Alpha Care Castlemaine Limited

# Castlemaine Care Home

## Inspection report

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Date of inspection visit:
14 September 2016
15 September 2016
22 September 2016

Date of publication:
09 December 2016

## Ratings

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

# Summary of findings

## Overall summary

Castlemaine Care Home provides care and support for up to 42 older people living with dementia. The care needs of people varied, some people had complex dementia care needs that included behaviours that challenged. Other people's needs were less complex and required care and support associated with mild dementia and memory loss. Most people were fully mobile and able to walk around the home unaided. At the time of this inspection there were 22 people living at the home and another three people received respite care.

At our last inspection on 24 and 25 November 2015 we found improvements were required in relation to safety and governance. Warning notices were issued and the provider was required to be complaint in these areas by February 2016. We also issued a requirement notice in relation to staffing numbers. The provider sent us an action plan that told us how they would address these. We carried out this unannounced inspection on 14, 15 and 22 September 2016 to check the provider had made improvements and to confirm that legal requirements had been met. We found that the provider had not addressed the breaches found at the last inspection. We also identified further breaches in relation to staff support and procedures for reporting safeguarding matters.

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 2008 and associated Regulations about how the service is run.

There was no advice in some people's care plans about how to evacuate them in an emergency or in the event of a fire. In others, the advice was not up to date. Record keeping in relation to the management of behaviours that challenged were not effective. In some cases incident reports had not been written, those that had, had not been properly evaluated and management were not aware that some had occurred. As a result there was no learning from these incidents and care plan documentation had not been updated. Risk assessments were updated monthly but not as and when people's needs changed. There were no risk assessments in place for some people.

There was a high turnover in the staff team and a high use of agency staff. There was no effective or timely monitoring of the impact this had on the staff team. Senior staff did not feel supported or listened to. They told us that physical assaults were often a daily occurrence and they had stopped reporting matters as they felt that nothing was done about them. Management did not have an understanding of the numbers and severity of incidents that occurred in the home.

Some of the staff team had not received appropriate training to meet people's needs. A number of staff had not received regular supervision and staff did not feel valued. Some staff did not have an understanding of the Deprivation of Liberty Safeguards (DoLS) and whilst they knew some people had a DoLS in place, they were not clear about others. (A DoLS is used when it is assessed as necessary to deprive a person of their

liberty in their best interests and the methods used should be as least restrictive as possible).

Although some improvements had been made to increase the level of auditing we found that matters had not always been addressed once identified. For example, water temperatures in wash basins had been above safety requirements but no action had been taken. There were no care plan audits and no cleaning audits in place. Although we were told that the provider visited the home regularly there was no documented evidence that they checked on the running of the home.

Despite the shortfalls we found that people were happy with the service provision. Relatives told us, "The staff cheerfulness and devotion is the best thing about the place." Another told us, "I've only ever seen (my relative) treated with kindness." Staff treated people with kindness and compassion. People's privacy and dignity was maintained.

There were safe procedures for the management of medicines. People had access to healthcare professionals when they needed specific support. This included GP's, dentists and opticians. Where specialist healthcare was required, for example, from a community nurse, arrangements were made for this to happen.

The overall rating for this provider is 'Inadequate'. At the last comprehensive inspection this provider was placed into special measures by CQC. At this inspection there was not enough improvement to take the provider out of special measures. CQC is now considering the appropriate regulatory response to resolve the problems we found.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

Procedures for the evacuation of some people in the event of an emergency were either not documented in care plans or not up to date.

When people displayed behaviours that challenged, incidents reports were not always written and as a result some incidents were not investigated and there was no learning from them. Risk assessments were not updated following incidents.

There was a high turnover in the staff team and this was managed with the use of agency staff. The full impact of the continued use of agency staff had not been assessed.

People's medicines were stored, administered and disposed of safely.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff did not feel supported or valued.

Although there was a wide range of training available some staff did not have appropriate training to fulfil their role.

Documentation did not always show that staff had information to ensure they acted in line with the Deprivation of Liberty Safeguards.

People were supported to access a range of health care professionals to help ensure that their general health was being maintained.

### Is the service caring?

**Good**

The service was caring.

People were treated with warmth, kindness and respect.

Staff knew people well and displayed kindness and compassion when supporting people. People's dignity and privacy was promoted.

Staff adapted their approach to meet people's individual needs and to ensure that care was provided in a way that met their particular needs and wishes.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

There was no organised plan in place to ensure that people were kept occupied when they activity person was on leave.

There was a complaints procedure in place.

Most care plans included advice and guidance about how people's needs should be met.

## Is the service well-led?

**Inadequate**

The service was not well led.

There was a lack of timely and effective monitoring in relation to accidents and incidents and people's dependency levels.

The service was not well run.

Quality assurance systems were not effective.

# Castlemaine 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.

Before our inspection we reviewed the information we held about the home, including previous inspection reports. We considered information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

This inspection took place on 14, 15 and 22 September and was unannounced. The inspection was carried out by two inspectors.

During the inspection we spoke with six people and four visiting relatives to get a view of care and support provided. We also met with the provider, the registered manager, head of care, three senior carers and two care staff. Following our inspection we received feedback from one professional who told us about their experiences of visiting Castlemaine.

Most people who lived at Castlemaine were unable to verbally share with us all their experiences of life at the home because of their dementia needs. Therefore the inspection team spent time sitting and observing people in areas throughout the home and were able to see the interaction between people and staff and watched how people were being cared for by staff in communal areas. This included the lunchtime meals. We also 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.

During the inspection we reviewed the records of the home. This included staff recruitment, training and supervision records, medicines records, complaint records, accidents and incidents, quality audits and policies and procedures, along with information in regards to the upkeep of the premises. We also looked at seven people's support plans and risk assessments along with other relevant documentation.

Inadequate

# Is the service safe?

## Our findings

At our last two inspections in 2014 and 2015 the provider was in breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following the inspection in November 2015 warning notices were issued that required the provider to be compliant with Regulation 12 by February 2016. At this inspection we found that the provider was still not meeting the requirements of this regulation.

At our inspection in 2014 the provider was issued a requirement notice in relation to not reporting safeguarding matters to the local authority. In 2015 the provider had addressed this matter. However, we identified further examples of this as part of this inspection.

In the 2015 inspection the provider was in breach of Regulation 18 as there were not enough staff on shift to meet people's needs. At this inspection we found that whilst there were enough staff deployed on each shift, there was no proper system in place to assess the impact of high use of agency staff on shift.

There was no up to date assessment of people's needs in the event of an emergency evacuation. We were told that there was a new format in place on the home's computer system to record each person's personal emergency evacuation plan (PEEP) but that these had yet to be completed for everyone. There were none in the care plans. In the interim there was a sheet at the entrance to the home which documented the action staff should take to support people in the event of a fire. However, the form had last been updated in May 2016 and did not include all the people living at the home at the time of our inspection. In addition it did not take account of people's changed support needs since May 2016. For example, one person was fully mobile in May 2016 and at the time of our inspection would have needed staff assistance to leave the building. This meant that in the event of a fire, agency staff and fire officers would not have the necessary information to support people to evacuate the building. This could potentially slow an evacuation and place people and staff at risk.

Strategies to mitigate identified risks were inadequate. For example, there were a number of records that showed one person had left the building on a number of occasions and been brought back safely. However, during one incident, this person had caused damage to furniture and doors. The evaluation of the incident stated that the maintenance person should ensure that the door was secured. There was no reference to what had caused the incident, no evaluation of how it had been managed or how similar incidents could be prevented or managed better and the risk assessment had not been updated. Advice within the care plan showed that it had been agreed that this person should be escorted to go out of the home as often as possible, when staff levels allowed. This person had been offered three outings in September. However, there was no risk assessment to assess what action staff should take should this person not wish to return to the home when out. There were no control measures to ensure that the risk was as low as was reasonably possible and this could have left them and the staff member at risk of harm.

The systems to ensure that care and support was assessed and provided in a safe way were not effective. One person who had been admitted in July 2016 on emergency respite had no care plans in place. Another person was admitted on respite six days before our inspection and whilst there was pre admission

documentation there were no care plans or risk assessments since moving to the home. Records showed that this person could be abrupt in manner but there was no advice about how this should be managed. We checked another two people's documentation and although both had a number of care plans there were no risk assessments. Therefore systems to assess the risks to the health and safety of people whilst they received care and treatment had not been carried out to determine if they were at risk of accident or injury.

People's needs were not reviewed in a timely way to safeguard against the risk of accidents and injuries. One person's mobility needs had changed in the week before our inspection. Their care plan documented they were fully mobile and there was no risk assessment in place. This person now needed the support of a staff member to move around the home. The person also had a risk assessment related to behaviours that could challenge others, but this lacked detail. The head of care listed the strategies they would expect staff to take should they have to deal with an incident. For example, they said that when staff approached the person they should ensure that they were in the person's line of vision because to approach from the side could startle the person and frighten them, triggering an incident. This had not been documented. Behaviour charts for this person showed a high incidence of behaviours that challenged when personal care was provided. Staff told us that they needed clearer guidance on how to support this person when providing personal care. We were told that risk assessments were updated monthly, not as and when people's needs changed. However, as there was a high use of agency staff and new care staff had been appointed, this left the potential for staff not having the information required to provide safe and appropriate care to people and had the potential to leave people and staff at risk of harm.

Although there were systems to carry out regular health and safety checks to ensure people's safety was maintained, these were not effective in practice. We noted that one person's prescribed cream had been left in the downstairs shower. People used this area regularly on an independent basis. Razors had been left in two people's ensuite bathrooms. There was no risk assessment documentation to state that people were safe with this arrangement. Appropriate action had not been taken to safeguard against the risk of accidents and this had the potential to place people at risk of harm.

The above issues are a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received safeguarding training and had an understanding of their responsibilities in order to protect people from the risk of abuse however, this was not always put into practise. They were able to recognise different types of abuse and told us what actions they would take if they believed someone was at risk and how they would report their concerns. They said they would not hesitate to raise issues with the head of care or the manager. A staff member told us, that they would raise any concerns with management and would expect management to report it to social services. However, there were at least two safeguarding matters recorded in behaviour charts where no incident reports had been written and two incidents reports where safeguarding matters had been recorded. None of these issues had been identified as safeguarding matters so this meant that staff did not always recognise when matters of concern were safeguarding matters and should be reported to the local safeguarding team. This placed people at risk of abuse not being dealt with appropriately.

The above is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been a problem with staff recruitment and retention. A relative told us, "Up until recently there was plenty of staff. I'm not happy about the staff turnover, I'd be worried if I was the owner. He should be down here." Staff told us that with the appointment of new staff they felt that staff levels would be sufficient.

However, the exception to this was when medicines were given, as they felt that an extra staff member was needed to be in the lounge to meet people's needs and ensure their safety. We were told that in addition to the manager there were five care staff in the mornings, four in the afternoons and three care staff at night. There was also a head of care who worked four days a week with people in the home and one day a week in the office. We took a number of factors into consideration when determining staff levels. This included, staff turnover and retention, the continued high use of agency staff, a lack of up to date information in some people's care plans and risk assessment documentation, and a lack of record keeping related to the management of behaviours that challenged. On the final day of our inspection staff told us that new staff had started in post and this had already had a positive impact on the support people received. With the addition of new staff it was assessed that staff levels were sufficient but this needs to be continually monitored with reference to the factors listed to ensure people's continued safety.

Medicines were stored, administered, recorded and disposed of safely. People's medicines were stored in locked trolleys within a locked room. There was advice on the medication administration record (MAR) about how people chose to take their medicines. Some people had been prescribed 'as required' (PRN) medicines. People took these medicines only if they needed them, for example if they were experiencing pain or were agitated. Although only senior staff gave medicines within the home, most of the staff had completed medicines training. Staff told us that they needed to have an understanding of the medicines people received.

Staff had received fire safety training in the past year. The manager had completed a fire safety report in September 2016. The manager told us that a professional carried out an assessment of the safety arrangements every three years and that they did an annual review of the findings. The manger's last review had been carried out in September 2016. A maintenance book was kept that included details of any faults identified and records of when they were addressed.

With the exception of the matters listed above there was effective health and safety monitoring. Checks included gas and electrical servicing, legionella and portable appliance testing. The electric hoist had been serviced regularly. Slings for the hoist had been checked monthly. Records showed that when a sling showed signs of fraying, this had been replaced promptly. Wheelchair maintenance checks had been carried out monthly. Due to the reduced occupancy numbers the home was no longer using the top floor of the home. A new stair lift had been fitted on the mezzanine floor.

Requires Improvement

# Is the service effective?

## Our findings

People were supported to attend health appointments as and when needed. A relative told us, "The food is good here." Most people were supported at mealtimes in a way that suited them. However, some staff had not received appropriate training to ensure they could meet people's needs appropriately.

Systems to ensure staff receive appropriate support, supervision and appraisal to make sure competence in their role is maintained were not working. An action plan completed in March 2016 by the provider and manager referred to the introduction of an annual appraisal of staff performance but the registered manager told us this had yet to be done. The head of care and the registered manager told us they felt supported but meetings of their supervisions were not documented. Senior staff told us they did not feel supported. One senior told us, "The Head of Care tries hard but they have to flit between the office and the floor." Another told us, "We don't have support from management so we support each other." The frequency of staff supervision meetings ranged from none, to one or two this year. The home's supervision contract stated that the frequency of supervision should be agreed with the individual staff member. However staff had different opinions on the frequency, and there was no evidence in staff files. A staff member told us, "Staff attendance is low at meetings as we need to have staff on the floor so only a few can attend." Records for a staff meeting in June showed that along with the manager, four staff attended the meeting. This along with a lack of opportunity for staff to attend regular supervision meant that the home was unable to demonstrate that they had effective systems in place to demonstrate they monitored staff performance and competence.

The systems to ensure staff received appropriate training to meet the needs of people with behaviours that challenged were not successful. Only five of the 14 care staff had completed training in the management of behaviours that challenged. One of the staff who had received this training told us the training was, "Great, and I learned a lot." However, they said that when they had raised questions about how to provide support in specific situations the training had been less detailed. As a result they did not feel confident in some situations so could not offer advice for new staff. Another staff member told us, "I asked for training on the management of challenging behaviour a month ago and was told, 'We'll have a look'." They said, "With very challenging behaviour you don't get help. One carer asked for help from managers and they just walked off." A staff member when asked if they felt supported said, "I don't know. If we are injured, we just deal with it and fill in behaviour charts. However, record keeping in relation to the management of behaviours that challenged was poor so it was not clear that management were aware of the support staff needed in this area.

Most of the staff team received ongoing training and support to meet people's needs. However, the registered manager had not ensured that night staff had received appropriate training to enable them to carry out the duties of their role. For example, two of the five night staff had not attended fire safety training, three had not attended first aid, food hygiene, infection control and MCA/DoLS. None of the night staff had attended health and safety training or training in the management of behaviours that challenged. As behaviour charts lacked detail and incident records were not always written it was not possible to assess if the management of behaviours that challenged were dealt with appropriately. This left people at risk of

receiving care and support that did not meet their needs.

The registered manager had not checked that a night senior was suitably qualified to fulfil duties of their role. For example, records for a senior night carer who had started work in May 2016 showed they had attended induction training and fire safety training. We were told that they had attended other training in their previous role but there was no record that certificates had been checked. As they had worked regularly with other night staff whose training was not in date this could have left people at risk of receiving inappropriate care. This person's name was not on the supervision plan so it was not clear if they had attended any supervision meetings.

The above issues are a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The majority of care staff had received training to enable them to meet people's needs. Most had attended dementia awareness training in either 2015 or 2016. Staff told us that this training had met their needs and they had a good understanding of the need to give people regular reassurance. We observed staff supporting people appropriately with their moving and handling needs throughout the inspection. We received information after the inspection about staff qualifications. The manager had completed the Registered Manager's Award. Six staff had completed a health related qualification at level two or above. Five care staff were studying for this qualification at level two or above. Two ancillary staff had completed qualifications appropriate to their role. For example, the cook had a catering qualification and the house keeper had a level two qualification. We were told that both the manager and the head of care were completing a management course. The registered manager tried to ensure that staff had the opportunity to participate in training appropriate to their role.

A new staff member told us they were enjoying their induction to the home. They said they had a six hour induction day and spent time looking at documentation and the home's policies and procedures. They had also had an introduction to the home's electronic care plan system. Training dates had been given for the following week. They said, "Staff make sure I do care properly, the core care is very good here, and the guys really care about the people." Another staff member told us they too had enjoyed a detailed induction to the home. They said, "I felt supported from day one." They said, "What you learn in training happens here." An example given was that when staff assisted people to move, "One person takes the lead and we continually reassure the person we are moving." We saw that when an agency worker started on shift who had not worked in the home previously, a staff member used an introduction to the home booklet to make sure they had day to day information that would be required by them.

At least half of the staff team had received training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and were able to describe its principles and some of the areas that may constitute a deprivation of liberty. 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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive people of their liberty were being met. Areas of the property were kept locked to ensure people's safety. The manager told us that

everyone had a DoLS in place. However, the section on the home's computer system to document this information had not been completed. We asked staff about people who had a DoLS in place and they told us the reasons why some people had them but they did not know if others had a DoLS authorisation. Staff did not have all the information they needed to understand why some people had restrictions in place.

In relation to one person, the manager told us the DoLS team had said staff should give the person clear guidelines and use a structured approach. We saw the manager use this approach with the person. However, this detail had not been recorded in the person's care plan. We were told that this information would have been given to staff at handover between shifts. However, with a high use of agency staff and new care staff there was a potential that some staff might not have received this advice. There was a risk staff would not have the information needed to support the person in a way that suited them and this left the potential for inappropriate care and a risk of increase in behaviours that could challenge. This is an area that requires improvement.

Staff asked people's consent before providing support. We were told that they had assessed people's abilities to make decisions. Most people had a care plan that related to cognitive ability. For example in relation to one person it stated, "Give time to let (person) say what they want as (person) gets muddled." Staff knew that should complex decisions need to be made, a 'best interests' meeting would be held. This was to ensure care was provided in line with people's assessed needs and wishes. In relation to one person an independent mental capacity advocate had been used to support one person with decision making.

There was a four week menu that was varied and well balanced. People who required support to have their meals were assisted first and then staff proceeded to serve others their meal. There was a difference in people's experiences between the first two days of our inspection. On the first day the overall experience was mostly a pleasant experience. When one staff member who was new went to support a person with their food, a senior staff member intervened to give guidance on how to sit at the same level so as to maintain eye contact with the person throughout their meal. Staff moved about and supported people as and when they needed it. One person refused their meal and a sandwich was given, which they ate.

On the second day, whilst for some people the mealtime was a pleasurable experience there were some notable differences. Staff did not always tell people what was on their plate. They were not as quick to prompt people to eat their meals, so four people were left sitting with a meal in front of them for a long period and there was no staff interaction. Three people had three different staff provide support during their meal. People were not offered an alternative if they did not eat their meal and were just given their dessert. We prompted a staff member to adjust one person's seating arrangement so that the person could eat independently. We recommend that the home explores information from a reputable source about meeting the dining needs of people with dementia to ensure consistent support and that mealtimes are a pleasurable experience for everyone.

Most people's dietary needs were reflected within care documentation. For example, there was information about the type of diet people required, and if they needed support with their meals. People were weighed regularly and where for example they had lost weight, they had been referred to the GP for dietician advice. Some people required a specialist diet for example diabetic, soft or fortified. The cook and staff had a good understanding of people's likes, dislikes and portion size, and food was offered accordingly. People were able to choose where to eat their meals. Most people sat in the dining room although some remained in the lounges.

The dining area was nicely presented with tablecloths, cutlery and condiments. People were offered a choice of a soft drink with their meal. The mealtime was not rushed and those who needed it were

supported to maintain their independence through the use of specialised equipment and cutlery.

People were supported to maintain good health and received on-going healthcare support. During the inspection we observed one person who experienced pain and discomfort. Staff attended to them promptly, they contacted the person's GP and specialist nurse and when they received advice that conflicted, they persisted until the advice was clear and the person was seen by the appropriate professional. Records confirmed that staff liaised with a wide variety of health care professionals. This included the community nurse, continence service, GP and chiropodist. People received care and treatment from appropriate healthcare professionals.

Good

# Is the service caring?

## Our findings

People were treated with kindness and compassion in their day to day care. One person told us, "The staff are lovely to us." Another said, "We're looked after." A relative told us, "The staff cheerfulness and devotion is the best thing about the place." Another told us, "I've only ever seen (my relative) treated with kindness." A social care professional told us, "I find that the standard of care is of a high calibre."

There was a relaxed atmosphere in the home and staff had a good rapport with people. Bedrooms had been personalised to reflect people's individual tastes. Staff knew people's needs, choices, personal histories and interests. Staff talked and communicated with people in a way they could understand and they encouraged people to make decisions and choices. For example, staff asked people where they wanted to have their meals and people's choices were respected.

Staff treated people with respect and dignity. If someone needed a hoist to move from a wheelchair to a chair a privacy screen was used. Staff explained what was happening and offered regular reassurance as they guided people to their changed position. The patio doors to the garden were open so people could use the garden if they chose to.

People were treated with patience and kindness. A staff member supported a person who had become quite agitated that a hand cream was not in their bag. Staff spoke calmly to the person and reassured them that it would be found. They assisted them in going through the contents of the bag and the cream was found. A relative told us, "The care is excellent. If there is a problem they phone or text and I visit regularly."

When one person needed immediate support with personal care we saw that a staff member provided a discrete explanation to the person and guided them to a private area where this was provided. Their calm and reassuring approach enabled what could have been a cause for embarrassment for the person, to be dealt with quickly and with no loss of dignity.

Staff gave us examples of how they maintained people's dignity. They said they knocked on people's doors and waited for a response before they entered the room. They told us they maintained people's privacy and dignity by always ensuring doors were closed when personal care was given. When food was served to people this was done in a way that met their individual needs and maintained their dignity. For example, staff sat at the same level as people maintaining eye contact and they spoke with people as they provided support. One person told us, "I'm very lucky to be here."

Staff were observant and attentive to people's needs. The SOFI and general observations showed interactions between staff and people were caring and professional. When staff approached people they did so respectfully and spoke to them using their chosen name. This meant people knew staff were addressing them. Support was provided in line with people's needs. For example some people wore tabards to protect their clothes, some had plate guards to help them maintain their independence and dignity and some had specialist cutlery. This showed staff understood the approach needed when caring for people living with dementia.

Requires Improvement

# Is the service responsive?

## Our findings

Visitors to the home told us they knew the procedure for raising complaints. They said that they were kept informed about important matters and were happy to discuss any concerns they had. A relative told us, "I would talk to the manager if I had any complaints."

There was no organised plan for activities whilst the activity coordinator was on leave or one to one support based on people's hobbies and interests. On the first two days of our inspection the activity coordinator was on leave and we were told that staff would do activities with people in the afternoons. During the afternoons of our inspection, games of skittles were offered in the garden. Both sessions were enjoyable experiences for those who participated but there was generally only four to five people in attendance. We also observed a ball game in the lounge and three people participated. A dog was brought to visit one day and people enjoyed the experience. The hairdresser also visited one day and those who chose to had their hair done. Whilst staff generally interacted well with people, for some, the interaction was fleeting. One person told us, "I like ballroom dancing and watching TV." They told us they were, "bored." One person sat in the lounge from 10.30 to 13.30pm with no interaction from staff other than to give them their food. We recommend that the provider ensures that people receive tailored support to meet their social needs. Individual needs should be identified in care plans and arrangements should be made to ensure they are met regardless of staff changes.

Doors to the garden area were open and people came and went freely. If people wanted to use the garden area and needed support, staff supported them to do so. We were given a copy of the activity programme for September 2016. There was a weekly dog visit. We saw this during our inspection and it was evident that people enjoyed the visit. There were two external entertainers during the month and a church service. Other activities included weekly hairdresser visits, flower arranging, skittles, bingo, garden club and exercise activities. On the last day of our inspection the activity coordinator had returned from leave. A game of bowling was organised. People enjoyed the activity, it was lively and there was greater level of participation among people.

There was a complaints policy which was displayed so that people and visitors knew how they could raise concerns should they wish to. The registered manager told us that formal complaints were rarely made as visitors and relatives had the opportunity to speak with them as soon as they arrived at the home and this way any minor concerns were addressed before they escalated. There was only one complaint recorded. This related to a concern raised by a relative in April 2016. The complaint was responded to in line with the provider's policy.

Care plan documentation was stored on the home's computer system. For most people this included information about people's medical needs, support needs and ability to give consent. The records contained information and guidance about people's routines, and the support they required to meet their individual needs. Within care plans about the provision of personal care, there was strong emphasis on ensuring that people were given choice and that their dignity was maintained. Most people had care plans and risk assessments in relation to their mobility. People's weights had been monitored and pressure areas

checked at regular intervals. There were systems to ensure care plans were evaluated by senior care staff on a monthly basis. If an evaluation was overdue, for example, if the staff member was on leave, this prompted signals on the computer so that the manager would be aware and the task reallocated. Staff recorded daily records that stated how people had been, what they had done and any support they had received.

Inadequate

# Is the service well-led?

## Our findings

At our last two inspections in 2014 and 2015 the provider was in breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following the inspection in November 2015 warning notices were issued that required the provider to be compliant with Regulation 17 by February 2016. At this inspection we found that the provider was still not meeting the requirements of this regulation.

Although there were some systems to ensure good governance these were not working because there was a lack of oversight and leadership in the home. The registered manager's office was positioned away from the main lounge. Whilst this meant they could receive visitors and respond to the phone, it also meant there were constant interruptions to their working day. The result was tasks started but not completed and a chaotic office. Record keeping in relation to auditing, care plans and risk assessment documentation, supervision and health and safety were incomplete.

There was also a lack of oversight from the registered provider. We were told that the provider visited regularly, spoke with people and staff, and looked at documentation but the registered manager was not sure if records of visits were carried out. There was an action plan for year ending March 2016. This included reference to the introduction of a monthly manager's report that would be compulsory. There were two manager's reports for August and September 2016. Both lacked detail and did not provide a full report on the running of the home. For example, it stated that PEEPs were available on the computer system but whilst the format was on the system there was no update on how many had actually been completed. There was no reference to the warning notices issued after the last inspection and to the home's action plan in relation to these. Apart from the two recent reports there was no other written evidence that the provider received regular detailed updates on the running of the home. Following the inspection we received correspondence stating that, 'Management reports are now being compiled in a different format to allow for more information to be included and expanded upon.

There were inadequate systems in place to ensure that matters that were required to be reported to the local safeguarding team had been. At the last inspection there was a lack of follow up in terms of accidents and incidents to ensure that appropriate preventative measures were taken to reduce occurrences. At this inspection an analysis of accidents and incidents had been carried out monthly from February until May 2016 but not since that date. Two incidents during May 2016 should have been reported to the local safeguarding team but this had not been done and this had not been identified as part of the analysis of incidents. The manager told us this was an oversight. Within behaviour charts there were another two incidents recorded that should have been reported to the safeguarding team but neither incident had been logged in day/night reports and no incident reports had been written. The manager told us they did not check behaviour charts when they carried out an analysis of incidents. This could have meant that there were additional incidents that had not been reviewed or reported and an inadequate system would not ensure that people were always safeguarded against the risk of abuse.

There was a lack of appropriate monitoring in relation to the management of behaviours that challenged and record keeping relating to this. There were eight incidents on one person's behaviour chart and three

incidents on another where staff recorded that they had been physically assaulted whilst providing personal care. These incidents were often not recorded in the day and night reports and incident reports were rarely completed. (Day/night reports are records staff keep about support provided to people and about how people have been throughout a given shift.) The level of detail in the behaviour charts was basic and there was no information about what happened before, during or after the incidents. We asked a staff member if incident reports were always written. They said, "100% not always recorded. Nothing is done so they are not reported." There was no system to ensure that when people displayed behaviours that challenged, the incidents were documented, investigated and risk assessments updated as a result. As the registered manager told us they did not check behaviour charts when incidents were analysed it was not evident that management had an understanding of the number of incidents, how serious they were, what had led to the incidents, how they had been managed and how people or staff were after the incidents. There was no learning from these incidents and this left the potential for people and staff to be at risk of serious harm.

There was a lack of appropriate monitoring in relation to care planning documentation to ensure that people were receiving safe and appropriate care and that where risks had been identified actions had been taken to mitigate them. At the last inspection, shortfalls that we had identified during our inspection had not been identified as part of the home's auditing of care plans and risk assessments. Within the last year four care plans had been audited. The registered manager told us that the system changed so that care staff evaluated each care plan monthly. However, there was no documented system whereby management assessed that care plans reflected people's needs. In addition, where people's needs had changed there was no assessment that any risks associated with the changed needs had been assessed and actions taken to minimise the risk of accidents and incidents. This lack of oversight meant that there was a potential for people to receive care that was inappropriate and could cause harm to the individual.

There was no quality assurance audit system to monitor nutrition in the home. We were told that a daily nutrition chart was completed on individual files on the computer but there was no system in place to carry out an audit of nutrition in the home. There was a fluid chart in place for one person that had been requested by their GP. Since the beginning of September there were no records for five days. Whilst most days where records were kept the fluid intake was appropriate one day the intake recorded was 50ml of lemonade and a pudding. Staff told us they regularly provided this person with drinks but they refused them. Records did not show this. There was no risk assessment in place to minimise the risk of this person becoming dehydrated. There was also no audit system to monitor the management of people's food or fluid intake. During our inspection this person was admitted to hospital and it was reported that they had been dehydrated.

Organisational quality assurance systems were in place, however they were not all fully up to date and had not identified the shortfalls we found. There was a high turnover in the staff team and although staff had been recruited, they had yet to start in post so there was still a high use of agency staff. The registered manager told us that they always ensured that there was extra staff on duty for appointments and staff training. A staff analysis report had been written in May 2016 but at the time of inspection no review had been carried out since then. On 28 September 2016 we received a copy of the staff analysis for the period June to August 2016. The analysis lacked detail and did not summarise the extent of the staffing problems. Although we had highlighted to the manager on 22 September that consideration needed to be given to behaviour charts as part of the accident/incident analysis, there was no reference to this in the staffing analysis. The analysis referred to training in dealing with behaviours that challenged, that had been booked for June. However, there was no reference to the fact that only five staff had attended and that further training had been booked for September. As people's care plans had not been audited and the accident /incident analysis had not been completed fully, this had not been considered when determining staffing levels to ensure people's safety and this left the potential for inadequate staff levels.

At the last inspection there were no cleaning audits available and this was still the case. Whilst there were expectations about which areas needed to be cleaned daily there was no formal procedures to monitor this was done regularly. There were however, two undated infection control audits. We were told that the most recent audit had been carried out in July 2016. Although the tool was detailed, the completion at times gave basic information only. For example in relation to the overall appearance it stated, 'Some areas need redecoration,' but not where.

The provider's systems for audit had not identified health and safety issues. A check on water temperatures in August and September 2016 showed that water in several wash basins showed readings in excess of safety guidance. We discussed this with the registered manager who told us that this had not been brought to their attention. On the final day of our inspection the manager confirmed that a heating engineer had been called in to address the matter. A servicing of emergency lights showed that one emergency light failed to work in August 2016. We were told that this had yet to be repaired. However, the monthly check on emergency lights for August showed that all areas had been working. We confirmed that this was inaccurate. On the third day of our inspection we were told that an electrician had been called in to rewire the light. Although the registered manager took action to address these matters once we had brought them to their attention, the staff member concerned had not reported the problem. There was no system to make sure that all required checks had been carried out and to check that appropriate actions had been taken.

Systems to ensure people's safety were not always effective. For example, a visitor had raised a concern about a trip hazard in their relative's bedroom. A temporary measure had been put in place to address a lighting problem. When the registered manager investigated, although the problem it had been addressed promptly, the trip hazard had been in place for an eight day period. There was no investigation into why staff had not addressed the trip hazard over the eight day period. If the complainant had not raised the concern the trip hazard could have resulted in a serious accident or injury.

The provider did not have effective systems in place to asses, monitor and improve the quality of the service being provided to people. The issues above are a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A 'walk through' audit was carried out but this had not been dated. We were told that this had been done in September 2016 and involved a full tour of the building to identify any maintenance or health and safety issues. All maintenance issues identified as part of this audit had been entered in the maintenance book and were gradually being addressed.

There were systems in place to seek the views of people and their relatives. A relatives/residents survey report carried out in February 2016 showed that 19 out of 30 people's relatives responded. Positive comments included, 'I am grateful to staff and happy that my mum is at Castlemaine.' Another said, 'Staff are caring and dedicated to the job.' We were told that there were no negative comments from the survey. The manager told us also had a family forum meeting in June 2016. However, only five relatives attended. In contrast 75 visitors attended a very successful summer barbeque. A social care professional told us, "The Manager and her Staff are always very attentive to the residents needs and show a caring attitude at all times."

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider did not have systems in place to identify safeguarding matters and to ensure that they were investigated.<br><br>Regulation 13 (1)(2) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>There was no proper system in place to ensure that all staff were suitably trained and to ensure that they were appropriately supervised and supported.<br><br>Regulation 18 (1)(a) |