Alpha Care Management Services No. 3 Limited

Grenville Court Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 13 November 2017.

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.

Grenville Court is a 'care home'. People in care homes receive accommodation and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Grenville Court accommodates people in individual rooms, each with an en suite toilet and basin facility. Each floor has some communal bathrooms and toilets in addition.

At this inspection we found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found serious and widespread concerns at this service. You can see what action we told the provider to take at the back of the full version of this report.

There were significant shortfalls in the care and service provided to people. There was widespread lack of regard for people's dignity throughout the home, as people were not adequately supported with their continence needs and personal care needs.

Staff did not encourage independence and confidentiality was not always upheld. We found practices in the home which showed a lack of respect and compassion for the people who lived there.

We observed some poor practice that put people's safety and wellbeing at risk. Whilst records showed that staff had received training it was either not being put into practice or the training was not of a suitable standard to ensure people were safely supported.

Staff were not always deployed appropriately across the home to keep people safe or to meet their needs in a timely way. The home was not kept clean and there were poor infection control practices.

We were concerned that staff did not always know how to support people with their meals. There was poor knowledge of people's dietary needs.

Risks to people's welfare had not always been identified. Risk assessments were not always accurate and detailed with people's individual risks. There was not always clear guidance provided to staff about how to mitigate risks to people.

Some staff did not engage appropriately with people. People were not receiving person centred care which met their needs or preferences. People's individual health conditions and needs were not always well

planned for and their hobbies and interests were not adequately supported.

Mental capacity assessments had been carried out, but these were not for specific decisions. Therefore people's consent to care was not always determined and best interests decisions were not always made properly.

We found there was a lack of effective management and leadership. This, coupled with ineffective quality assurance systems, meant that the issues we found had not been identified or resolved. Problems across the home that had been raised in the form of complaints had not been used to learn from and improve the service.

The overall rating for this service is 'Inadequate' and the service is therefore 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.

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.

Risks to the health, safety and wellbeing of people who used the service had not always been identified, assessed or planned for. There was insufficient guidance for staff about how to support people in a safe manner.

Staff were not always available to meet people's needs.

Recruitment processes were in place to ensure that staff suitable to work in care were employed.

Is the service effective?

Requires Improvement

The service was not always effective.

Training records were in place for staff, however not all staff training was effective in ensuring they were competent in their roles.

People did not always receive effective support with eating and drinking enough because care plans were not always consistent, and staff had poor knowledge or needs.

The service was not fully compliant with the Mental Capacity Act (MCA).

Is the service caring?

Inadequate

The service was not caring.

People were not supported to maintain their dignity, privacy or independence.

People did not always receive care that was compassionate, from caring staff.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs were not met in a person-centred way. People's health, emotional and social needs were not always planned for and people did not receive individualised care.

The service did not always learn from complaints and improve the service.

Is the service well-led?

Inadequate

The service was not well-led.

Systems in place for auditing and monitoring the service were not effective as they did not identify concerns or lead to actions.

There was a task-led culture in the home and poor leadership in place.

Grenville Court 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 checked 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 on13 November 2017 and was unannounced. The inspection team consisted of three inspectors, a medicines inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection, we reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law.

During our inspection visit, we observed how people were being supported and how staff interacted with them. We also spoke with two people living in the home and six relatives. In addition, we spoke with one member of care staff in private and four more in a group. We spoke with a senior care staff member, the registered manager, and the cook. We also spoke with two visiting healthcare professionals.

A member of the CQC medicines team looked at how the service managed people's medicines and how information in medication records and care notes supported the safe handling of their medicines. We looked at nine care records and checked through the daily records of people's care. We also looked at a range of management documentation relating to how the home is run, such as audits and staff training.

Inadequate

Is the service safe?

Our findings

During our last inspection on 21 February 2017 we found the service was safe, and was rated 'Good' in this area. During this inspection we identified serious shortfalls and the service was not safe.

Risks associated with people's mobility and falls were not always accurately assessed, recorded and mitigated. For one person, we saw they were walking unsupervised with walking sticks, but their care plan stated they walked with supervision and a walking frame. We found this person was mobilising unsupervised, as staff had not responded to their shouts for help. This person had two walking sticks but had dropped one of them. The person also had a slipper coming off one foot, which put them at risk of falling. This meant the person was not being supported in accordance with the risk assessment in their care plan.

An inspector used the bell in the person's room to call for assistance on their behalf so staff could attend to the person. We found that the call bell was under the person's bed and not within their reach. On looking at the person's care plan it was unclear whether the person understood how to use the call bell and their ability to use it had not been assessed. Because the person frequently called out for help, staff were understandably not able to respond every time. However, with the exception of routine visits by staff to the person's room, there were no clear systems in place to help consistently ensure the person's safety whilst alone in their room.

Some people had behaviours which could challenge others and present a risk to their safety. There were not always clear plans in place in people's care records which contained enough guidance for staff about managing this risk or identifying and avoiding triggers for the behaviour. People's behaviours associated with living with dementia were not always managed effectively in a safe way. A visiting relative told us, "[Relative] isn't as safe as I would like her to be, there are some people who walk about hitting people" This relative also said, "One resident takes the table cloth off or tips cups up and hits people." Another relative gave us an example of their family member becoming very distressed as another person kept entering their room. During our inspection visit, we saw one person enter another person's room. This person was living with dementia and seemed disorientated.

When we looked at the records for another person, we found that several recent incidents relating to distressed behaviours had been recorded. However, there was no detail regarding the reasons or possible triggers for the person's behaviours. Therefore, staff were not able to adequately support this person to alleviate their distress and help ensure that they and others remained safe. Staff had also failed to look for and record any patterns of behaviour that could identify possible underlying causes that may need investigating or addressing.

We observed an inappropriate and potentially unsafe moving and handling practice in the home. On one occasion we observed a person in their room whilst talking with their relative. This person had poor mobility, and needed assistance to stand from sitting in the chair. The person's care plan stated that they were able to walk short distances with a walking frame and the aid of two care staff. However, it did not

guide staff on how to safely support the person to get up from the chair, for example by using a stand-aid or the appropriate method for manually supporting them. On this occasion we saw one staff member lift the person from under their arm, with a relative of the person on the other side. This is not safe moving and handling practice and could cause injury to any party involved. The person's relative told us, in respect of moving or transferring their family member, "Sometimes we come and there isn't anybody [staff] about. They [staff] say we need two [staff]. I offer to help; some say I can and some say I can't." From our observations and discussions, we concluded that the inappropriate moving and handling practice we had witnessed was not an isolated incident for this person.

We found that equipment, such as walking frames, commodes and wheelchairs, was being stored in unused bathrooms which were unlocked and accessible to people living with dementia. This posed a hazard to people who frequently walked around the home in a confused state or disorientated. There was a risk that people may trip or become trapped and, because the bathrooms were not in use, people may not recognise the environment they were in. We therefore concluded that these were not safe areas and should not be accessible for anyone to use because of the equipment stored within.

We noted areas of the home where external medicines were not secured and where people could access them placing themselves at risk of accidental harm or ingestion.

There were poor infection control practices, increasing the likelihood that any outbreak of infection could not be properly contained and managed. Staff did not always use personal protective equipment (PPE) when dealing with personal care or food management. When we arrived for our inspection, breakfast was being served. We saw that none of the staff were wearing protective aprons. After approximately 20 minutes we heard one member of staff instruct other staff to wear them. Later in the day, we observed some staff continue to go backward and forwards to people's rooms to support them or escort them through to the dining room whilst still wearing the same apron.

We also saw one member of staff carrying a red laundry bag full of soiled laundry, with no personal protective equipment on such as an apron. The staff member went into a room to attend to someone, still carrying this bag. This heightened the risk of spreading any infection contained in the soiled laundry. We were concerned that wearing aprons was not common practice when transferring between personal care and dealing with food.

The dining area on the upstairs floor was unclean. For example, we noted there were lots of residual food and drink spatters on the curtains, walls and notices near the serving counter and food trolleys. The floor was sticky and the permanent serving counter in the dining room was dirty and dusty with greasy and sticky residue in places. The portable serving trolleys also looked unclean with grease and food debris. These were not fresh and had not been caused during the breakfast session. We saw that these spatters had not been cleaned by the time we observed the lunch session, nor later in the afternoon when we saw staff preparing the tables for tea time.

Communal bathrooms were not kept clean. We also saw that dirty laundry was being stored in an unlocked shower room. There were poor cleaning standards within people's en-suite toilet facilities. For example, we checked one person's toilet in their en-suite regularly throughout the day, and saw that it remained soiled and their bedroom carpet remained dirty throughout the day of our inspection visit. For another person, their toilet remained unflushed during the day of our visit.

The practices we observed presented a risk that infections could be transferred and any outbreak would not be properly managed to ensure people's safety. People's personal cleanliness was not consistently

encouraged and upheld by staff. We saw in the daily records that showers and baths were not always provided as routine care. We saw during our visit, that people were not always encouraged to change their clothes when they had experienced difficulties with their continence. We asked a member of staff about people not having showers or baths. They told us that often people refused, but were not able to explain how this was further managed.

There was a lack of hand-washing or sanitising facilities for staff in some of the areas where staff were handling food. For example, the upstairs dining room had no facilities for hot or cold running water and there was no hand sanitiser in this room either. We observed staff entering this dining room after supporting people with personal care or completing tasks in other areas of the home and then serving people with their food and drinks, without having somewhere suitable to wash their hands. We saw one member of staff bring a person into the dining room from their room, then walk over to the serving counter and put some bread into the toaster. They handled the bread before and after it was toasted but had not cleaned their hands between completing a care task and handling the person's food. We were concerned about the lack of appropriate facilities and asked two members of staff how and where they washed their hands before, during and after serving people with their meals. One member of staff person replied, "In the sluice room." Another shrugged and said, "I know, it's not good." Neither of these responses were appropriate and compounded our concerns.

We saw that audits and checks were in place for aspects of health and safety, such as infection control. However, the checks we looked at had not identified a number of the concerns we found during this inspection, such as the lack of hand cleaning facilities in the upstairs dining room and the unhygienic food preparation and serving area in this room.

Although the registered manager had reviewed reports of incidents and accidents, they had not always used these as an opportunity to improve the service. We found that people remained at risk due to environmental hazards and the fact that people's care plans were not always up to date and consistent.

These concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed that there were not enough competent staff consistently and effectively deployed throughout the home. We also observed that staff were not always available to support people in a timely manner. In one instance, we had heard a person calling for help and an inspector had assisted the person to alert staff by using their call bell. This person wanted assistance to go to the toilet but we observed that staff took over ten minutes to respond to the person's needs.

Another instance was upstairs near the nurses' station, when a person approached an inspector in a distressed state, saying, "I need the toilet urgently." This person had had a continence accident and was crying, red in the face and embarrassed. There were no staff in the vicinity at this time, so the inspector went to find someone to assist and reassure the person.

We noted several times throughout the day of our inspection visit that there were no staff deployed in communal areas to supervise or interact with people. For example, during the afternoon we observed that there were two members of staff at the care station upstairs completing notes at the same time. At this time, we observed there were eight people seated a lounge with no staff present. We encountered a conversation between two people living with dementia, where one person shouted at another, and no staff were there to supervise and ensure the situation did not escalate. Staff were not deployed in a way that contributed to people's safety.

Staff told us they felt they were well-trained for their roles. However, this was not always reflected by their actions. Whilst some staff members had recently completed dementia training, our observations identified that some staff demonstrated a lack of understanding with regard to communicating and interacting with people living with dementia. One relative explained that they felt the staff did not communicate effectively to encourage people to join in activities or have a shower. They said, "The [staff] come in ask [relative], she says no so she is just left; if you are good at your job you should be able to talk [people] round."

During this inspection we concluded that staff training was not fully effective and there was not always a suitable skill mix to ensure people received consistently safe care. For example, we saw poor moving and handling, despite training provided to staff in this area. Other areas where we found concerns, despite most staff having received associated training, were in managing behaviour which some could find challenging and understanding infection control and ensuring the appropriate procedures were followed.

These concerns constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at Medicines Administration Records (MAR) and found that there were some gaps, which meant they did not always confirm people received their medicines as prescribed. Records for medicines prescribed for external use such as creams and ointments were completed by senior carers and not those members of staff who actually applied them to people. This was not good practice in ensuring accountability for completing the application of these products.

We noted that there had been some medicines that had not been given because they had not been received from the pharmacy in time to ensure people's treatments were continuous. Following this inspection, the provider informed us that they had been in daily contact with the GP surgery and the pharmacy to chase these medicines. The provider also confirmed that they had since changed pharmacies and that the issue had been resolved.

We noted that the staff member administering medicines was delayed by other tasks and enquiries. For example, we observed that they carried a portable telephone and were interrupted by incoming phone calls. This increased the risk of error and delayed the medicines round. We noted that some medicines were given at a time earlier or later than scheduled and not as intended by prescribers. This meant that some medicines were not given to people as prescribed which may have impacted on their safe use.

People prescribed medicated skin patches had additional records to show where they were applied to their bodies and to confirm they were removed before the next patch was applied. However, these records were not always being completed. It is important to ensure the old patch is removed before a new patch is applied and records to confirm this should be completed consistently. This ensures that people are not at risk of receiving any residual medicine from the old patch in addition to the new patch, which could subsequently increase the dosage.

The lists of people's medicines we saw were sometimes inaccurate and not kept updated following changes to their medicines by prescribers. This could lead to staff confusion and errors in ensuring people received the right medicines at the right time.

When people were prescribed medicines on a when-required basis, including pain-relief and sedative medicines, there was not always sufficient person-centred written information available to show staff how and when to give them to people to ensure they were given consistently and appropriately. In addition we noted that records did not always state why they were needed when given to people who were prescribed

them. For people prescribed pain-relief medicines on this basis, and who were unable to tell staff about their pain, there were insufficient means by which staff could assess their pain-levels to give them their pain-relief medicines.

Members of staff who handled and gave people their medicines had received training and had their competence assessed to ensure they managed people's medicines safely. We observed part of the morning medicine round and observed that staff giving people their oral medicines did so in a caring manner. Some supporting information was available for staff to refer to when handling and giving people their medicines, such as known allergies and medicine sensitivities.

Oral medicines were stored securely for the protection of people who used the service. There were gaps in medicine room and medicine refrigerator temperature records so medicines may not have been stored at correct temperatures and remained safe for use.

All the staff we spoke with told us that, before they had started working in the home, references had been provided and Disclosure and Barring Services checks (DBS) had been carried out. This helped ensure that only staff who were suitable to work in care were employed. We looked at a sample of recruitment files, which confirmed this was the case.

Some aspects of the service contributed to people's safety. One person using the service said, "I feel safe, they look after you pretty well." Four visitors told us they felt their family member was safe at the home. One member of staff told us, "If there's an incident or I'm concerned about anybody I know it needs to be reported to [manager] straight away. I'm comfortable doing that. We always need to write a statement about what happened and that information gets passed on to safeguarding."

Although we found some risks associated with people's welfare were not always fully mitigated, other aspects were managed appropriately. For example, risks of falling out of bed. A relative told us "Yes [person] is safe, she had a fall and a sensor mat was put in place." Equipment such as pressure mats to alert staff if people mobilised, and crash mattresses to prevent injury, was in place to mitigate these risks. Risks associated with pressure care were also managed. We saw that some people had equipment such as pressure cushions in place, and were supported to reposition regularly if they were cared for in bed. We saw there were adequate systems in place to protect people from the risk of fire and lifting and electrical equipment had been serviced appropriately.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 21 February 2017, the service was rated 'Good' in 'Effective'. During this inspection, we found the service was not consistently effective.

We were concerned that people were at risk of not having their nutritional needs met appropriately due to a lack of knowledge and clear guidance to staff regarding individual's dietary requirements.

People were not always supported to maintain a healthy balanced diet, which catered for their individual needs. Some staff also did not demonstrate good knowledge or respect for what diets people required, and what their support needs were.

For example, we observed one member of staff collect a person's lunch from the serving trolley, then sit with the person to assist them to eat. However, we observed that the person was reluctant to eat their meal and, after a few minutes, the member of staff took the person's meal back to the serving trolley. At this point we heard the member of staff comment that it should have been the mushroom stroganoff rather than steak and kidney, as the person was vegetarian. This meant that, although the staff member was aware of this person's individual dietary requirements, they had not ensured these were met until after the person had refused to eat what they had initially been offered.

Another example of this was when we saw that another person had been given a beaker of orange juice with their meal, which they did not drink. Half way through the lunch session, we observed a member of staff go to the person and say, "Would you like cranberry instead? I know you don't normally like orange." To which the person replied, "Oh yes please; thank you." The person then drank the cranberry juice.

We found that there was very limited guidance available for kitchen staff to know what types of consistencies and special diets should be provided to people. For example, there was no guidance for kitchen staff on how to prepare special diets, such as meals for people with dysphagia (swallowing problems), or the difference between soft mashable and pureed diets. The cook told us that, where needed, staff mashed or pureed people's food before serving it to them. However, this could present a risk to people where some ingredients, such as peas or baked beans, may need to be avoided due to the husks presenting a choking hazard. In addition, there was no information available for kitchen staff that specified any allergies or sensitivities that people may have.

Following this inspection, the provider assured us in their factual accuracy response that the full time, and long-serving, cook did have comprehensive knowledge of the people living in the home. However, we remained concerned that clear information regarding people's specific dietary requirements was still not available for new kitchen staff or those that covered for the times when the full time cook was absent.

We were concerned that staff did not always know who was responsible for supporting people to eat. We heard one member of staff ask another staff member who needed assistance in their rooms, to which the other member of staff replied, "I don't know who's being assisted." This posed a risk that some people could

be missed.

People's dietary needs were not always monitored properly or consistently recorded within their care plans. We saw that each person had a summary sheet on the wall in their bedrooms, which provided basic information, at a glance, for staff to know a person's general needs. However, some of this information was not consistent with what was recorded in people's care records. For example, one person's summary sheet stated that the person had a normal diet and fluids and were independent with eating and drinking. However, this person's care records stated that the person needed supervision when eating and required their food to be cut into small pieces, but with no explanation as to why.

For another person, we saw their care plan said they had 'minor problems chewing and swallowing' but there was no further information about the nature of these problems. It is important that this information is consistent and accurate to help ensure staff are aware of the potential risks associated with any problems and ensure people have the most appropriate diet. We saw in the daily records that another person had been recently assessed by a dietician, who had recommended a fortified diet. However the person's care plan had not been updated with this current information. This meant there was a risk of the person not being provided with a diet that met their nutritional needs.

In some instances we identified there was not always enough information available within care plans for staff to ensure they supported people in the most suitable way regarding their diets. On other occasions, we noted that staff were unaware of changes that had been made and recorded in people's care records.

For example, we saw that staff did not always prompt people with their meals in an appropriate and reassuring manner. We saw that some people were withdrawn when their breakfast was served and needed encouragement to eat. However, we saw that staff were inconsistent with their encouragement, with passing comments such as, "Come on [name] eat your breakfast." Rather than sitting with the person and encouraging them.

We observed that one person was disinterested in their meal when staff served it to them and made no attempt to eat it. After approximately 20 minutes a member of staff walked past and said to another, "[Person] needs assisting." The second member of staff asked, "Since when?" the first member of staff replied, "Since Saturday (two days previous)." To which the second staff member stated, "Oh, I didn't know!" We saw this information had been recorded in the person's care records but it was evident that not all staff were aware of the change in the person's support needs.

The breakfast time experience on the first floor was not respectful of individual's needs, especially for those people living with dementia. For example, one person was given toast and marmalade, which they started to eat and then a bowl of cornflakes was also put in front of them by staff. This distracted the person from eating the toast. The person looked confused and stopped eating altogether. However, staff did not recognise or acknowledge the person's predicament.

We noted that one person had chosen to have just mashed potatoes for their lunch and was served four scoops on their plate. We saw that the person ate less than one scoop before saying they didn't want any more and their plate was removed. We queried this person's diet and a member of staff told us that the person only liked potatoes for their main meal; saying, "Mashed, jacket, chips or roast." This member of staff also told us that this was okay because the person would have toast for their breakfast and a sandwich at tea time.

We asked if there was any guidance in place or whether the person's food intake was monitored, which

could help encourage them to have a more nutritionally balanced diet. The member of staff we spoke with told us that, because there were no concerns about the person's weight, there was no need to monitor their diet or seek advice from dietary professionals.

Some people's fluid intake was also not always monitored accurately when needed. This information is important in order to identify and mitigate the risks to people of dehydration, urinary tract infections and skin breakdown. For example, we noted that one person, who was deemed to be at risk of developing a urinary tract infection, had some drinks recorded in their daily records. However, the amount of detail recorded was not consistent, and the care plans did not state a target amount of fluid required. For example, on one day there were some amounts written down, whilst on another day the records simply stated, 'Fluid intake good.' This information was not sufficient to effectively monitor how much fluid the person had actually drank, nor highlight whether any action was needed to ensure that the risks associated with not drinking enough were being mitigated.

These concerns constituted a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to access some health services, such as a GP who visited the home regularly. We spoke with a visiting healthcare professional who told us they felt the home made appropriate referrals to them and followed their guidance.

Some new members of staff told us that as soon as they began working in the home, they had started their inductions. They said that they felt well-supported and shadowed more experience staff to begin with. All of the staff we spoke with said they took part in regular supervisions. These discussions provided an opportunity for staff to discuss their role with a more senior member of staff. However, we were concerned that the induction process, as well as staff supervisions were not fully effective due to the concerns we found during our inspection visit.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Some people had DoLS authorisations applied for within the home, and two of these had been authorised. We saw that mental capacity assessments had been carried out where required.

We saw that the environment people lived in was not always well-cared for. For example, the communal bathrooms were being used for storage of equipment and not for people to bathe in. The dining room upstairs was missing a curtain at one of the windows and looked unkempt.

We found that some people's bedrooms and one of the lounges felt very cold. One person's relative said, "The radiators never seem to be on, I visit most days and it's freezing in this room." We also found that the environment was very noisy, with call bells constantly beeping loudly throughout the day of the inspection. Two people we spoke with also told us they found it noisy living in the home.

The home had different coloured corridors to help people recognise where their room was. However, there was not always adequate signage to either the communal toilets or people's en-suite toilets. This meant that some people living with dementia were not fully supported to identify where the nearest toilet was or whether they had an en-suite toilet within their rooms.

We concluded that these environmental factors were not conducive to creating a calm and pleasant environment for people to live in.

Inadequate

Is the service caring?

Our findings

At our last inspection on 21 February 2017, the service was rated 'Good' in 'Caring'. During this inspection, we identified serious shortfalls and found the service was not caring.

The service did not ensure that people living in the home consistently received a good standard of care. We witnessed occasions during this inspection, and some relatives told us of instances, where people experienced situations that compromised their comfort, dignity and self-respect.

For example, people were not always offered appropriate or timely opportunities to change their clothes or have a wash if they had been incontinent. One person's relative told us about an unpleasant smell in their family member's room. This relative said, "It was that bad I actually couldn't physically be in the room." They went on to say that the matter had been resolved but only after they had raised it with staff. Another relative we spoke with said, "[Family member's] room always smells." This was also fed back by two more relatives we spoke with.

We observed that one person remained in the same clothes throughout the day after they had been incontinent and wet their clothing, which the registered manager was seen to report to a member of staff. The person continued to walk throughout the home, in and out of their room, as well as into another person's room, remaining in the same clothes. An inspector checked this person's bedroom and found that there was a strong malodour in there.

Dignity and self-respect was not consistently upheld or promoted on occasions when people had an accident in respect of their continence. People's welfare was also heavily impacted by the staff's inability to consistently attend to people's toileting needs and personal care in a timely way. People's relatives we spoke with also reflected the poor standards of dignity for people living in the home. One said, "A couple of months ago [family member] needed the toilet she had to wait 10 to 15 minutes, by the time the staff got to her it was too late."

Staff did not always demonstrate respect for people by ensuring that when they supported people, the person, their room and their en-suite, was left in a clean, tidy and hygienic condition. One relative described to us a time when they had visited their family member and found their bedclothes to be, "Disgusting."

We viewed a number of people's bedrooms at repeated intervals throughout the day. For some people we observed that their bedding remained dirty and ill-fitting on every occasion we checked, including that for one person who remained in their bed full time.

For example, one person's bed was seen to have a very creased and stained bottom sheet, a dirty pillow and a mattress topper, which was being used as a duvet. The mattress topper did not have a cover on it and was also dirty with what appeared to be residue of food and drink. We revisited this person's room on four occasions throughout the day. There was evidence that staff had supported the person with personal care on their bed during the day but the bedding remained dirty, dishevelled and missing.

A second person's bottom sheet had 'G2' hand-written boldly in marker pen in two places at one end of the sheet. 'G2' did not relate to this person's room number nor their name. This person's bedding was also stained and ill-fitting.

There was an evident lack of respect for people's property and six relatives told us about clothing or bedding, that they had brought in for their family member, going missing. For example, one relative told us how they had brought a new duck-down pillow for their parent but this had gone missing and was no longer on their parent's bed.

Care provided was not responsive to people's needs for personal care, and did not reflect people's preferences. Prior to the inspection visit, we had received several concerns and complaints relating to poor personal care being provided at the home. These concerns had included staff not supporting people to wash and change their clothes, and not supporting people to use the toilet.

During our inspection visit we saw that a number of people looked unkempt, unclean and not well-cared for. We observed that many people's hair looked greasy, uncombed and matted at the back of their heads. Some people's finger nails were long and dirty and some people were wearing clothing with stains down the front. A relative we spoke with said, "[Relative] has never had her hair washed since being here from May."

People did not always receive personal care according to their individual needs and preferences, which could have a significant impact on their well-being, dignity and self-respect. We saw in one person's care plan that they wished to have a shower three times a week and to have their hair styled daily. This was not provided to them according to daily records, and their relative confirmed this.

In the daily records of care provided for the ground floor, we saw that there were only three people who had been recorded as having received a bath or shower within the last two weeks. We asked a member of staff about this and they told us that many people refused to have a shower. This member of staff also showed us a table which guided staff as to who had showers on which days; the staff member said, "[Person's name] is down for Wednesday and Saturday so will be offered a shower on those days." However, there were no records or systems in place for people to be offered a shower at any other time, should they initially refuse their allocated time-slot. Our observations of people, together with the records we saw and some relatives' comments told us that people were not encouraged or supported to bathe or shower regularly.

Whilst most people's relatives told us that staff were caring, not all of the staff demonstrated a compassionate or caring approach to people. One relative explained that one member of staff was particularly caring saying, "[Person] really likes [staff member], she goes to him freely about everything and anything." However, two relatives told us that some staff were short with people. Another said, "Most of the staff speak nicely. Some [people] will ask for a cup of tea, and one member of staff says abruptly 'you will just have to wait'". A further relative said, "No, [relative] always looks dirty, her clothes are not clean and she is always in her room. Her clothes get lost; her sons have bought her four really good blankets and they are all lost."

Some staff also showed a lack of respect for people by speaking to other members of staff across the dining room, about the needs of people using the service. For example, we heard one member of staff calling across to other staff in the serving area of the dining room, "I need someone to take [person] to his room; he's spilt drink all down his trousers." This request was not responded to straight away and was repeated by the staff member approximately 10 minutes later.

We were concerned about the confidentiality of some personal information for people living in the home.

We saw that there were named folders on the desks at the care stations, which were for staff to complete people's daily notes, such as personal care and fluid and food intake. Although there was a low gate to enter, the care stations were not secure areas and there were many occasions when there were no staff in the vicinity. This meant that anyone could enter the care station, or reach over the gate, and access the documents laying on the desk. This meant that confidentiality, and therefore people's privacy, was not fully respected.

We observed that independence was not consistently promoted for people living in the home. For example, we saw that for people who were able to mobilise independently, staff did not always prompt or encourage them to do so. One person's care records stated that they were able to mobilise with supervision and a frame. However, we observed an instance in the person's room, when this person was transferred straight into a wheelchair without staff offering encouragement or support to stand or walk for themselves. We observed another instance in the dining room during the church service when a person got up from their chair and started walking towards the minister. The person looked stable on their feet but a member of staff told them to stay where they were while they got the person's wheelchair, rather than supporting the person to walk or return to the chair they had been sitting in. This person's care records also stated that they could walk with supervision and a frame.

We saw there was a highly task-led approach within the home. For example, we observed a staff member supporting one person to eat their lunch but saw that they did not interact with the person or explain what was on their fork. We also observed very little to no staff interaction with the people in the dining room at breakfast time, other than asking what they wanted to eat or drink. Of the staff we observed during our inspection, we saw that most were very task led and very few engaged in meaningful conversation with people. Another example was when we heard a member of staff ask a person, in passing, if they were enjoying their breakfast. The person responded, "Oh yes, I always do; no really, I always do really enjoy this." However, we observed that the member of staff had not waited for the person's response and had already moved on to their next task, leaving the person talking to themselves. This did not demonstrate respect for the person's views and that staff took time to engage with them.

These concerns constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we received mixed feedback about whether the staff were caring, one relative said, "The staff are very caring, they are really friendly, they come in and put their arms around [person], you can tell from her face she is pleased to see them. The office staff are very approachable, I can visit whenever I like." Another reflected, "The staff are always lovely, they are always respectful, patient, kind to [relative]."

Staff contacted relatives when appropriate to update them on any incidents. One relative said, "They phoned and let me know what was happening." Another relative also confirmed this.

Inadequate

Is the service responsive?

Our findings

At our last inspection on 21 February 2017, the service was rated 'Good' in this key area. During this inspection, we identified serious shortfalls and found the service was not responsive.

For example, we heard one person's relative asking a member of staff for a duvet for the person's bed because they were cold. The relative said that they had asked for a duvet the previous week, but one had still not been provided. The relative also showed us how the bed had no bottom sheet and how the bed clothes were made up of fleece throws and knitted blankets, some of which the family had brought in. In our presence the member of staff said they would arrange for a duvet and bottom sheet to be provided immediately.

Staff did not always adapt care plans in line with people's changing needs in a timely manner. For example, two people were staying in the home on a temporary basis and had fluctuating needs with regard to their continence. However, the relevant healthcare professionals had not been consulted regarding this. We asked the deputy manager about one person and they told us they did not refer this person to the continence team because they were on respite. This did not demonstrate care that was delivered according to people's individual needs. The person's family had instead been asked to bring in some continence aids, which the person had not been assessed for. In both of these people's care plans, there was inadequate information and guidance about their continence needs and how staff should support them.

For another person, their family member told us they had discussed their relative's continence needs with staff, and it had been agreed that a continence assessment was needed. However, staff had not ensured the person also had a bladder scan, which they had discussed with the family as being needed. Because this had not been completed, we could not be sure that the person had the most appropriate continence products in place to suit their needs. This person's relative told us that they had purchased some continence aids for their family member to use but no assessment had been carried out to ensure they were suitable. This told us that the service was not consistently flexible and did not adapt to people's individual needs.

We found that care plans did not always contain accurate, up to date and relevant information about people's individual health conditions which was needed to enable staff to provide adequate care. For example, one person had a particular health condition which required attention on a daily basis but there was no mention of this condition or any guidance for staff on how to manage it within the person's care records.

We were present when this person's relative arrived for a visit and heard the relative say, "Haven't they done your [ailment] again?" This person's relative explained that the ailment really needed to be dealt with twice a day. They also told us that, although the person had this prior to moving into the home it had never been this bad. They said, "If it was seen to every day it wouldn't have got like it has…" They also added, "The staff say she won't let them but if two of them do it one can distract her whilst it is being done." This relative then proceeded to attend to the person's ailment, which they told us they had to do on every visit, or it wouldn't get done at all. This demonstrated that the service did not always respond appropriately to people's

individual needs which, in this instance, had a negative impact the person's health and wellbeing, as their ailment remained untreated by staff.

We identified other instances where staff did not respond to people's needs in a timely manner. One relative said, and we saw, that there were long waits at times for call bells to be answered and people's needs to be responded to. A member of staff said, "We don't really get much time to talk to people or do things with them because as soon as one job is done, it's time to do the next one." Throughout our inspection visit, inspectors supported people to attract staff's attention. People's rights were not always upheld as a result.

There was a risk that people living in the home could experience social isolation and exclusion. During our inspection visit we saw that many people were in their bedrooms with the doors closed. We observed that one person was distressed and crying out but did not receive appropriate attention from staff when they needed it. This person's relative told us that whenever they visited the home their family member was always alone in their room. They felt this was because they often became distressed and cried out. They said they did not feel that staff managed this well.

Another person was crying out throughout the day of our inspection. This person told us, "I just want somebody to come and talk to me." A relative said, "I would like more stimulation for [relative]." We saw that there were some people who remained in the dining room in the same place between breakfast and lunch, with no stimulation. For one person, they were sitting in a wheelchair at a table from breakfast through to lunch, and dozed off a few times. The person's care plan said, 'None' for interests and hobbies. We looked at people's preferred hobbies and interests in their care plans, and found that these were not always recorded, so staff did not always have guidance on how to support people with their individual interests.

A visiting healthcare professional told us they felt the main area which required improvement in the home was occupation for people. They felt that people did not have enough stimulation and were bored. They felt that for some people living with dementia, this had a negative impact on their levels of distress, which could subsequently trigger behaviours which some people could find challenging.

We found that staff did not always respond appropriately to behaviours that people displayed which others living in the home could have found unpleasant. For example, during our observation of breakfast on the first floor, we saw one person shout at another person who was sitting at their table, who then began to get distressed. Staff did not acknowledge this, make comment or intervene in any way.

Although there were activities on offer at times within the home, some of these were not carried out with appropriate and flexible support from staff. This meant that some activities were not meaningful for people because staff did not adequately support them to engage with it. For example, during the day of our inspection visit, there was a pottery activity. Each person at the table had a lump of clay and a rolling pin on a board, with which they were making pots or similar. However, we saw that the mid-morning drinks round took place part way through this activity. During this time staff became disengaged from doing the activity with people and their focus was redirected to ensuring everyone in the room had their drinks and biscuits.

We observed a period of 20 minutes where there was no interaction between staff and people at the table relating to the activity, only to give people their drinks. During this time we saw that some of the people seated at the table became withdrawn. Others seemed confused about what to do with the clay. We saw one person pushing their board away from them and another person prodding at the clay saying, "What is it? What's that for?" It is particularly important for people living with dementia to be able and supported to focus on one thing at a time to help avoid confusion and information overload.

These concerns constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that where family members had made a complaint, it had been responded to by the registered manager. However, there was insufficient oversight to ensure remedial action was consistent and ongoing. For example, with regard to some people's personal care, we saw that this was still inconsistent or lacking, even after people's families had complained. This demonstrated that the complaints system was not fully effective because the staff did not always take the action required to ensure the complaint remained resolved.

There were occasions when people living in the home needed to be supported as they approached the end of their lives. However, we were concerned that there was no specific training provided to staff on end of life care. For one person living in the home at the time of this inspection, we were also concerned that staff did not consistently have sufficient time to spend with the person in their room. This could have a negative impact on the quality of the end of life care the person received, as there may be occasions when the person's physical or emotional wellbeing needs were unattended.

Inadequate

Is the service well-led?

Our findings

Following our last inspection on 21 February 2017 the service was rated 'Good' in 'Well-led'. During this inspection, we identified widespread and significant shortfalls in the way the service was led.

We looked at a range of management audits and found that the auditing process in the service was ineffective. We paid particular attention to the most recent audits which had been completed between October 2017 and November 2017. This was in order to establish whether any of our concerns had already been identified and determine what plan for remedial action was in place.

However, a detailed audit of infection control across the home carried out in October 2017 did not identify any concerns or remedial action. However, during our inspection visit, we identified poor practice in terms of hygiene and infection control, which were widespread across the home. The failings we identified highlighted serious risks that any outbreak of infection may not be contained because appropriate standards of cleanliness were not consistently maintained.

The registered manager had carried out a home management audit in October 2017, which had checked areas such as the dining experience, activities, privacy and dignity and care plans. This audit also concluded that no further action was needed. However during our inspection we found there were shortfalls in all of these areas.

We saw that the registered manager had recorded their observations of individual staff, which included mealtime observations, continence care, communication and moving and handling. Again, we had serious and widespread concerns relating to all these areas which the registered manager had not identified. There was no system in place which checked that people were receiving personal care as they required either in line with their care plan or their preferences.

We saw that the registered manager had also observed staff and recorded details of staff competencies, covering all aspects of care delivery. However, we saw widespread poor practice during our inspection visit, which the registered manager's audit records had not identified.

Paper files with details of people's care were often left unattended on the desks at the care stations and could be easily accessed by unauthorised people. This meant the management system in place for ensuring these files were kept secure and confidential was not fully effective.

There was poor leadership and poor organisation of shifts in the home, as staff were not always sure of their own responsibilities. The senior care staff member who was leading the shift during our inspection visit also had poor oversight. For example they were not able to explain how they ensured people were offered baths and showers on a regular basis or, if initially refused, at times other than their allocated time-slots. The registered manager had not ensured that the senior care staff had good leadership of the shift and that care was delivered to a high standard. This meant that seniors were not always properly supported and supervised in their roles. There was a task-led culture of the staff working within the home and they did not

always have good knowledge of people's needs. This meant they did not consistently provide individualised care. Therefore, care and support provided to people was not guided by good practice such as person-centred care.

Feedback regarding the quality of care was not consistently sought from people living in the home or their relatives. For example, one relative told us, "No I haven't been asked for any feedback." This person also added, "I haven't been told of any changes although I feel there has been a gradual change over the last couple of months my [relative] never looked dirty before."

A second relative said, "I haven't been asked for any feedback as yet although [relative] hasn't been here very long." A third relative also confirmed, "I haven't been asked for any feedback, although [relative] is not permanent here it was only meant to be for [time period] and then reviewed."

We noted that when people had given feedback via the formal complaints process, this had not always been used as learning opportunities. For example, we noted that several complaints we received prior to our inspection visit, had also been sent to the provider and the registered manager via the formal complaints route, for them to resolve appropriately.

We looked at several of the complaints raised prior to our inspection visit on 13 November 2017. However, whilst we saw that the service had provided responses to the complainants, many of the issues raised related largely to the same as those that we identified, observed and were told about, during this inspection. Such as, poor standards of personal care and people's clothing and personal items going missing. This demonstrated that ongoing monitoring and auditing of complaints was ineffective, as improvements were not consistently sustained. It also meant that people's views and experiences were not always taken into account, in order to help improve the quality of the service provided.

The provider submitted a factual accuracy response following receipt of our draft inspection report. This response confirmed that the provider's representative (one of the directors) was based at the home and had regular meetings with the manager, staff and relatives and had continual oversight and input with regard to the running of the service.

We were also told that the registered manager's audits were checked and counter signed after being reviewed by the provider's representative. In addition, we were told that the provider's representative had a robust quality assurance and auditing process in place to monitor and ensure that all the required standards were met.

However, we concluded that the systems and processes used by the provider's representative for monitoring the quality and safety of the service, and supporting the registered manager, were ineffective. This was because the numerous shortfalls and concerns we found during this inspection had either not been identified or not appropriately acted upon and improvements were not consistently sustained.

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

One visiting relative told us they had attended a meeting to discuss the running of the home. They told us, "I attended a meeting not too long ago to bring up anything you wanted and I brought up the doors needed to be kept locked and from then on they were."

All the staff we spoke with said they understood how to raise concerns would report any concerns to the

registered manager straight away. They said the registered manager was available whenever they needed them. The staff team also had meetings regularly, and staff told us they worked well as a team.

The registered manager was aware of their responsibilities to contact other authorities; they had notified CQC of incidents when required, for example deaths, injuries and authorised DoLS applications.

The service registered with CQC, as a new company but with the same directors, on 18 July 2016. However, the service has not demonstrated their ability to sustain improvements and consistently deliver a good service. This is evidenced from our inspections carried out in January 2015, February and July 2016 and November 2017. We therefore do not have confidence that the directors can ensure a high standard of care is consistently provided to people.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care How the regulation was not being met: There was not adequate provision for people to engage in activities and person centred care was not provided in line with preferences and choices. 9 (1) (a) (b) (c) (2) (3) (a) (b) and (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect How the regulation was not being met: People's continence needs were not met leading to a lack of respect for people's dignity. Confidentiality was not upheld. Staff did not listen to people. 10 (1) (2) (a) and (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Risks to people were not always adequately assessed and mitigated. Infection control practices were poor. There was unsafe manual handling. 12(1) (2) (a) (b) (f) (g) (h)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met: Staff had poor understanding of people's dietary needs and records were inaccurate. People did not always the appropriate support to eat and drink enough. 14 (1) (4) (a) (c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: The provider had failed to implement systems and processes that effectively assess, monitor and determine risks to people or maintain accurate, complete up to date records. The provider had not always sought and acted on feedback. 17(1) (2) (a) (b) (c) (e) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: Staff were not effectively deployed and available to support people. 18 (1) (2) (a)