supplements did not match up. This meant we could not be sure if people were having their medication administered correctly.

Five medicines for two people were not available. This meant that appropriate arrangements for ordering and obtaining people's prescribed medicines were failing, which increased the risk of harm.

For a medicine that staff administered as a patch, a system was in place for recording the site of application; however, staff had not fully completed this for one person whose records we looked at. This is necessary because the application site needs to be rotated to prevent side effects.

Some people had medicines administered covertly. This is when medicines are given in food or drink to people unable to give their consent or refuse treatment. We saw that the GP had authorised covert administration (adding medicines to food) for people who did not have capacity and were refusing essential medicines. However, the information on how this would be done was not clear and there was no information to confirm that guidance had been sought from the pharmacist to make sure that these medicines were safe to administer in this way. This information would help to ensure people were given their medicines safely when they were unable to give consent.

Most of the people who used this service had their medicines given to them by the staff. We watched a carer giving people their medicines. They followed safe practices and treated people respectfully. Staff wore a red tabard to prevent interruptions, however the morning medicine round went on until 11:30am and the actual time of administration was not recorded. This is necessary so that an appropriate gap can be left between medicines such as Paracetomol.

We looked at the guidance information kept about medicines to be administered 'when required.' Although there were arrangements for recording this information, we found this was not kept up to date and information was missing for some medicines. This information would help to ensure people were given their medicines in a safe, consistent and appropriate way. For example, one person was prescribed a medicine that could be used for agitation and anxiety. There guidance in place was did not give specific information for this person and there was no information on how much time should be left between doses.

Medication kept at the home was stored safely. Appropriate checks had taken place on the storage, disposal and receipt of medication. This included daily checks carried out on the temperature of the rooms and refrigerators that stored items of medication. Staff knew the required procedures for managing controlled drugs. We saw that controlled drugs were appropriately stored and signed for when they were administered. Two eye drops, which have a short shelf life once opened were not marked with the date of opening. This meant the home could not confirm that they were safe to use.

We looked at how medicines were monitored and checked by managers to make sure they were being handled properly and that systems were safe. The home had completed weekly audits, but these were not robust and had not picked up any of the issues we found.

One relative told us they felt that staff did not share information about accidents appropriately and this led to follow up action not being taken. They said, "My relative was complaining of pain in their side and shoulder and told me they had suffered a fall. I asked staff if they had fallen, and they told me. "No they hadn't." A couple of days later I was helping to bath them, as staff hadn't done it again, and notice bruising to their side. I asked my relative what had happened and they said again they had fallen, The GP checked my relative over and staff were asked again and told us no they had not fallen. It later turns out my relative had fallen during the night and the information had not been passed over to day staff. I was not happy but I have spoken to the manager about it." We discussed this matter with the registered manager who confirmed that following this being brought to their attention steps had been taken to improve communication between staff.

We reviewed five peoples care files and saw risks to people's safety were identified and risk assessments had been completed for any areas that were considered to be of concern. We saw risk assessments for pressure area care, the risk of choking, the risk of malnutrition and the risk of falls. However risk assessments and care plans lacked the detail needed, contained conflicting information and were not always updated when people's needs changed.

For instance, a risk assessment had been completed for one person and stated that the person was unable to use the call bell due to limited mobility and movement. Care plans within the care file did not correspond, often stating 'Ensure call bell is within reach at all times.' Whereas a moving and handling care plan and risk assessment stated that two staff were needed to assist with transfers. However, the 'Maintain a safe environment' care plan detailed that 'At least three care staff should help stand person up'. This was all conflicting information.

Although refurbishment work had been completed, this had not involved ensuring the lighting and heating

were adequate. Poor lighting increases the risk of falls for older people. The registered provider was asked to ensure the lighting levels complied with health and safety guidance, which suggests lighting levels to between 150 and 500 lux.

We found that regular checks of the hot water temperatures were completed. These checks revealed water was routinely between 38°c to 39°c, which is below the recommended temperature of 43°c, but no action was taken to increase the water temperature.

Staff washed plates and cutlery in the sink in the dining room, which had a thermostatic valve in place and again the hot water was below the recommended temperature. Staff did not recognise the infection prevention and control risks posed from not using hot water to wash dishes. The registered provider had a dishwasher installed, however this was a domestic not industrial one so could not accommodate all of the dishes. The registered manager undertook to obtain an industrial dishwasher.

A third of the people chose to sit in the lounge in their overcoats. Staff said this was because people believed they were going to work, but people we spoke with told us it was because they were cold. No ambient room thermometers were in place so staff could not check the temperature of the home so could not be assured the recommended temperature of 21°c was met.

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

People we spoke with felt staffing levels were too low and this impacted upon the care that was being delivered.

A relative said, "Staff are caring, but I think they are under-staffed."

We asked for information about how the service determined their staffing levels; however we did not receive this and staff could not tell us how staffing levels were calculated. During inspection, we found there was one senior carer and three care staff on duty throughout the day and two carers during the night. When we arrived at inspection, we found that one person had experienced a fall at 6am, but had been left unattended. We found that one staff member had rung 111 emergency service and the other staff member had gone to check on other people using the service.

We observed practices at the home until after teatime and saw staff were constantly tending to tasks. Staff were very busy, and did not always have time to complete their support of one person before helping another. For example, we saw staff were called away from supporting people to eat their meals, to assist other people or to take meals to people who remained in their bedroom. This meant people did not receive the assistance they needed at mealtimes.

The dependency level record produced by the registered manager on 12 November 2016 showed 13 people were rated as having a high dependency; 15 people rated at a medium dependency and one person was rated as low dependency. Although the level of need had been assessed this did not translate into a change in staffing numbers, as the rotas showed no variation in staff on duty. On the day of the visit the number of people who lived at the home was 27 but this impact of this change was minimal. The registered manager worked in a supernumerary capacity and the deputy manager during the week who told us they would assist if needed but this was dependent upon their workload. We found from the review the dependency levels, discussions we staff and people and our observations there were insufficient staff on duty to meet the care and support needs of people. There were insufficient staff on duty overnight to ensure people could be

safely evacuated from the home in the event of a fire. The registered provider accepted our concerns that there were insufficient staff to meet people's needs and since the inspection they have being in the process of recruiting more staff. However the updated dependency tool they provided still indicates that only two staff are needed overnight.

When staff had time, we saw that they took the time to speak with people. However we identified lengthy periods where people were sat without any interaction from staff. For example, we completed a SOFI observation in the lounge and saw that the people had no interaction with staff for 45 minutes, though staff did look into the lounge when passing to check that people were safe. A SOFI is a short observational tool specific to people living with a dementia.

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

We spoke with staff about safeguarding. Staff were able to describe the different types of abuse, and the action they would take if they became aware of an incident of abuse. Staff told us that they would report any concerns to the registered manager. Staff were confident they would be listened to and that appropriate action would be taken. We found safeguarding training was up to date for all staff. However we noted that no alerts had been made for two years. Accident and incident records suggested there had been occasions when people came into conflict, or people had needed to be physically escorted back into the building or staff had not handed over information from falls. Records indicated incidents that should have been reported to the local authority safeguarding team.

Staff told us they would not hesitate to use the home's whistle blowing policy and that they were confident the registered manager would protect their confidentiality. Whistleblowing is where an employee reports misconduct by another employee or their employer. One staff member said, "I would not think twice about going to the manager to report anything, I have got no worries about that, as they always listen to what we say." Despite staff feeling confident to raise concerns they had not raised safeguarding alerts in relation to staff not handing over information.

We found the systems in place for monitoring incidents was not picking up issues that would indicate potential abuse had occurred and therefore be reported to the local safeguarding team.

This was a breach of Regulation 17 (Good governance) of The Health and Social Care Act (Regulated Activities) Regulations 2014.

During the inspection we looked at recruitment records for six staff. Recruitment records contained a completed application form and interview questions. We could see that gaps in employment history had been investigated and recorded. All of the six staff had received a Disclosure and Barring Service check before employment commenced. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people working with children and vulnerable adults. Two checked references were available in the staff records we looked at but for one person this was not from their last employer. The registered manager explained that some staff had not previously worked so they had approach the available referees. Other people had moved from outside of the United Kingdom so they found it difficult to obtain references.

Checks of the building and equipment were carried out to minimise health and safety risks to people using the service and staff. We saw documentation and certificates which showed that relevant checks had been

carried out on the electrical installation, gas services, portable electrical equipment and the services lift. We saw that a fire risk assessment was in place and regular checks of the fire equipment were carried out to ensure that these were in safe working order. Records showed that fire drills were held to ensure that staff knew how to respond in the event of an emergency.

A Personal Emergency Evacuation Plan (PEEP) was in place documenting evacuation plans for people who may require support to leave the premises in the event of a fire. The PEEPs detailed information such as how many people were needed to support the person, what equipment they would need and how far the person could walk. This showed that the registered provider had taken appropriate steps to protect people who used the service against risks associated with the home environment.

The registered provider had a business continuity plan, which provided information about how they would continue to meet people's needs in the event of an emergency, such as flooding or a fire forced the closure of the service. This showed us that contingencies were in place to keep people safe in the event of an emergency.

The home was clean. The domestic staff told us they had access to all the equipment they needed. All the necessary control of hazardous substances to health (COSHH) information was in place. COSHH details what is contained in cleaning products and how to use them safely.

Requires Improvement

# Is the service effective?

## Our findings

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) authorisations.

At the time of inspection Deprivation of Liberty Safeguards (DoLS) authorisations were being obtained but of the 12 sent only five had been completed. Staff incorrectly thought that sending an application away would mean the DoLS authorisation was in place.

The conditions imposed were not always met and there was no system in place to monitor how staff were meeting conditions and that renewals were requested in a timely manner. For instance the condition of one person's DoLS was that they must be allowed to regularly access the garden space and participate in walks in the local community with support from staff as this person enjoyed being outdoors and going on long walks. We looked at the person's daily records over a four week period and could see no evidence that support in this area had been provided. This person was not supported to access the garden during our inspection. The staff we spoke with were not aware this was a condition of their DoLS authorisation.

Staff were unaware that people had the right to contest the DoLS authorisation and they were entitled to legal aid should they wish to make representations to the Court of Protection about their detention.

Staff were unaware that some people who used the service had been detained under a section of the Mental Health Act 1983 (amended 2007) and were now residing at the home under a community treatment order (CTO). This lack of awareness had led to staff not obtaining information about the conditions these people had to abide by or that the person had a right to appeal to the Mental Health Tribunal about their detention and were entitled to legal aid.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The care records we reviewed contained assessments of the person's capacity to make decisions. We found that the staff had an understanding of the MCA and what actions they would need to take to ensure the home adhered to the code of practice.

Staff had ascertained the legal status of family members when making decisions for people who used the service. Information was available to determine if relatives had lasting power of care and welfare or had been appointed as a deputy by the Court of Protection. Staff we spoke with were aware that if a person makes decisions for a person who lacks capacity they needed to have the legal authority to make care and welfare decisions.

However, we found that care records did not always detail the action staff had taken to establish the least restrictive option for people. Records did not also detail how these choices had been communicated to people. We found that some people's records were unclear about people's capacity. For example, people's records stated people had capacity and lacked capacity. There were no records to confirm that 'Best interest' discussions had taken place with the person's family, external health and social work professionals or senior members of staff prior to decisions being made, such as to give medicine covertly. For instance one person who lacked capacity to make decisions had been a lifelong vegetarian but since moving into the home, staff had been giving them meat. There was no information to show why this was occurring or if this change in diet had been taken following the completion of a 'Best interest' meeting.

This was a breach of regulation 17 (Good governance) of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

At our last comprehensive inspection of the service in February 2015 we found staff needed additional training around delivering appropriate care for people living with dementia and the requirements of the Mental Capacity Act 2005 (MCA).

At this inspection, we found that the service had taken action to address this and staff had completed this required training. Although not fully up to date the majority of staff had completed mandatory training in safeguarding, MCA, health and safety, moving and handling, COSHH, fire and infection control and had undertaken condition specific training. The registered manager was aware of the shortfalls in training, which related to ensuring the newest members of staff, and had arranged for this training to take place.

We spoke with relatives about staff and they told us, "There are a few new ones but they all seem quite nice. I know a lot of them as I have worked with some of them." And, "My other sister visits set days too. I know the home would ring me if there were any concerns between by visits."

Staff we spoke with said, "Since the [Registered] manager come in to post we have had lots of training. I am currently about to start a NVQ level five. We completed a course at the Friarage Hospital about completing assessments and we start completing our annual refresher course next week." And, "I have learnt a lot from the [Registered] manager and we certainly have been able to go on lots of training over the last two years, obviously the mandatory training but also courses like dementia care, completing effective care plan evaluations and Malnutrition Universal Screening Tool (MUST) records."

The six staff files we looked at had up to date training in areas including, moving and handling, infection control, health and safety, food hygiene, first aid, nutrition, dementia and care planning. However, only two of the six staff files contained certificates to confirm they had received training in safeguarding and none had certificates for MCA or DoLS training. The registered manager explained that recently an administrator had left and they had found the files not to be order. They and the deputy manager were going through the staff files to make sure they contained all of the correct documents.

Supervision and appraisals are formal methods of support provided to all staff. We found that staff had been supported with regular supervisions. Areas that were discussed included record keeping, relationships with staff and people who used the service, safeguarding and a review of set objectives. Annual appraisals had been conducted and gave staff the opportunity to discuss their performance and areas of improvement. We discussed with the registered manager the need to ensure key issues such as reviewing staffing levels and checking that staff were completing training formed a part of the discussion and the outcome was factored into the development plan.

We asked people who used the service what they thought of the food. People we spoke with said, "The food is good." Another person said, "I think the food is tasty."

We observed breakfast and the lunchtime as well as afternoon refreshments. People had the option to eat where they wanted, such as any dining room, their own room or in a communal lounge. Most people chose to eat in a dining room. People were asked what they wanted to eat for lunch at breakfast time. However the option for lunch was always one cooked meal or sandwiches, which meant some people may never have a hot meal if they did not like the choices on offer.

One visitor told us that their relative had experience weight loss initially but had now gained weight and said "The meals seem fine. I haven't eaten here but my Dad seems to enjoy them." And, "Lunch time seems ok and a lot more organised. Meals are served in the dining area but on a tea time there is no management at all. It's like a 'Snack tea' and things are put out on the tables and people are expected to just help themselves. Most of the time the staff are just chatting amongst themselves in the kitchen. I do wonder how many people actually eat at tea time."

The service used the Malnutrition Universal Screening Tool (MUST) to assess people. This is an objective screening tool to identify adults who are at risk of being malnourished. As part of this screening we saw people were weighed at regular intervals and appropriate action taken to support people who had been assessed as being at risk of malnutrition. Care records showed the service was referring people to a dietician or speech and language therapist (SALT) if they required support with swallowing or dietary difficulties.

Over half of the people using the service required a fortified diet. This is a way of providing extra nutrition to people. From speaking with the registered manager, we found that the catering budget for 57 people was £600 per week. We queried with the nominated individual how sufficient fortified food was provided on this budget. They informed us that since our inspection of the sister home the budget had been increased. Staff also informed us that in recent weeks the quantity and quality of food had improved, as previously they had often run out of items such as milk and bread.

People had contact with health professionals when they needed to. We saw records to confirm that people had visited or had received visits from the dentist, optician, chiropodist, dietician and their doctor. The registered manager said that they had good links with the doctors and district nursing service. People were supported and encouraged to have regular health checks and were accompanied by staff to attend hospital appointments.

One relative told us "GP visits the service every Thursday so I know my relative will get seen if there are any concerns." We spoke with a visiting community nurse who told us staff from their team visited daily and they found the staff appropriately raised matters with the team. They found the staff were really helpful and on the whole were satisfied with the care being delivered. The very occasional blips that occurred were quickly resolved and they felt the registered manager had made a real difference to the home, which meant it was now running well.

Good

# Is the service caring?

## Our findings

People told us they were happy living at the service. Relatives told us they found staff worked hard to meet people's needs and they were satisfied with the care being provided. People told us they were content with the care being delivered.

People said, "Staff are very friendly and helpful." And, "I'm happy here. They do a good job." And, "Dad is happy to be here and always says the staff are kind." And, "They [Staff] are very kind." And, "They [Staff] are nice here."

Visitors and relatives said, "I find the staff very caring, friendly and attentive, if my relative needs anything staff are ready to help." And, "When we first started coming to the service we used to see people wet and dirty. We don't see that now, so I think things have improved." And, "My relative gets up and goes to bed when they want. I can visit whenever I want. The door is always open. I generally visit the same days each week as it helps my relative with their routine and memory."

A member of a befriending charity that regularly visited the home said, "Care staff did have a caring nature and were very good at what they do but that there were a lot of new faces that he couldn't comment on." They also felt that a number of staff's English was poor and this impacted how effective they were in delivering care.

The service had received several written compliments from people and their relatives. Relatives wrote, 'Dad was well looked after for which we are very grateful.' And, 'The staff are friendly and helpful.'

A number of people who used the service had difficulty expressing their views so we observed practice. We found that when staff had the opportunity to speak with people they were respectful and spoke with people. However, we found that staff were extremely busy throughout the day so had little opportunity to spend much time in meaningful conversation with people. We also noted that, for some staff, English was not their first language and they had difficulty chatting to people. We could see these staff were still learning conversational English.

We saw that staff were courteous towards people who lived at the service, knocking on bedroom doors prior to entering and dealing with any personal care needs in a way that respected the person's privacy and dignity. Throughout the inspection we saw that staff treated people with respect and took steps to maintain their dignity. One staff member we spoke with said, "I always make sure I'm discreet when providing personal care." Another staff member said, "I explain what I am doing and what is happening to make the person feel at ease."

Staff encouraged people to maintain their independence and only assisted them with the things they found difficult or could not achieve. One staff member said, "I encourage people to do as much as they can for themselves."

People were seen to be given opportunities to make decisions and choices during the day, for example, what to have for their meal, going out or what activities to do during the day.

The registered manager and staff that we spoke with showed genuine concern for people's wellbeing. It was evident from discussion that all staff knew people very well, including their personal history preferences, likes and dislikes and had used this knowledge to form very strong therapeutic relationships. We found that staff worked in a variety of ways to ensure people received care and support that suited their needs.

The environment supported people's privacy and dignity. We looked in some people's bedrooms and found they contained personal items that belonged to the person, such as photographs and pictures and lamps.

We asked the registered manager if anyone needed the support of an advocate and they told us that where people required this type of support this was accessed. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them. There were leaflets on display to inform people about services available locally.

Requires Improvement

# Is the service responsive?

## Our findings

At the inspection in February 2015, we found that the home was not meeting the regulation related to providing person-centred care. However we found the registered provider had taken action and this failing was resolved when we re-inspected in August 2015.

During this inspection we reviewed the care records of three people who used the service and found care plans had not always been updated in a timely manner. For example, we looked at one care plan which detailed the persons 'Left hand contracted and required daily cleaning and then a splint to be put on.' It had been identified during a care plan review that this person's hand was now too contracted and a splint could no longer be worn. The care plan had not been updated to reflect this information. For another person, a review had taken place to discuss this person's dietary needs. The review documented that the person was now prescribed Procal shots and on a fortified diet. The dietary care plan had not been updated to reflect this.

The information contained in people's care plans was no always consistent. For example, in a care plan for one person, it stated that 30 minutes safety checks of the person needed to be carried out, however other care plans for this person stated that 60 minute safety checks should be carried out. We could not clarify from the information records, how often checks were being carried out.

One person's medical history care plan detailed that they suffered with alcohol withdrawal. We looked at a record which detailed an incident when this person had become agitated and showed signs of behaviour that may challenge and was offered alcohol by staff. There was no protocol or guidance in place for staff to follow with regards to how best to manage this person behaviour. We discussed with the registered manager whether this was a suitable way of trying to defused the situation for this person and the importance of guidance being available for staff. The registered manager stated this was not an approach they would advocate and agreed to take action to ensure the care records and staff practices adhered to appropriate best practice.

Mental Health care plans gave no clear guidance on how to manage episodes of anxiety and the best methods to use to defuse the situation. Care plans stated, 'Staff should reduce any anxiety levels and anticipate triggers' but no other guidance was provided. Staff were able to discuss with us the actions they took in these situations and we observed staff calmly approach the person and support them to become less distressed.

Another care plan detailed that the person was dyslexic and needed support to read and write. During the inspection we saw no evidence of staff assisting to help this person to read materials, such as menu choices. We discussed this with staff who agreed information was lacking in the care records and staff needed to proactively support this person to read material.

This was a breach of Regulation 9 (Person-centred care), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that people were involved in activities and outings. During the inspection we saw no planned activities staking place other than those provided by a local volunteer group, 'Community Buddies'. Some of the activities this group provided included afternoon tea parties, live bands and a Christmas party in the village hall. Volunteers told us that Community Buddies visited the service every Monday afternoon. People from the volunteer group told us they thought the registered provider saw them as a replacement for having their own activity coordinator. They said, "I think because we come and do activities they don't really bother." And, "People do need more stimulation. There is a massive activities room that has loads of potential. We sometimes use it when we plan larger events, but otherwise it is just unused. Activities don't seem to take place here."

Staff were unable to spend time engaging people in meaningful occupation, as they were attending to general tasks and supporting people with their personal care needs. During the inspection we observed one person completing a jigsaw puzzle with very little interaction from staff despite often calling staff for reassurance.

The staff rota showed that an activities coordinator was in place, three times a week. However the rota did not indicate how long this person spent in the home and we did not find any evidence to show what activities were provided, when they were provided and what people thought of these activities. People we spoke with told us very little activities that took place. The people who used the service or relatives we spoke with could not tell us when they had last seen the activities coordinator. Relatives said, "I have never seen any activities taking place but there seems to be playing cards and bits and pieces around the lounge so I presume they get used." And, "There is an activities coordinator but she is mainly based at Archery Bowers [Sister service] and I have never known her to come over to this home." And, "I have never seen any activities taking place and I come almost every day."

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

The relatives we spoke with felt the registered manager was approachable and had made positive changes to the home. They found that concerns were now being addressed and felt improvements had been made at the home.

A relative who visited twice weekly told us they were happy with the service, saying, "All is fine, I have no concerns. I feel my relative is safe." Another relative said, "I cried and cried for the first few days as I just did not want to leave him here. They didn't seem to have a clue. I have pulled them up on everything and things have got better, still a long way to go but better than they were."

We were shown a copy of the complaints procedure which gave people timescales for action and who to contact. Discussion with the registered manager during the inspection confirmed that any concerns or complaints were taken seriously. We saw that all concerns were recorded and the action taken to resolve them recorded. The registered manager made sure the proposed action was taken and monitored to ensure the complainant was satisfied with the outcome.

Requires Improvement

# Is the service well-led?

## Our findings

At the inspection in February 2015, we found that the registered manager had recently come into post and was taking action to improve governance arrangements and by August 2015 they had taken enough steps to ensure this regulation was no longer in breach. We recommended that the registered provider continues to implement and monitor improvements identified in their action plan.

At this inspection, people told us they felt improvements had been made but there was still more work to do to make sure the home provided a good service. People told us action needed to be taken to improve staffing levels, activities and the cleanliness of the home at all times.

Relatives said, "When we first started coming to the service we used to see people wet and dirty. We don't see that now, so I think things have improved." And, "We had to raise a number of concerns when my relative first came to the home, which included my relative not being given a shower/bath, bed being soiled and the bathroom dirty. This seems to have improved for the moment and hopefully this is sorted." And, "The smell in this place can be really bad sometimes. It's not too bad today but some days it is unbearable."

One of the visitors commented that the nominated individual (formal representative of the registered provider) had been absent for the past six months or so. They previously had been on site during the week and during their absence the visitor felt the service had "lacked leadership." They found that if they had any concerns or suggestions, they spoke with the nominated individual who would ensure they were concerns actioned or resolved, "eventually."

The registered manager carried out a number of quality assurance checks to monitor and improve standards at the service. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. The registered manager carried out weekly and monthly checks of areas including medication, health and safety, staffing levels, infection control and falls.

Accidents and incidents were accurately recorded and included action plans and any remedial action needed. Timescales for actions to be complete had been documented but these timescales were not reviewed to ensure the actions had been taken within timescales.

We could see that a high number of accidents occurred during the night. In November 2016 there had been a total of seven accidents; five of these had occurred during the night. In September 2016 there were a total of three accidents, two occurring at night and in August 2016 a total of 6 accidents, five of them occurring at night. The registered manager used a tool to identify trends of accidents which highlighted an increase in accidents at night. We could not see any action taken to reduce the risks, such as increase in staffing levels.

The home completed weekly audits of medication but these were not robust and had not picked up any of the issues we found.

New staff had been employed following the home's recruitment and selection policies and this ensured that only people considered suitable to work with vulnerable people worked at the service. However, one person had transferred from a sister home but the registered manager had not checked their file. This file showed the person had previously been a nurse but suspended from practice; the previous home had not followed this matter up. This meant the registered manager had failed to identify that the sister home had not completed robust recruitment procedures and had not investigated whether this person was competent to work at the home.

The system for calculating staffing levels was unavailable but we found there were insufficient staff, yet this had not been identified in any of the systems for overseeing the service.

Health and safety audits were completed but had not identified the failure to monitor ambient temperatures or the poor lighting.

Although our records suggest that very few safeguarding matters were raised with the local authority safeguarding teams, comments from relatives suggested they, in the recent past, had raised concerns around potential neglect of people's personal care, lack of activity and information about falls not being passed on. None of this information featured in the management documents and if it was shared with the registered manager had not led to them taking action.

Although the registered manager, staff and audits showed they identified and responded to concerns they had not picked up issues we identified about people being confrontational. Therefore these incidents had not been reported to the local safeguarding team. In light of this the registered provider could not be assured that all risks were recognised and reported.

Albeit improvements were being made further work was needed to ensure action was taken to critically review the service and put in robust measured to mitigate risks.

This was a continued a breach of Regulation 17 (Good governance) of The Health and Social Care Act (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification.' We found that this was not occurring at the last inspection. We found that notifications had not been submitted to CQC appropriately, in respect of DoLS authorisations and incidents that effect the operation of the home, such as the lift being out of order for 11 days in September 2016.

This is a breach of regulation 18 of the Care Quality Commission (Registration) regulations 2009. We are dealing with this matter outside of the inspection process.

The service had a new registered manager in place since March 2015. Staff told us that the registered manager was approachable, very supportive and dedicated to providing an effective service. One staff member said, "The registered manager, in my opinion, is one of the best we have had. I have learnt so much from them" Another staff member said, "I feel the registered manager really wants what is best for the residents."

People who used the service made complimentary remarks about the registered manager and felt they were working to ensure the home met people's needs and was well-run.

We asked the registered manager how they gathered and used the views of the people who used the service. The registered manager stated they do a daily walk around and speak to people who used the service, their relatives, visitors and staff. They were also in the process of issuing an annual survey for people, relatives and visitors to complete.

We saw the service had developed some links with the local community such as the neighbours to the service, GP surgeries, voluntary groups and local churches.

We saw evidence to confirm that staff meetings were now taking place regularly and were also planned in advance for the rest of the year. Topics discussed during these meetings were training, induction, policies, rotas, medicines, and the importance of using foot plates on wheel chairs. Records showed that there was a good turn out to staff meetings.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept, easily accessible and stored securely.

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 9 HSCA RA Regulations 2014 Person-centred care<br><br>The care and treatment provided to people did not always reflect their needs and preferences.<br><br>Regulation 9(1), (2) |

| 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 provider had not ensured people received care and treatment that was safe and had not taken action to mitigate risks.<br><br>Regulation 12 (1) |

| 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 ensured the systems for overseeing the operation of the home were effective.<br><br>Regulation 17 (1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>There were insufficient numbers of staff deployed at the home to meet people's needs. |