# Larchwood Care Homes (South) Limited

# Sherford Manor Care Home

## Inspection report

Wyvern Road
Taunton
Somerset
TA1 4RA

Tel: 01823337674

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## Ratings

| Overall rating for this service | Inadequate |
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|---|---|
| Is the service safe? | **Requires Improvement** |
| Is the service effective? | **Inadequate** |
| Is the service caring? | **Requires Improvement** |
| Is the service responsive? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

This inspection took place on 7 & 8 December 2016. It was carried out by three adult social care inspectors.

At the last inspection carried out over three days in March 2016 we rated the service as requiring improvements and there were two breaches of our regulations which related to the failure to notify us of significant incidents and good governance. At this inspection we found that some action had been taken to improve the service and meet the actions set at the previous inspection. However; we found further improvements were needed.

Sine our last inspection we received a number of concerns from whistle-blowers and the local authority safeguarding team. Since then the provider has been meeting with the local authority and the clinical commissioning group and concerns were being investigated by the local authority. Investigations are on-going.

Sherford Manor specialises in providing care to people who are living with dementia and/or who have mental health needs. The home is registered to provide accommodation with nursing care to up to 105 people. The manager informed us that, given the configuration of the home, the maximum number of people they accommodated was 77. At the time of this inspection there were 63 people living at the home. Sherford Manor consists of four separate units. The Rose and Sunflower units provided care and support for people who required assistance with personal care needs. Redwood and the Sutherland Unit provided nursing care. People were living with dementia which meant some people were unable to tell us about their experiences of life at the home. We therefore used our observations of care and our discussions with staff and visitors to help form our judgements. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager was not available for this inspection. The home was being managed by two of the provider's peripatetic managers who were supported by one of the provider's regional managers.

Prior to our inspection we received concerns about staffing levels at the home being insufficient to meet the needs of the people living there or to keep people safe. The peripatetic manager (the manager) told us staffing levels had been reviewed and increased and were now sufficient to meet people's needs and keep people safe. The home used a high level of agency staff to cover vacancies and we were informed the home was actively recruiting permanent staff to reduce agency usage. No concerns were raised with us at this inspection about staffing levels or of the ability of staff to meet people's needs with the number of staff available.

People who were able told us they felt safe living at the home however; individual risk assessments and care plans did not fully protect people from the risk of receiving unsafe or inappropriate care. For example one person's care plan told us they were diabetic and they should not receive a diet containing high levels of sugar. Daily records and our observations showed the person had been given foods which were very high in sugar. Another person had been assessed as being at high risk of choking and required oral suction to be available when eating. We observed the person being assisted with their meal however the suction machine was unassembled in a box in the nursing office meaning it was not readily available. We read the care plan for one person who had been assessed as being at high risk of falls. We observed the person mobilising with a wheeled Zimmer frame however staff placed this out of reach when the person sat down and the person's care plan made no reference to the fact they used a Zimmer frame.

Staff had received training and were confident in reporting any issues of abuse. People received their medicines in a safe way by staff who had been trained and deemed competent.

The home specialised in providing a service to older people who were living with dementia. However the environment did not promote a welcoming or suitable environment. There was no clear signage, the standard of décor was poor and the people on Rose unit were living in cramped conditions which made it difficult to wander. The lunch time experience did not promote a sociable experience for people and people were unable to make an informed choice about what they wanted for lunch. On the first day of our visit soft/pureed diets had not been presented in an appetising way.

Not all staff were provided with sufficient training to enable them to effectively meet the needs of people who were living with dementia. For example, people were left for long periods without any interactions from staff or any form of stimulation. On Redwood Unit lounge chairs were arranged in a circle with little room to move around or for staff to sit and chat to people. Many people were able to interact with us and with other people however we did not observe staff assisting or offering people to sit together so they could chat. Activity co-ordinators had not received training in providing suitable and meaningful activities for people living with dementia.

Staff spoke to people in a kind way when they assisted them with a task. However; we noticed opportunities for social stimulation were not always recognised or responded to by staff meaning that people sat for long periods with little or no interactions. For example we observed staff walk through a communal area where people were sat without acknowledging them. Some people were able to tell us about the staff who supported them. One person said "They [the staff] are very acceptable. I get up when I want and I go to bed when I want." A visitor described the staff as "lovely."

People were not always treated with respect. For example we observed a member of staff standing over a person whilst they assisted them with their meal. We also found the standard of bedding and pillows on two of the units to be poor and some bedrooms were sparse with no rationale for this detailed in the plan of care. Some care plans contained personalised information however; this was not always followed by staff. For example one care plan detailed how the person liked to look and what was important to them. We observed the person was not presented as they chose and staff had no knowledge of the importance of a cuddly toy. Another person's care plan did not contain sufficient information about the management of their diabetes. Another care plan told us the person was not at risk of social isolation as they liked to interact with other people who live at the home and staff. When we read their daily records we saw they had experienced very limited interactions over a seven day period.

At this inspection we found the provider had not taken action to ensure people's care plans contained important information which would enable staff to provide person centred care. The majority of the care

plans we read contained no information about people's life history and when we spoke to staff, they had no knowledge about peoples past history. As noted at our last inspection, care plans remained bulky and contained a lot of historical information which meant it would be difficult for staff to easily locate current information.

The home was not always well led. Although the provider had supplied additional management staff to oversee the running of the home, systems had not always been effective in ensuring people received an improved quality of care. This mainly related to the standard of the environment, the skills and knowledge of the staff team, the lack of improvement in care planning systems and the effectiveness of internal audits.

The overall rating for this service is Inadequate and the service is now 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.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of 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 always safe.

Risk assessments and care plans did not always ensure people were protected from the risks of unsafe or inappropriate care.

People received their medicines when needed from staff who had been trained and deemed competent.

Staff knew how to protect people from the risk of abuse.

### Is the service effective?

**Inadequate**

The service was not always effective.

The environment did not promote an enabling or pleasant environment for people living with dementia.

Staff did not always have the skills and knowledge to effectively care for people who were living with dementia.

People's legal and human rights were not always protected because the service had not ensured applications to deprive people of their liberty had been fully considered or approved.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

Staff were kind but did not always recognise opportunities for positive interactions with people.

The standard of decoration, bedding and the manner in which some people were assisted with their meals did not always promote a culture of respect.

People's privacy was respected as each person had their own bedroom which they could spend time in if they chose.

### Is the service responsive?

**Inadequate**

The service was not always responsive

Care plans contained insufficient information to enable staff to provide person centred care.

People did not always receive care and support in accordance with their plan of care.

People did not have opportunities for meaningful activities or social stimulation.

## Is the service well-led?

**Inadequate**

The service was not always well-led.

Required improvements were not always implemented.

Quality assurance systems were not always effective in identifying areas for improvement.

# Sherford Manor 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 inspection took place on 7 & 8 December 2016 and was unannounced. It was carried out by three adult social care inspectors.

We looked at previous inspection reports and other information we held about the home before we visited. We looked at notifications sent in by the provider. A notification is information about important events which the service is required to tell us about by law.

At the time of this inspection there were 63 people using the service. People were living with dementia which meant some people were unable to tell us about their experiences of life at the home. We therefore used our observations of care and our discussions with staff and visitors to help form our judgements. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at a sample of records relating to the running of the home, staffing and care of the people who lived there. These included the care plans for 11 people and three staff personnel files. We also looked at records relating to the management and administration of people's medicines, staff recruitment and training, health and safety and quality assurance.

Requires Improvement

# Is the service safe?

## Our findings

Some people's risks were not being managed safely. For example, care plans contained risk assessments about assisting people to mobilise and reducing risks to people who were at high risk of malnutrition and pressure damage to their skin. Records showed staff monitored people's intake of food and drink. Each person had a nutritional assessment which detailed their needs, abilities, risks and preferences. However, we read the care plan for one person who was diabetic. The care plan stated "staff should ensure your [the person's] diet does not contain high levels of sugar as you have type 2 diabetes." Records of the person's daily intake showed that they had been given foods high in sugar. For example one day breakfast consisted of porridge followed by bread and jam. On the same day after lunch they had been given cake and cream and after tea they had cake and custard. This continued throughout the week. They had also been give biscuits as snacks throughout the day. We met with a member of staff who was assisting the person, who was in their bedroom, with lunch. We observed a generous portion of lemon gateaux and asked the member of staff if it was suitable for a diabetic. They told us "No; it's normal gateaux. [Name of person gets one diabetic pudding a day and that's at tea time." This was not reflective of what we had read in the person's plan of care and demonstrated their specialist dietary needs were not catered for and could place the person at risk.

We read the care records of a person who received nursing care and had diabetes. This did not provide staff with sufficient information about the management of the person's diabetes. For example there was no clear information about the person's eating and drinking needs. The plan stated "Type II diabetes" and "likes all foods especially pudding." There was no information about what were acceptable blood sugar levels for the person and there was no information about the signs, symptoms or action to take in the event of a hypo or hyper-glycaemic attack.

Another person's eating and drinking care plan stated that "oral suction must be available when eating." This was because they were at high risk of choking. We observed the person being assisted with their lunch however; the suction machine was in its original packaging in the office. This meant the suction machine was not assembled or ready for use which could place the person at significant risk if they aspirated. We spoke with a new member of staff who had been asked to assist people who required support to eat their meals. This included assisting one person who had been assessed at being at high risk of choking. They had not been shown how people should be supported. They said "I try out different sizes of spoons until its right. I learn from them and they learn from me." This lack of training and support could place people at risk.

We observed one person used a wheeled frame to assist them to mobilise. When the person was sat in the lounge, the person's frame was removed by a member of staff which meant the person did not have access to it when needed. We read the person's care plan. They had been assessed as being at high risk of falls however the care plan made no mention of the person using a wheeled frame.

This was a breach of Regulation 12(2) (a) (b) & (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to our inspection we received concerns about staffing levels at the home being insufficient to meet the needs of the people living there or to keep people safe. The peripatetic manager (the manager) told us staffing levels had been reviewed and increased and were now sufficient to meet people's needs and keep people safe. Each unit was led by a unit manager who had responsibility for the management of people's care and the staff team. The unit managers on the nursing units were registered nurses and senior care staff led the residential units.

The manager told us there were a high number of staff vacancies which were currently being covered by agency staff. They explained there was a recruitment drive to employ permanent staff and they had recently interviewed four people for care staff positions. A member of staff told us "We do have agency staff but at least we get regular staff which means they know the residents and routines."

At the time of our inspection there were 21 people living on the Sutherland Unit which provided nursing care. Staffing levels consisted of a registered nurse and four care staff during the day with a registered nurse and a care assistant during the night. The Redwood unit provided nursing care to 21 people and was staffed by a registered nurse during the day and at night with five care staff in the morning, four in the afternoon and two during the night. There were a total of 21 people receiving care and support with their personal care needs. Eleven people lived on the Rose Unit and ten people lived on the Sunflower unit. Staffing levels on Rose unit consisted of three care staff during the day with two at night. Sunflower was staffed by two care staff during the day and one carer during the night. We asked staff on each of the units whether staffing levels were sufficient to safely meet people's needs. No concerns were raised with us about staffing levels and staff confirmed they were able to meet people's needs. One person received funding for one to one support to help keep them safe. We saw and records confirmed a member of staff was allocated to provide this support at the agreed times.

Not everyone was able to tell us whether they felt safe living at the home and with the staff who supported them. During the days of our visit we observed staff were available to assist people with their basic care needs when needed. One person told us "I've been here a while now and yes; I do feel safe. Staff help me when I need help."

People's medicines were managed safely. Systems were in place that ensured medicines were ordered, stored, administered and recorded to protect people from the risks associated with them. Medicines were administered in a safe way to people and people were asked if they needed any medicines that were prescribed on a 'when required' basis such as pain relief. People told us they were happy with the way they were given their medicines, and that they got them when they were needed.

Staff knew how to recognise and report abuse. They had received training in safeguarding adults from abuse and they knew the procedures to follow if they had concerns. Staff told us they would not hesitate in raising concerns and they felt confident allegations would be fully investigated and action would be taken to make sure people were safe. Where allegations or concerns had been bought to the provider's attention they had worked in partnership with relevant authorities to make sure issues were fully investigated and people were protected.

The procedures for staff recruitment helped to minimise the risks to the people who lived at the home. Before commencing work all new staff were checked to make sure they were suitable to work at the home. These checks included seeking references from previous employers and carrying out disclosure and barring service (DBS) checks. The DBS checks people's criminal record history and their suitability to work with vulnerable people.

To ensure the environment for people was kept safe specialist contractors were commissioned to carry out fire, gas, water and electrical safety checks. There were risk assessments in place relating to health and safety and fire safety. Each person who lived at the home had an emergency evacuation plan. These gave details about how to evacuate each person with minimal risks to people and staff. The service had a range of health and safety policies and procedures to keep people safe. Staff also carried out regular health and safety checks.

Inadequate

# Is the service effective?

## Our findings

At our last inspection we found that the service was not always effective and improvements were required. We recommended the provider sought information on current best practice on providing a dementia friendly environment which promoted independence. Improvements were also needed to ensure people experienced a consistent approach to the meal time experience.

At this inspection we found the home's environment did not promote a homely or welcoming environment for people and did not provide a suitable environment for people who were living with dementia. The standard of the décor on Rose, Redwood and Sutherland units was poor. Paintwork was tired looking and chipped. There was no clear signage to assist people to orientate themselves around the units. On Rose unit there were memory boxes outside of people's bedrooms which would assist people in recognising their personal rooms however; the majority of these were empty. The ground floor of Rose unit had not been used since October 2016. We were originally informed this was because the heating boiler had broken. At this inspection we were informed a programme of re-configuration and redecoration would be carried out before the ground floor was re-instated. This meant people who lived on the Rose Unit had been moved up to the first floor where empty bedrooms had been used for lounge and dining areas.

Conditions felt cramped and the only area for people to wander was a narrow corridor. We observed one person walking up and down the corridor for the majority of the first day of our visit. There were two seating areas in the corridor but nothing of any interest for people. There were no magazines, and nothing for people to interact with. The lounge contained six arm chairs and one two-person sofa. This meant there was insufficient space or seating for the people who lived on the unit. A member of staff told us "We are having to do everything in people's bedrooms. I feel embarrassed. People need more space to move around." We observed little staff interaction with people and on the first day of our inspection we observed people slept for long periods. A member of staff said "I like it up here because the residents don't wander so much and they stay in one place." The dining room was cramped which meant staff had to kneel on the floor to serve the pudding from the trolley as there were no surfaces/tables to put the pudding on.

This is a breach of Regulation 15 (1) (c) (d) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed people having lunch on each of the units. The lunch time experience did not promote a sociable or pleasant experience for people. Nobody knew what was for lunch. On Redwood unit there was a blackboard in the dining room but the writing was illegible. The positioning of a white menu board on Sutherland unit meant that it could not be seen by the people who lived there. We did not see a menu on Rose unit. Staff told us people were asked about their menu choices the day before. This would not be appropriate for people living with dementia as many would not remember what they had chosen. Picture menus or other alternative methods to support people to make meal choices had not been introduced which meant it may be difficult for people to make an informed choice. On Redwood and Rose units staff were heard informing people that it was roast pork for lunch when it was in fact turkey. Meals were plated by staff from a hot trolley. This meant people had no control over portion size or what vegetables they wanted

and did not provide people with opportunities to maintain a level of independence. On Sutherland unit tables were not laid for lunch. People were provided with their cutlery when staff gave them their meal. There were no drinks on the table for people to help themselves and people were only given a drink when they had finished their meal.

We were informed that catering staff had received recent training about 'dining with dignity' which focused on the importance of the presentation of soft or pureed meals. Whilst this was positive; it was disappointing to see on the first day of our visit that the carrots and cabbage had been pureed together which had resulted in an unappetising grey coloured mush. We discussed this with the provider's director who visited the home on the second day of our visit who addressed this with the catering staff.

This is a breach of Regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Sherford Manor states it specialises in providing a service to people who were living with dementia and/or mental health problems. However; we found staff did not have the skills, knowledge or training to provide effective care and support to the people who lived at the home. Staff told us they had completed an on-line dementia awareness programme which was described as 'very basic.' Some staff had not yet completed this training. Our observations and discussions with staff highlighted areas for improvement and staff development. For example, people were left for long periods without any interactions from staff or any form of stimulation. On Redwood Unit lounge chairs were arranged in a circle with little room to move around or for staff to sit and chat to people. Many people were able to interact with us and with other people however we did not observe staff assisting or offering people to sit together so they could chat.

We met with a member of staff who was providing one to one support to a person who had very complex needs. We asked the member of staff if they had access to the person's plan of care and whether this provided them with enough information about the person's needs, risks and preferences. The member of staff found it difficult to understand our question and did not understand what we meant by a care plan. The member of staff was not a permanent member of staff and had been supplied by an agency. This demonstrated the skills and knowledge of staff were not always considered when supporting people. A visitor commented on the kindness of staff however they said "Staff say [person's name] doesn't do what they ask but [name person] doesn't understand what is asked of them so how can they know what staff are asking." This further demonstrated the lack of skills and understanding of caring for people who were living with dementia.

All staff completed a period of induction when they commenced employment to make sure they had the basic skills and knowledge to care for people. However we met with one member of staff who had not yet completed their induction. Records showed the member of staff had signed to confirm the topics completed however the inductee had not signed the induction record to confirm the member of staff was competent in the task.

These issues were a breach of Regulation 12(2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. A range of healthcare professionals visited the home to support people's care and treatment needs. These included podiatrists, nurse assessors, speech and language therapists, social workers and GP's. On one day of our visit we noticed that one person had a sore eye. When we brought this to the attention of the registered nurse, they had already noticed this and had

requested a visit from the person's GP. One person told us "They're pretty good. They will get the doctor to visit if you don't feel right."

Staff were aware of their responsibilities under the Mental Capacity Act 2005 (MCA) Staff had been trained to understand and use these in practice. 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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Care plans demonstrated that assessments of people's capacity to consent to their care and treatment had been assessed. Where a person had been assessed as lacking the capacity to consent, staff had involved people's representatives and health and social care professionals to determine whether a decision was in the person's best interests. Examples included the use of bed rails, pressure mats, specialised diets and thickened fluids. A best interest decision had also been completed for one person who transferred from a residential unit in the home to a unit which provided nursing care.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). 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). Assessments about people's capacity to consent to living at the home had been completed and DoLS applications had been completed for people who were unable to consent to this and for those who required constant monitoring by staff. However information given to us by the manager showed that of the 57 applications made, only two had been approved and one declined. Some of the applications were completed in 2014 and 2015. This needs to be followed up as people may be deprived of their liberty unlawfully.

Staff told us they received regular supervision sessions and annual appraisals. This helped to monitor the skills and competencies of staff and to identify any training needs staff might have. The management team had taken action where staff competency and skills required improvements. Staff told us they felt well supported. The general consensus from staff was that the level of support they received had improved. One member of staff said "Things have really improved recently. I get excellent support. You get the training you need but it's mostly on-line and the dementia training was really basic." Another member of staff said "Management are approachable and listen. I've completed the training but it's all on-line and you have to do it in your own time."

Requires Improvement

# Is the service caring?

## Our findings

On both days of our inspection we noted the atmosphere on each of the units we visited was sombre. There was no laughter or friendly banter between staff and the people who lived at the home. Staff spoke to people in a kind way when they assisted them with a task. However; we noticed opportunities for social stimulation were not always recognised or responded to by staff meaning that people sat for long periods with little or no interactions. For example we observed staff walk through a communal area where people were sat without acknowledging them. We also observed staff sitting at dining tables writing their reports. On one of the units there was a person who lived at the home sat at a dining table with their head on the table. It was unclear if the person was asleep but they did not look comfortable and staff made no attempt to engage with them. On one of the units one person who lived at the home started to sing. There was no attempt by staff to engage with them and another person who lived at the home shouted at them to "shut up.' This resulted in the person becoming disengaged.

Some people were able to tell us about the staff who supported them. One person said "They [the staff] are very acceptable. I get up when I want and I go to bed when I want." A visitor described the staff as "lovely."

The standard of décor on Redwood, Sutherland and Rose Units and corridors leading to each of the units did not promote a pleasant or enabling environment for people. We found the standard of bedding on Rose and Sutherland units were poor. For example each person only had one pillow and some pillows appeared damaged and did not look comfortable. Sheets appeared thin and on Sutherland unit there were no duvets or blankets on the beds. There were thin covers which were worn around the edges. A number of bedrooms on Sutherland unit appeared very sparse with little or no personal items. The care plans we read did not provide any rationale for this.

People who required assistance to eat their meals were not always supported in a manner which promoted their dignity or respect. On one of the units we observed a member of staff assisting a person with their meal whilst standing over them. Whilst walking through the dining room with the empty plate, they stopped and spooned a few mouthfuls of food into another person's mouth. These issues demonstrated a lack of respect for people who lived at the home.

This was a breach of Regulation 10 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said staff respected their privacy. All bedrooms were used for single occupancy and each had en-suite toilet and bathing facilities. This meant people could be assisted with their personal care needs in the privacy of their own room. Staff knocked on doors and waited for a response before entering. We noted that staff never spoke about a person in front of other people at the home which showed they were aware of issues of confidentiality.

Inadequate

# Is the service responsive?

## Our findings

At our last inspection we rated "Is the service responsive?" as requiring improvement. At that inspection we found some care plans did not contain information about people's life histories which meant care plans were not being consistently used in a person centred way and people's preferences, likes and dislikes could be overlooked. Following that inspection the provider submitted action plans which stated they would ensure individuals past histories were obtained to help staff engage with people more effectively. On their action plan the provider stated this would be completed by 30 November 2016.

At this inspection out of the 11 care plans we read eight did not contain important information about people's life history. In one person's care plan all that had been recorded about their life history was their preferred name and where they were born. Two of the visitors we met with told us detailed and interesting information about their relative's life and employment history. The life history document in the person's care plan was blank. When we asked staff what they knew about the person, they had no knowledge about their past history. We spoke with another person who lived at the home and they chatted to us and laughed about the job they used to have and of the antics they got up to. Again, there was no information recorded in the person's care plan and staff were unaware of the person's employment history. It was evident from our conversation with the person that they had become animated and enjoyed talking about their life. This meant staff did not have the information needed to provide person centred care to the people they supported.

At our last inspection in March 2016 we found care plans were bulky and contained a lot of historical information which made it difficult to easily locate information about people's current needs. The registered manager and the provider's regional manager for the service reassured us at the time they were planning to implement a new format which had proved successful in some of the provider's other homes. At this inspection we found there had been no progress with this and we found care plans remained bulky and contained historical and duplicated information. For example in one of the care plans we read there were two care plans which related to supporting the person with food and drink. Both contained the same information however one was dated February 2016 and the other June 2016.

It was not clear how people who lived at the home were provided with opportunities to express a view about the care and support they received. Care plans did not contain information about person centred reviews which would involve and seek feedback from each person who lived at the home. The visitors we spoke with told us they were involved and consulted about the care and well-being of their relative. One visitor said "My [relative] comes to all the reviews. I think the communication is quite good really."

People did not always receive the care and support detailed in their plan of care. For example; we read a care plan for one person which detailed how they liked to look. The care plan stated the person liked to wear bands and clips in their hair and liked to have their nails painted. It was also recorded that the person wore spectacles and had a special cuddly toy which helped them to settle at night. When we met with the person their hair had not been done as stated, they did not have their spectacles and their finger nails were long and unkempt and had not been painted. We asked staff where the person's cuddly toy was however;

they were not aware of the importance of this to the person, nor did they know where the cuddly toy was.

The home employed two activity co-ordinators who covered seven days a week between them. We met with both activity co-coordinators. One had recently been employed and had no previous experience in working in care or with people who lived with dementia. They told us they had not received any training in dementia care or how to provide meaningful activities for people living with dementia. They told us about one person who remained in their bedroom. They explained there was no information in the person's care plan about their life history or past hobbies/interests and they told us there was no specialist activity equipment to support people who had sensory impairments. The other activity co-ordinator also told us they had not received any training in providing activities for people who were living with dementia.

One care plan we read had not been updated to reflect the recommendations made by a health care professional and the person did not receive care in line with the recommendations. The person remained in their bedroom and the recommendations were that they were asked regularly by staff if they wished to spend time out of their bedroom and that their bedroom door was to be left open to enable them to come out of their room when they wanted to. This information had been recorded by the health care professional in their report following an assessment of their needs. A plan of care was not in place and we observed on both days of our visit, the person remained in their bedroom with the door closed. There was no evidence in the person's daily records to demonstrate the person had been asked if they wanted to come out of their room.

One person's care plan told us they were "at low risk of social isolation" because they "liked to interact with other residents and staff." We read the daily records for this person and for the past seven days records showed they had spent the majority of their time with no social interaction. Entries detailed times and included "bed", "eat" and "communal chair."

These issues are a breach of Regulation 9 (1) (2) & (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were limited opportunities for social stimulation. On one day of our inspection we observed activity co-ordinator playing floor snakes and ladders with two people on one of the units. Although they were very enthusiastic, there appeared to be little engagement from the people involved. We carried out a Short Observational Framework (SOFI) on three of the units for thirty minutes in communal lounge/dining areas. We saw there was minimal interaction from staff for people until staff started getting people ready for lunch. The television was on and people were mostly asleep. On one unit we found three people in their bedrooms with their radio on. Radios were tuned into pop channels and information we read led us to believe the channels selected were not people's preferred choice of music. For example we read one person liked classical music and they had many CD's of classical music in their room.

Our observations demonstrated there was no information for people about activities/events which they could plan and look forward to. When we asked staff if there were any plans leading up to Christmas we were told "I haven't heard anything. The activity staff would deal with this." Another member of staff told us "We have a bus and we used to take residents out. This has fallen off now. It's a pity we can't take people out." The manager told us a Christmas get together had been planned for the people who lived and the home and their relatives however there was no information about this displayed in any of the units.

The visitors we spoke with told us when they had raised concerns prompt action had been taken to address them. One visitor said "I raised some concerns with [name of registered nurse] about my [relative's] legs and they dealt with it very quickly." Another visitor told us "If I had any concerns I am pretty sure they would be

dealt with." We were informed the service had received one formal complaint since out last inspection which was in the process of being responded to by one of the managers. This related to the standard of the accommodation on Rose Unit.

Inadequate

# Is the service well-led?

## Our findings

The service was not well led and systems to monitor the quality of care to people were not effective. This had resulted in areas identified for improvement throughout this inspection report. The services own quality assurance systems had failed to identify these areas. In addition, these issues were similar to what had been identified as requiring improving at our last inspection.

Since our last inspection we received a number of concerns about the management of the home. These are currently being investigated by the Local Authority Safeguarding Team.

The registered manager for the home was not available for this inspection. In the absence of the registered manager, two of the provider's peripatetic managers (managers) were providing day to day management cover at the home. A regional manager also supported and visited the home at least two days a week.

The provider has been meeting regularly with the safeguarding team, commissioning group and CQC to discuss their actions and progress in relation to the quality of the care provided and of the concerns and allegations being investigated. The provider has agreed a voluntary ban on further admissions to the home during this process.

We met with the provider's operations director who was also the nominated individual for the service. A nominated individual is a requirement of our (The Care Quality Commission's) registration process where a provider is represented by an appropriate person nominated by the organisation to carry out this role on their behalf. The nominated individual is responsible for supervising the management of the regulated activity provided. The operations director told us their quality assurance systems had identified a number of significant failings which were in the process of being addressed. Areas which required improvement were detailed on a home development plan and a copy was made available to us. We found a number of shortfalls had been addressed or were nearing completion. These mainly related to the maintenance and replacement of systems such as a hot water/heating boiler and the re-wiring of the fire system throughout the home. The operations director explained major works to the environment needed to be completed before the 'soft' upgrading such as redecoration could take place. We discussed our concerns about the cramped environment for the people who lived on Rose Unit and provided examples where this affected the quality of life for the people who lived there. We were informed the ground floor area of Rose unit would be decorated, re-furbished and re-commissioned by 1 January 2017.

However there were a number of shortfalls identified where we were unable to see progress or sustained improvements which impacted on people's quality of life. For example, the environment on Rose, Redwood and Sutherland units did not provide a pleasant and enabling environment for people who lived with dementia. We found people could be at risk because staff did not have the training they needed. The majority of the care plans we read contained no information for staff about people's life history and some care plans were not reflective of people's needs. The meal time experience for people was not a sociable one and menus had not been made available in an accessible format for people. There were few opportunities for social stimulation.

The home's development plan stated that the home was to ensure evidence of staff induction and that all new staff were to complete the Care Certificate. The timescale for this was 30 November 2016 which was prior to our inspection. At this inspection we found a recently employed member of staff had not even completed their basic in-house induction.

There were internal monthly audits which monitored such areas as a monthly weight loss plan, pressure relieving equipment, bed rails, skin tear incidents, pressure area care, falls catheter care and any new infections. All these audits had been completed and any actions noted had been completed in a timely manner. For example, we saw one person had been referred to a falls clinic following an increase in the number of falls they had. However, the audits were not always effective in identifying areas of concern. For example we found the standard of bedding and pillows on some of the units to be poor however the audits on pillows and bedding had not identified any concerns.

These is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt well supported and that they found the manager approachable. One member of staff said "I feel positive about the changes. There is much more support and I am feeling more optimistic and positive as I feel we are moving forward now." Another member of staff said "[Name of manager] is really good and listens to what you say. When we said we couldn't work on the number of staff we had; staffing was increased." Another said "Things are really improving and I feel much more supported."

Following our last inspection action was taken to notify us about the significant events which had occurred at the home which had not previously been reported. When we read people's care plans including accidents and incidents involving people who lived at the home, we have no reason to believe we have not been informed of notifiable incidents which have occurred.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>The provider failed to ensure people were treated with respect and dignity at all times. This related to the poor standard of bedding and pillows, the lack of personalisation in some bedrooms and the manner in which come people were assisted with their meals.<br>10 (1)(2) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>The premises did not provide an appropriate or enabling environment for people who were living with dementia. The standard of décor on some units was poor. The environment on Rose unit was not appropriate for the needs and numbers of the people who lived there.<br>15(1) (c)(d)&(e) |

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The provider is failing to ensure service users receive care and treatment which meets their individual needs and preferences. The provider is failing to ensure service users have the opportunity to make choices and they are failing do everything practicable to support this.<br>Regulation 9 (1), (2) & (3) |

**The enforcement action we took:**

We have issued a warning notice against the provider for this breach.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider is failing to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.<br>Regulation 12, (2) (a) (b) & (c) |

**The enforcement action we took:**

We have issued a warning notice against the provider for this breach.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider is failing to ensure their governance systems to assess, monitor and drive improvement for the quality and safety of the services provided, including the quality of the experience for service users, are effective and are unable to sustain improvements.<br>Regulation 17, (1) (2) (a) (b) (e) (f) |

**The enforcement action we took:**

We have issued a warning notice against the provider for this breach.