Platinum Care Homes Limited

Church View Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Church View provides accommodation with nursing for up to 78 older people, some of whom were living with dementia. The home is purpose built and set over three floors with six units each containing their own communal lounge and dining areas. At the time of our inspection there were 59 people living at the service.

The inspection took place on 26 July 2017 and was unannounced.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had left the service shortly after our last inspection. An interim manager had been appointed and consideration was being given to their appointment and registration on a permanent basis. The interim manager and general manager supported us during our inspection.

At our previous inspection on 17 and 18 October 2016 continued breaches of legal requirements were found and we took enforcement action against the provider and registered manager. We issued a warning notice in relation to the governance of the service. In addition we found breaches of the regulations in relation to unsafe care, staff training and supervision, staff not following the principals of the Mental Capacity Act, a lack of safe person-centre care and a lack of respect and dignity shown towards people. Following the inspection the provider submitted an action plan to us to tell us how they planned to address these concerns.

We inspected the service again on 6 and 9 February 2017 and found that although improvements had been made in some areas they had not taken sufficient action to meet the warning notice. We identified continued breaches of the regulations in relation to safe care and treatment, person centred care, protecting people's legal rights, staff deployment, the support of staff and good governance. The service was placed into special measures. The provider submitted regular action plans to update us on the progress they were making in meeting the breaches identified. At this inspection we found that improvements had been made regarding the staffing levels in place, training and supervision of staff and meeting the principles of the Mental Capacity Act. However, continued breaches relating to safe care and treatment, dignity and respect, person centred care and good governance were identified. As a result of this Church View remains in special measures.

People's medicines were not always administered safely by competent staff. Staff continued to administer medicines following competency assessments showing gaps in their knowledge and practice. Safe medicines were not practiced by some staff and guidance provided regarding the administration of covert medicines was not always followed. Risk assessments regarding people's nutritional needs were not always effective in ensuring they received safe care. Monitoring forms regarding people's nutritional intake were not monitored and action was not always taken when people's weight fluctuated significantly.

Improvements were seen in the way people received their care although individual staff members were seen to treat people with a lack of respect. Staff were not always aware of people's backgrounds and preferences and staff were observed to speak to people in a disrespectful manner.

People's care plans were not always updated when their needs changed. This was a particular concern for people who were receiving end of life care. Activities provided were not always appropriate to the ages of the people living at Church View and people were left for long periods without social interaction from staff.

Auditing systems to monitor the quality of the service were in the process of being implemented although were not always effective in identifying and addressing concerns. There was a continued lack of management oversight and a lack of leadership in individual areas of the service.

Improvements were observed in the way individual risks were addressed in areas including moving and handling, skin integrity and supporting people whose behaviour challenged others. Staffing levels were now sufficient to meet people's care needs although the high use of agency staff impacted on the care people received. Accidents and incidents were monitored and measures implemented to manage risks identified. The general manager told us that a number of staff had recently been recruited which would reduce the number of agency staff used. Safe recruitment practices were in place to ensure that only suitable staff members were employed.

People were protected from the risk of abuse as staff were knowledgeable about their responsibilities. Up to date safeguarding and whistle-blowing policies were in place and displayed in communal areas. There was a contingency plan in place to ensure that people would continue to receive care in the event of an emergency.

Staff received induction, supervision and training to support them in their role. Additional training had been provided to staff and new staff had the opportunity to shadow more experienced staff members before working alone. People told us they enjoyed the food provided and choices were available. Appropriate referrals were made to healthcare professionals and guidance provided was followed.

People's legal rights were protected as the principles of the Mental Capacity Act 2005 were followed. Decision specific capacity assessments had been completed and staff were able to describe their responsibilities in gaining consent before providing care to people.

We observed some individual staff members treated people with respect and spent time with people. Staff were observed to knock on people's doors before entering and people told us staff respected their dignity when supporting them with personal care. Visitors were made to feel welcome at the service and there were no restrictions on the times people could visit.

Improvements had been made in some areas of people's care plans and personalised information was available to staff. Where people had requested additional activities such as access to community activities this had been provided.

Regular meetings were held to gain the views of people and relatives and action was taken when changes were requested. Staff told us they felt supported by the interim manager and general manager and regular staff meetings were held. A complaints policy was in place and concerns received had been addressed to people's satisfaction.

Records were now stored securely and maintained in an organised manner. Where significant events had

occurred the CQC had been notified in order to ensure the service was monitored.

The overall rating for this service is 'Requires Improvement' with an 'Inadequate' rating in Well-led. Therefore, the service remains in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures."

During the inspection four continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. You can see what action we have taken in the full version of this 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 consistently safe.

Risks to people's safety were not always effectively monitored. Improvements had been made in the way in which some risks were managed.

Medicines were not always managed safely and staff competencies were not appropriately assessed.

There were sufficient staff deployed to meet people's needs although the high use of agency staff impacted on people's care.

Safe recruitment procedures were followed to ensure staff employed were suitable to work at the service.

Staff were aware of their responsibilities in identifying and reporting potential abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received regular training and supervision although clinical supervisions were not in place for nursing staff. We have made a recommendation regarding this.

People's legal rights were protected as the principles of the Mental Capacity Act 2005 were followed.

People were offered a choice of foods and staff were knowledgeable about their needs.

Where required people had access to health and social care professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

Individual staff members did not always speak to people with respect. We observed some instances where staff treated people

with kindness.

People's dignity was maintained and their independence encouraged.

Visitors were made to feel welcome to the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were not always updated when their needs changed and staff were not always aware of people's past lives and preferences.

Activities provided were not always person centred and people spent long periods without social interaction.

Complaints were addressed in line with the provider's policy.

Is the service well-led?

Inadequate

The service was not always responsive.

There was no registered manager in post.

Audits were not always effective in identifying areas of concern.

There was a lack of management oversight and leadership within individual units of the service.

The storage and organisation of records had improved.

Church View Care Home

Detailed findings

Background to this inspection

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

This was an unannounced inspection which took place on 26 July 2017. The inspection team consisted of three inspectors, a nurse advisor and an expert by experience. The nurse advisor specialised in supporting older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the information we had about the service, such as notifications, safeguarding's and other information they had submitted to us. A notification is information about important events which the service is required to send us by law.

During our inspection we observed the care and support being provided and talked to relatives and other people involved in people's care. We spoke with 10 people, seven relatives, 10 staff, the acting manager and the general manager. We looked at a range of records about people's care and how the home was managed. For example, we looked at 10 care plans, medication administration records, risk assessments, accident and incident records, complaints records and quality assurance audits that had been completed. We also reviewed five staff recruitment files.

We last inspected Church View in February 2017 where we identified eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service safe?

Our findings

During our inspections in September 2015 and October 2016 we found that risks to people had not always been managed appropriately. At our inspection in February 2017 we found that although improvements had been made in some areas, staff were not always identifying and addressing risks in a consistent manner. At this inspection we found that the management of risks relating to people's safety had further improved as guidance to staff was more detailed. However, the monitoring of control measures to mitigate risks were not consistently implemented. In addition, concerns regarding the safe administration of medicines were identified.

People's medicines were not always administered safely by competent staff. Medicines were administered and managed by qualified nurses who received training in this area of their role. However, we checked the medicines assessments for two nurses which had been completed in March 2017. These showed that neither had been assessed as being fully competent in their understanding of medicines management. No further competency assessments had been completed since this date to enable the provider to assure themselves that people were receiving their medicines safely.

One person's records stated their medicines should be administered covertly (without the person's knowledge or consent) as they would regularly refuse their medicines. We observed this guidance was not followed and the person was offered their medicines which they refused. The staff member said they would come back with the person's medicines later. However, when we checked the person's medicine administration record (MAR) it recorded their medicines had been destroyed. We asked the staff member why the person's medicines were not administered covertly. They told us, "(Name) is currently compliant with their medication." Medicines records viewed showed that seven people were assessed as requiring their medicines to be administered covertly. However, one staff member responsible for the administration of medicines was only aware of one person who required this type of support. This meant that people were at risk of not receiving their medicines in line with prescription guidelines.

Safe infection control practices were not always followed when administering medicines. We observed one staff member hold a person's medicines in their hand prior to administration. They then approached another person and again held their medicines in their hands without washing them between. The staff member held the medicine in their hand for several minutes which meant there was a risk of the tablets coating being damaged.

There were no formal methods or protocols in place for assessing and managing pain in people who could not verbally express their needs. Staff told us they were aware of each person's way of expressing pain and it was judged on an individual basis. However, the lack of protocols available meant new staff members or agency staff would not have the guidance they required to help them identify if someone was in pain.

A medicines audit was completed by an external pharmacist in April 2017. The audit recommended that a stock balance of medicines be kept for each person prescribed PRN medicines (as and when required). We found that this had not been implemented throughout the service. We viewed one person's records who

required their medicines to be administered via a patch applied to their skin which needed be changed weekly. The person's records showed the patch should have been applied at 07;30 on the morning of the inspection. There was no record of the person's patch being changed. A staff member told us they did not know if the patch had been changed as night staff would have been responsible for doing this. The stock balance from the previous week recorded that five patches were in stock. However, a count of the patches available showed there were six still in stock. We informed the manager of this discrepancy in order for them to check where this discrepancy had occurred and ensure that the person received their required medicines.

With the exception of the above concerns, medicines were administered in accordance with prescription guidelines and MAR records were not signed until the person had been observed to take their medicines. PRN protocols were in place to guide staff on when people may require their medicines to be administered and contained relevant detail. Medicines administration times were appropriately planned throughout the day to ensure people received medicines in a timely fashion and were not given medicines, such as analgesia, too close together. Medicines were stored safely and securely in locked rooms and medicines trolleys were not left unattended when unlocked. Medicines requiring refrigeration were stored in lockable fridges which were not used for any other purpose. The temperature of the fridges and the rooms in which they were housed were monitored regularly to ensure the safe storage of medicines.

Risks to people's safety and well-being were assessed although control measures were not always monitored effectively. One person's risk assessment had identified they were at risk of dehydration and their fluid intake should be monitored. The daily intake for the person was calculated at 1000mls per day. However, recording charts in place showed that on three occasions during the past 26 days the person's fluid intake had been 300mls and on a further sixteen occasions was 900mls or less. There was no evidence to show the person's fluid charts were being monitored and no guidance for staff in what action to take should the person's fluid intake fall below recommended levels. Another person's records stated their fluid intake should be monitored due to the risk of skin breakdown. However, no fluid monitoring charts were maintained for this person. Following the inspection the manager informed us that charts were now being totalled at the end of each day and any concerns being passed during handover meetings.

A third person's nutritional risk assessment stated they were at risk of malnutrition and dehydration and their food and fluid intake should be recorded and monitored. Records showed that the person's food and fluid intake had only been recorded on three occasions during the past 26 days. In addition the person's risk assessment stated they should be weighed weekly to monitor any weight loss. The person had not been weighed for over three weeks and records showed that prior to this they had consistently been losing weight. We asked that the person was weighed during the inspection which showed further weight loss. At lunchtime we observed the person was supported to eat by an agency staff member who did not know the person and they refused their meal. This was not recorded on the person's monitoring chart. A staff member told us that the person needed patience and encouragement to eat their meal and it was better for the person to be supported by someone who knew them well. A second staff member confirmed this was the case. We alerted the acting manager to our concerns. Following the inspection the manager informed us that this information had been added to the food requirements sheet and all staff had been informed.

During the inspection we observed that the floor in one area of the service was being mopped at lunchtime. We brought this to the attention of the acting manager who told us this was the best time to mop the floor as people were normally seated in the dining room. We observed one person being supported out of their room and the manager indicated they should stop as the floor was wet and ask that the floor be dried immediately. We again expressed concern regarding this routine. The manager told us they would discuss the timings of cleaning with the staff concerned.

The failure to ensure that people's medicines were managed safely and risks to people's safety were appropriately monitored was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks to people's safety were identified and appropriately managed. People's care files contained individual risk assessments and gave guidance to staff on how to support people safely. Risks identified included mobility, falls, skin integrity and anxiety. One person required staff to hold their hands on occasions during personal care due to their anxiety. Detailed guidance was in place including how to approach the person and staff were able to describe the support the person required. We observed that people requiring the use of a hoist were supported appropriately and staff gave reassurance to people.

Accidents and incidents were reported and action taken to minimise risks where required. Records showed that appropriate action had been taken to address any concerns arising from individual incidents. Following one person experiencing a fall a sensor mat had been put in place to alert staff when the person was standing to mobilise. Records showed that the person had not experienced any further falls since this measure had been taken. A central log of incidents was maintained although this had not been used to identify possible trends. The manager initially told us they intended to complete this exercise on a quarterly basis but later confirmed they would undertake this analysis monthly.

At our last inspection in February 2017 we found that sufficient staff were not deployed to meet people's needs in a consistent manner. At this inspection we found there were sufficient staff available to ensure people did not have to wait for care and their needs were met promptly. We observed that call bells were answered in a timely manner and where people requested support this was provided. Staff did not appear rushed and had time to spend with people. However, a number of people commented on the continued high level of agency use in the service. One person told us, "There is always someone around. They don't leave you on your own. They come and check if you are okay." Another person told us, "If they had more permanent staff it would be better. There seem to be different [staff] and changing frequently." One relative said, "There's enough staff although they do seem to change a lot with the agency." A second relative said, "There's staff around although some of the agency carers just sit and watch TV and don't talk to anyone."

The general manager told us that since our last inspection the number of people living at the service had reduced but staffing levels had been maintained. They acknowledged the high use of agency staff and told us that as far as possible regular agency staff were block booked to provide as much consistency as possible for people. Recent recruitment had been successful and a number of staff were ready to start once recruitment checks had been completed.

Safe recruitment practices were followed before new staff were employed. Checks were made to ensure staff were of good character and suitable for their role. Staff files we looked at contained evidence that the provider had obtained a Disclosure and Barring Service (DBS) certificate for staff before they started work. DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. Staff files also contained evidence that a face to face interviews had taken place references obtained to demonstrate that prospective staff were suitable for employment.

People were protected from the risk of abuse. There were up to date safeguarding and whistleblowing policies in place and guidance for staff was displayed around the service. Staff were able to describe their responsibilities in safeguarding people and received regular training in this area. They were able to identify the different categories of potential abuse and signs which would lead them to report concerns. One staff member told us, "If I suspected abuse I would report it straight away." Another staff member said, "I have done safeguarding training recently. It was helpful and I feel confident in dealing with it". Staff told us there

was an open door policy within the service and they felt confident that the manager would listen and act upon any concerns reported.

A contingency plan had been developed which highlighted the action which should be taken in the event of an emergency or if the building could not be used. Staff were aware of their responsibilities detailed in the plan which ensured people would continue to receive the care they required. Contact details for the local authority and other external agencies were listed in the plan to ensure that relevant people were informed of any emergencies.

Requires Improvement

Is the service effective?

Our findings

At our inspections in October 2016 and February 2017 we found that staff were not receiving effective supervision and training to support them in their role. At this inspection we found that training for staff was now being provided and that supervisions were taking place regularly.

New staff received an induction into the service which included shadowing more experienced staff members to learn about people's needs. Staff told us that prior to starting work they had received mandatory training and had worked alongside more experienced staff members until they were confident in their role. One staff member told us, "I did five or six training courses before I started; safeguarding, fire, moving and handling and MCA. I shadowed for two weeks, this was useful to me, I hadn't worked in care before so I could learn for other staff."

Training within the service had been reviewed and additional learning opportunities provided to staff. Staff told us that since the last inspection there had been a lot of training available. One staff member told us, "The training has been good. It's reminded us of things and I think we work better now." The training matrix showed that staff had received training in areas including moving and handling, challenging behaviour, documentation, health and safety, infection control and food hygiene. Training for clinical staff was now being recorded although supervision records showed that a number of training courses had been requested by staff which had not yet been organised. The manager told us they were maintaining records of what courses had been identified and these would be provided. They were confident that across the clinical team that the skills required in areas such as catheterisation and taking bloods were available and records confirmed this was the case.

A supervision matrix was now in place which showed that staff were now receiving regular supervision every three months in line with the providers policy. Staff told us they found this process useful to aid their development. One staff member told us, "I have supervision with my manager; it's made me more confident than I was before. It's about good communication between everyone." Another staff member said, "They ask you what you need or if you have any problems and they make us feel comfortable." The manager acknowledged that clinical supervision was not taking place for nursing staff at present. They told us that regular nurse meetings were held currently as a way of sharing learning and knowledge. They said they intended to introduce clinical supervisions in the near future. Group supervision is one method of nurses sharing best practices but individual supervision would enable the provider to address individual performance issues and set standards.

At our inspections in October 2016 and February 2017, we found that staff were not meeting the requirements of the Mental Capacity Act 2005 (MCA) and lacked knowledge regarding their responsibilities. At this inspection we found that improvements had been made and people's legal rights were now being protected.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own

decisions and are helped to do so when needed. When they lack mental capacity to make 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 staff were working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's rights were protected because the staff acted in accordance with the MCA. Where appropriate, people's care records contained mental capacity assessments for specific decisions including locked doors to exits, the use of bedrails, consent to care and physical restraint. Best interest decisions were in place where it had been determined that people lacked capacity to make decisions regarding their care. Involvement was sought from relevant medical and social care professionals as well as family members where appropriate. DoLS applications had been submitted to the local authority which gave detailed information regarding the decision and how it had been reached.

Staff received training in relation to the MCA and were able to demonstrate their understanding. One staff member told us, "Never assume that they don't have capacity. Always try and understand and remember the five key principles. You'd try different methods before considering any restrictions. If this wasn't successful you would need to consider what was in the best interests of the person." Another staff member told us, "It's about how to help make decisions. We carry a card to remind us of the principles." We observed staff took time to gain people's consent before providing care and explain to people what was happening.

People told us they enjoyed the food provided and choices were available. One person said, "The food is good. There's a menu of two or three things. There's a group of us who eat together." Another person told us, "The meals are quite nice. There's a choice and I always find something I like." One relative told us, "(Family member) has put on weight since coming here. They give her small portions as a full plate is intimidating." Another relative said, "The tables in the dining room are done nicely now, with flowers and tablecloths. The food is lovely; dinners and the puddings."

A choice of meals and drinks were provided and additional alternatives were provided where requested. Menus were displayed on tables and where appropriate visual options of meals were offered to help people make a choice. The food presented looked and smelt appetising. Guidance was available to staff regarding the consistency of food people required and we observed this was followed. Where people required support to eat this was provided in accordance with people's individual needs and people were not rushed. Where people had made suggestions regarding the food these were acted upon. Minutes of residents meetings showed that people had requested a hot meal option was provided in the evening as they were becoming bored with the options available. A variety of hot foods were now being made available and people spoke positively about this change.

People were supported to access healthcare services when required. People told us that the GP visited the service regularly and that staff would arrange appointments when they needed them. Appropriate referrals were made to external health and social care professionals such as dieticians, speech and language therapists and hospital consultants and advice and guidance given by these professionals was followed. For example, where people had been assessed as requiring modified diets to minimise the risk of choking these were provided and staff were aware of people's needs in this area. People's care records evidenced that routine check-ups such as opticians, dentist and chiropody were completed regularly and monitored.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were caring and treated them with kindness. One person told us, "The care is ideal, it's excellent. The staff are extremely good. Very willing. I'm happy here, if I wasn't I'd go somewhere else." Another person said, "It's a very nice place here. They look after you very well. They're very good." A third person told us, "The staff are lovely to me." One relative said, "I'm quite happy with the care. (Our relative) is very well looked after. They are so nice and caring." A second relative told us, "The permanent carers are very nice. They motivate everyone. I am happy; (my relative) is happy." Despite people's positive experiences we observed examples where staff treated people in a disrespectful and uncaring way.

At our inspection in October 2016 and February 2017 we found inconsistencies in the care that people received and that people were not always treated with dignity and respect. At this inspection we observed some improvements in the way staff supported people but continued to see poor practices by some individual staff. Further improvements were needed to ensure people are consistently treated and referred to in a dignified way.

Staff did not always speak to people in a respectful way. We observed one staff member approach a person who was holding a large domino and appeared to be getting this confused with the biscuits on a plate in front them. The staff member approached the person and asked them for the domino and directed them to their biscuits. The person moved their hand back to resist the staff member removing the domino. The staff member then forcefully snatched the domino away from the person and walked away. No reassurance or explanation was provided to the person. Whilst we were speaking to one person who was asking us questions a staff member called across the room, "You'll have to excuse him." We asked what they meant by this and they replied, "He asks lots of questions." We found this was undignified for the person concerned. We reassured the person we were happy to chat with them and answer their questions.

In a different area of the service we observed one person come into the lounge and place their walking frame in front of their chair. A staff member approached them and said they would move the walking frame to the other side of the room. The person objected to this as they wanted their frame close to hand in case they wanted to get up. The staff member told them it could not stay there as other people may trip over it and they would pass them the frame when they needed it. There was then a tussle over the walking frame between the person and the staff member. The person eventually let the staff member take the frame. They then sat back in their chair and closed their eyes with an expression of frustration. We observed one person watching a film in another communal lounge. A staff member was present and they occasionally shared a comment about the film. A second staff member came into the lounge and started talking loudly about lunch arrangements. The first staff member gently explained that the person was watching the film and they needed to be quiet. This comment was ignored by the second staff member who continued to speak loudly and for a short time stood in front of the television, blocking the person's view. We observed the person closed their eyes and did not engage further until they went through to the dining room 10 minutes later. This showed a lack of respect for the person's home and their preferences.

People were not always supported by staff who knew them well. Staff we spoke to were not all

knowledgeable about people's interests or family. We asked five permanent staff members about a number of people's lives. They were unable to tell us in any detail about people's past occupations, family lives, hobbies or preferences. When speaking to staff they initially told us about people's functional care needs rather than speaking about them in a personal way.

There was a lack of interaction from staff in some areas of the service. We observed a staff member in one lounge periodically sit with people and offer them puzzles. However, there was very limited verbal interaction and people did not engage in the activity. Later in the day a staff member was observed slumped in a chair with their legs outstretched not engaging with anyone. In another communal lounge people were sat with the television on very quietly making it difficult to hear. With the exception of supporting people with drinks there was no verbal engagement with people and there was little atmosphere. The six people sat in the lounge occasionally interacted with each other but spent the majority of their time looking into space or sleeping. During a routine fire alarm test we observed staff members left three communal lounges for a few minutes without giving any explanation as to what was happening or reassurance to people.

The lack of respect and poor interaction with people was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw other occasions where people were treated with care and kindness by staff. We observed one person become upset and started to cry. A staff member went to comfort the person and said, "A nice lady like you shouldn't be crying." The staff member was rubbing the person's back and holding their hand. They stayed with the person until they were calm and chatted to them about the music they were listening to. We observed one staff member supporting someone to walk around, they chatted about things they could see. They were attentive to the person's needs and showed patience regarding the person's communication. Another staff member spent time chatting with a person about their love of boxing. The person was engaged in the conversation and it was clear the staff member knew them well. At lunchtime we heard a staff member supporting someone to eat their lunch. They offered gentle encouragement and told the person, "Your husband is coming to see you later. He will be so happy to see you." The person responded well and to this encouragement and ate the majority of the meal.

People told us they had choice regarding their daily routine and were encouraged to maintain their independence. One person said, "I choose when I get up and go to bed. I get up at six. A carer or a nurse will make me a cup of tea. They can't do enough for you. They say 'Do you want some help?' and you say 'yes' or 'no'." Another person said, "I plan my day; I get up and go to bed by myself. I don't let anyone else do it. They encourage you to do as much as you can for yourself. It's a bit better than it was six months ago." We observed people being encouraged to mobilise independently where it was safe for them to do so. One person was trying to stand-up from their chair. The staff member gave them guidance on how to use the chair and their walking frame to support them. They were then able to stand independently and walk to their bedroom. A variety of adapted cups and crockery were available to people to support them to maintain their independence when eating and drinking.

People's privacy was respected. When entering people's rooms' staff knocked on doors and shouted their name to alert people as to who was entering. Personal care was undertaken discreetly, with doors closed. Staff told us they understood the importance of maintaining people's privacy. One staff member said, "You need to think what you would want to happen. It must be difficult to find you need care so we have to give people the privacy they need. I will always knock on doors and make sure they are closed and use a towel to cover people for personal care."

Visitors told us they were made to feel welcome when visiting the service. One relative told us, "I visit most

days and have never been made to feel uncomfortable. They keep me informed of what's going on." Another relative said, "I can come when I like. The receptionist is always friendly and chats to us." There were no restrictions on visiting times and we observed relatives being greeted warmly by staff.

Requires Improvement

Is the service responsive?

Our findings

People told us they were happy with the care they received. One person told us, "I think they're looking after me very well thank you. I'm happy living here." Another person said, "At first I didn't like it here but I do now. They used to ask me how I was and I would say: 'Well, I'm bored stiff sitting here.' There are more things to do now. They encourage me to go into the garden and pull weeds up." One relative told us, "Generally the care is acceptable. The staff seem to try their hardest and do their best."

At our inspections in October 2016 and February 2017 we found inconsistencies in people's care plans and in the support they received. At this inspection we found that whilst some people's care plans now contained comprehensive guidance and information, others were not updated when people's needs changed.

People's care plans were not always updated when their needs changed. We viewed two people's care records who were receiving end of life care. Referrals had been made to the palliative care team. There was no other indication from the care plans that the people concerned were in receipt of this type of care. No care plans were in place to guide staff in how to care for the people concerned at this stage of their life or regarding their wishes. On the day of our inspection we found one person had recently had their medicines changed due to the pain they were experiencing. The person appeared disorientated and was not following their normal routine. Their mobility care plan stated they were able to walk independently although we observed staff supporting the person using a wheelchair. We asked staff if they were aware of any possible causes for the changes in the person's routine. They told us the person was not their self today but did not explore the possible reasons for this such as being in pain or the change in medicines. We alerted the manager to our concerns. Following the inspection the manager informed us that a palliative care nurse had been contacted and a medicines review had been completed.

With the exception of the above we found that people's care records contained information regarding their past lives and gave guidance to staff on how people preferred their support to be provided. One person's care plan described how they preferred to dress and advised staff to check they were feeling well- dressed before going to the lounge. We observed the person was dressed in the way the plan described. Another person's records described in detail the support they required to reposition themselves in bed. Staff were able to describe the process they followed to support the person.

At our last inspection we found that people were not provided with activities in line with their individual needs. At this inspection we found that activities provided were not always appropriate to the age of the people participating and that people spent long periods with no social interaction.

We received mixed responses from people and relatives regarding the activities provided. One person told us, "We have quite a bit of entertainment. The weekend just gone we had singing and dancing. They get you up and clapping. I'm having my hair done today. We have classes to keep you going: knitting, painting, so we're never idle. The vicar visits me." Another person told us, "I spend my time dozing or just sitting around." One relative told us, "There are enough activities but (my relative) does not participate. They do Bingo,

knitting, trips out. (Family member) will join in a sing-a-long." Another relative said, "Having more to do would be good. I think he gets frustrated sometimes."

Activities were not always appropriate to people's ages, particularly when supporting people living with dementia. We observed an activity taking place in one lounge which involved animal recognition. A children's picture book was used to show people cartoon pictures of animal faces. The staff member spoke to people in a childlike manner. For example, people were asked, "What noise does a lion make." Followed by the staff member demonstrating this and then saying, "And what about Mummy, what should Mummy be called." People did not appear to be engaged with the activity and appeared confused as to what was being asked of them. Other resources such as drawing books, puzzles, games and books seen in the service were designed for children rather than specialist resources for adults living with dementia. We observed that in one lounge music was playing and the television was also on with subtitles. In another lounge the television was on very loudly, causing staff to have to speak very loudly. There was no acknowledgment from staff that this may cause confusion and disorientation for people living with dementia.

We observed people spent long periods of time without interaction. No activities took place in three units during the day of the inspection. In one lounge people spent their time sleeping or dozing. An agency staff member spent time in the lounge periodically, they spent the time watching television rather than interacting with people. In another lounge people again spent the majority of their time sleeping. With the exception of putting puzzles and colouring books on people's tables there was very little interaction from staff. People again spent their time sleeping or walking around the corridors. In the afternoon the activity was scheduled to be hand massage and manicures in all units. We did not see this activity take place and people again spent their time with little interaction. One staff member told us, "There is room for improvement in the dementia unit. We need more stimulation for them." People who spent time in their rooms only received interaction from staff when being supported with drinks, food or personal care. The manager told us that there were usually more activities available but due to one activity worker being on annual leave activities were reduced.

The lack of appropriate activities provided to people and care plans not always reflecting people's current needs was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people were able to occupy themselves resources were made available to them. Residents meeting minutes showed that people had requested knitting patterns for dog coats be sought in order that these could be donated to charity. The patterns had been obtained and we observed two people spending their time knitting. Other people spent time doing puzzle books and reading. We observed staff periodically take an interest in what people were doing and engaged them in conversation. Activity records evidenced that entertainers visited the service regularly to provide sing-alongs and pet therapy. Occasional trips to local places of interest had also been planned at the request of people and their relatives.

Information on how to make a complaint was displayed around the service and people told us they would feel comfortable in raising concerns. One person told us, "I'd tell them if anything was wrong." One relative told us they had raised minor concerns regarding the presentation of their family member's room. They told us their concerns had been addressed promptly. There was a complaints log in place which evidenced that people's concerns had been addressed and a response had been provided. Staff we spoke to were able to describe how they would react if they received a complaint and were clear that they would report this to a senior person on duty. One staff member told us, "I would try to help them or explain to them why something was happening. I would tell the nurse or the manager." We observed one person raise concerns during the inspection. The manager and general manager spent time listening to them and provided

reassurance their concerns would be addressed.

Inadequate

Is the service well-led?

Our findings

People and their relatives told us they knew the manager and felt comfortable speaking with them. One person told us, "We've got a new manager who comes and says 'Good Morning' most days." One relative told us, "We've got to know the new manager quite well. She is open to people's queries, comments and concerns. She's trying to raise the home up."

At our last inspections in October 2016 and February 2017 we found a failure to maintain accurate, contemporaneous care records and a failure to carry out quality audits in order to improve the service people received. Following the inspection in February 2017 we were told the registered manager had left the service and an interim manager had been appointed. At this inspection improvements had been made in the maintenance of records and an audit schedule had been implemented. However, the continued concerns identified during the inspection evidenced that further work was required to ensure people were receiving a consistently safe, effective, caring, responsive service which was well-led.

The manager and general manager had begun to implement a series of audits within the service. However, we found that these were not always effective in identifying concerns. A new care plan audit form was in place although this had not been completed regularly to ensure that concerns were identified and addressed. Medicines audits were completed but did specifically look at the management of covert medicines in order to ensure that these procedures were being correctly followed. Food and fluid charts were not regularly monitored to ensure people were being supported in line with their needs. The manager told us that they had only recently started to complete audits as they had spent their time supporting staff and ensuring that systems and up to date policies were in place. They said that they believed that progress had been made in these areas and they now intended to ensure that audit systems were fully implemented.

The provider had commissioned the services of a consultant to support them in addressing the concerns identified following our inspection in February 2017. A comprehensive action plan had been implemented and progress assessed on a monthly basis. This identified areas which required on-going development including care plans, food and fluid monitoring, auditing and end of life care plan implementation. The action plan evidenced that progress had been made in areas including MCA and DoLS, policy development, staff training and record keeping. These findings were in line with our observations during the inspection. The general manager told us the consultant would continue to support the service on an on-going basis in order to provide an external view of the service.

There was a lack of management oversight on individual units of the service. We observed the manager spent time during the day visiting each unit and speaking to people. However, we found people's experience of the care they received differed depending on the area of the service they lived in. We observed the way in which nurses led the shifts and found whilst one nurse provided direction and leadership, others were focussed on the nursing element of their role and worked more in isolation. One staff member told us, "There's enough staff when and if the nurse interacts as well. Nurses need to lead the whole unit but they don't." The manager told us that a number of the nurses currently were employed via an agency on blocked booked contracts of three months or more. They said they felt they had the skills required for the role and

had undertaken training alongside permanent nursing staff. They acknowledged that some nurses required additional support in the area of shift leading. They told us, "They are willing to learn but need more confidence in their role. They do understand their responsibilities but are learning about people on different units." This lack of oversight meant that the care people received was not routinely assessed by senior staff in order to monitor people's experience, direct staff and set the standard of care.

There has been a continual failure to meet regulations 9, 10 and 12 since October 2016 which demonstrates that, despite the improvements that have been made, there is a failure to implement effective systems for reviewing quality, recognising shortfalls and improving the service to meet the regulations.

The failure to ensure quality monitoring was effective in ensuring continuous improvement and the continued breaches of regulation 9, 10 and 12 was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt supported by the management of the service. One staff member told us, "They always appreciate us. Everyone is equal. The new manager is really good. It's changing. She's encouraging us all the time and any problems we can go to her." Another staff member said, "The managers are good. You can ask them if you have a problem." A third staff member told us, "They support us. If we are struggling with anything they will always listen to us." Records showed that regular staff meetings were scheduled and staff were encouraged to contribute. Staff had been kept informed of the action plan in place and their responsibilities in attending training and ensuring records were updated. Heads of department meetings were also held regularly to ensure open communication within the management team.

People and their relatives had the opportunity to comment on the running of the service. Resident and relatives meetings were now being held and the general manager told us they were pleased about the attendance and contribution from people. A number of changes in the service had been implemented following requests during the residents meeting. These included hot food now being served in the evenings, outings and walks being organised and the knitting group contributing to charity groups. The last CQC report and progress regarding improvements had also been discussed at relatives meetings.

Records were now stored securely and in an orderly manner. Staff were able to access information requested during the inspection quickly and records were now more legible. The CQC had been notified of all significant events that happened in the service in a timely way. This meant we were able to check that the provider took appropriate action when necessary.