Shivshakti Nivas Ltd

Park House Rest Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection of Park House Rest Home took place on 2 and 6 July 2018 and was unannounced.

This service was last inspected in October 2017. This was a focussed inspection and was carried out as a result of concerns raised about poor and unsafe care and treatment regarding poor hygiene practices and general lack of cleanliness of the home. The focussed inspection found that risks associated with the environment were not being effectively managed. At this inspection we found that risks associated with the environment had been assessed and were managed effectively.

There had been a history of non–compliance with the regulations at this service since February 2016. Following the inspection in February 2016 we started our enforcement action. The subsequent four inspections and this inspection have helped to inform what action we should take regarding our enforcement pathway. At the previous full comprehensive inspection in March 2017, we found the provider had made some progress with compliance against the regulations. However, at this inspection, we found five new breaches of regulations. These had all been previously
breached in the history of non-compliance for this service.

Park House Rest Home is a 'care home'. People in care homes receive accommodation and nursing or 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.

Park House Rest Home is registered to provide accommodation for up to 18 older people. There were 16 people, some living with dementia, at the home at the time of the inspection. It is situated in a residential area of Hayling Island. The home has bedrooms provided over two floors in single and shared double occupancy rooms. Stair lifts provide access between the floors. There is one communal lounge joined with a dining area and appropriate toilet, bathing and shower facilities. Externally there is an enclosed garden with gravel pathways and an area of lawn.

A registered manager was in place. 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.

A quality assurance process was in place. However, this had not identified the areas of concern we found during this inspection and ensured that improvements were sustained over time.

Audits to monitor the environmental risks had been carried out and were managed safely. Risks to fire were managed well and each person living at the home had an emergency evacuation plan. Most areas of the home were clean and there were systems in place to protect people from the risk of infection. Staff had access to personal protective equipment to reduce the risks.

Risks to people's safety had been assessed but a lack of detailed guidance for staff about how people should be supported to keep safe, meant that people were placed at risk of unsafe care and treatment.

There were not enough staff to provide person centred care at key times of the day. Staff did not always engage with people respectfully and support them to be involved in meaningful activities.

Recruitment processes were not safe and checks to assess the suitability of staff to work with vulnerable people, had not been completed.

Medicines had not always been managed safely. Temperatures of the room where medicines were stored had not been effectively monitored and medicines that required additional security measures, had not been booked into the medicines record book.

Staff were not always sufficiently trained to safely meet the needs of people living in the home.

We observed some staff support people in a caring manner, but we found this was not always the case. Staff did not always consider people's communication needs and how living with dementia could affect the support they needed to be engaged in their surroundings and with other people.

Activities were not consistently provided, and staff had not always considered the communication and sensory needs of people.
People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.'

People had access to a range of health professionals, such as GPs, chiropodists and community nurses. Where people and their families needed to consider end of life care, care plans contained individualised information about people's current end of life wishes and preferences.

Care plans and confidential documents were kept securely in a lockable cabinet which staff could access. Care plans contained background information about each person including details of their care preferences. Care plans were reviewed monthly to keep them up to date. However, descriptions of how staff needed to support people's specific needs, were not clear and we observed poor and unsafe practice as a result.

Staff received supervisions and appraisals to support them in their roles.

People's nutrition and hydration needs were met. Meals were provided by an external company and people told us that they thought the food was good.

Staff told us they were happy working at the home and felt supported in their roles by the registered manager.

We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Full information about the commission's regulatory response to the breaches will be added to the report 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?

Requires Improvement

The service was not always safe.

Recruitment practices did not ensure that staff were assessed as suitable to work with vulnerable people before commencing direct work.

Medicines, including those that required additional safety measures were not always managed safely. At night there was not always a staff member on duty who was trained in medicines administration.

There were systems in place to monitor environmental risks. However, risks to individuals had not been clearly identified so that staff could support people safely.

Staff understood their responsibility to safeguard people and the action to take if they were concerned about a person's safety.

Staff knew what action to take in an emergency.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not receive adequate training to carry out their role. This meant that some practices were poor and placed people at risk.

There was not always enough staff to meet people's person-centred needs at key times of the day.

Staff had regular supervisions and appraisals to support them in their role.

The principles of the Mental Capacity Act 2005 were followed which meant staff promoted people's rights and followed least restrictive practice.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed that some staff did not always communicate with people in a way that was dignified and respectful. However, other staff interacted positively with people, considering their communication needs.

Staff knew how to protect people's privacy. Care plans and confidential documents were kept securely.

People's ethnic diversity and human rights were considered and met by staff. Individual needs were clearly identified in care plans.

Is the service responsive?

Requires Improvement

The service was not always responsive.

At key times of the day there were not enough staff to provide person-centred care.

Care plans had been developed, but these had not been reviewed regularly with the involvement from people and their families.

People's care needs at the end of their lives had been considered and care plans contained information about their end of life wishes.

There was a complaints policy in place. People and relatives knew how to raise concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Governance arrangements were not effective in meeting fundamental standards of quality and had not identified concerns we found during the inspection, to ensure compliance with the regulations.

Staff were happy working at the home, but there was a lack of monitoring, which led to poor practice.

People said they were happy living at the home and had confidence in the management. They were consulted about the way the home was run.

Park House Rest Home

Detailed findings

Background to this inspection

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

This inspection took place on 2 and 6 July 2018 and was unannounced. On the first day of the inspection there was two inspectors and an expert by experience in the care of older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day there was one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

During our visit we spoke with the registered manager and four staff members. We spoke with six people who were living at the home and two relatives or friends of people. We tried to contact external professionals for feedback but did not receive any.

We looked at care plans and associated records for six people and pathway tracked three people using the service. This is when we follow a person's experience through the service and allows us to capture information about a sample of people receiving care or treatment. We looked at staff duty rosters, feedback questionnaires from relatives, quality assurance records, records of compliments and complaints, accidents and incidents, four staff recruitment files and the providers policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People and their families told us they felt the home was safe. One person said, "I feel very safe, I am well looked after." A relative told us, "I know that my loved one is well looked after, I am confident that the home keep them safe." Staff told us they felt able to raise any concerns with the registered manager and that these would be acted upon. One staff member said, "The manager is always available to help and will sort out any issues quickly." However, we found some concerns that impacted on people's safety.

Three of the four staff records reviewed did not demonstrate staff recruitment processes were robust and we could not be assured that the staff employed were suitable to provide safe care. The most recently employed staff member's recruitment file did not have a Disclosure and Barring Service check (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people being employed. On the first day of the inspection we were told that this member of staff was working their first day in the home. We saw that at times the member of staff was not working alongside more experienced staff and we observed them going into people's bedrooms and serving food in the kitchen unaccompanied. We discussed this with the registered manager who told us that they were unaware of this and told us that new staff should shadow the senior staff member on duty throughout the day. This meant that people could have been placed at risk as the registered manager could not be assured that the staff member was suitable to work with vulnerable people. In a second staff member's recruitment file, we saw that they had worked in the home for two months before their DBS check was received. We discussed this with the registered manager who confirmed that the person had worked alone with people during this time. A third staff member's recruitment file, contained references from people that they were having a personal relationship with, as they lived at the same address. We asked the registered manager about this and they were unable to demonstrate an understanding of the risks caused by references being sought from people, with whom the staff member had a personal relationship with. In addition, we also saw that application forms for two staff members did not have detailed records of previous employment history. There were no dates showing when staff had worked at previous jobs and no explanations for any gaps in employment. This meant that the registered manager could not be assured that all staff employed were suitable to work with vulnerable people.

The failure to follow safe recruitment procedures was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Individual risks to people were not always managed effectively. Risk assessments had been completed for people, such as falls risk assessments; nutritional risk assessments and pressure area risk assessments. However, these did not always have clear guidance for staff to follow. For example, on the first day of the inspection we saw one care staff supporting a person to walk across the dining room area by holding the person's hands out in front of them. The staff member was walking backwards whilst doing this. Supporting someone to walk in this way is recognised as poor practice, as the person was not being safely supported, was not walking at their own pace and could have been at risk of falling. The person's risk assessment and care plan identified that they may be unsteady on their feet but did not describe to staff how they should support them to walk. In addition, we saw another staff member pull a person out of their chair by their

wrists. At the same time a person who was visiting the home to provide a service for people, assisted the staff member by pulling the person's other wrist as they stood. The visitor then went on to support the person to walk down the corridor. The person's care plan and risk assessment identified that they needed support to walk and were at risk of falls but did not give clear descriptions of how staff should support the person to stand and then to walk safely.

On the second day of the inspection we saw staff again supporting the same person to stand up from a seated position. This time the person was pulling themselves up by holding onto the staff member's hands. This could place staff at risk of injury. We observed a third person being supported to stand by a staff member. The person had one hand on the arm of a chair and the other on their walking frame. The staff member did not give clear instructions or guidance to the person so that they could stand safely, by placing both hands on the arms of the chair before standing. This meant that we could not be assured that staff were following best practice when supporting people with their mobility. We spoke to the registered manager about our concerns, who told us that staff had received moving and handling training, which we confirmed by looking at training records. The registered manager responded promptly, speaking to staff and updating people's care plans and risk assessments with detailed guidance for staff on how to support each person. In addition, we raised these concerns with the local authority.

However, we did observe more positive support for people to move. We observed staff supporting a person using a hoist to move them from a wheelchair to an armchair in the lounge. The staff spoke to the person throughout the transfer and said, "Are you ready, we're going down now." This meant that the person was aware of what was happening and was reassured by staff. We spoke to the registered manager about our concerns and they recognised that the examples we discussed, were not safe practice and told us that they would speak to the staff and ensure that visitors did not assist with people's mobility needs. The registered manager told us that they would review the person's moving and handling assessment and would also request an assessment from an external professional, to decide if any moving equipment was required.

The registered manager was aware of the risks posed by a fluid thickening powder if ingested without it being mixed with fluids. However, there was no risk assessment to identify the risks or to consider where fluid thickener should be stored. We saw that some fluid thickener was stored in the dining area in a low cupboard with no lock. We discussed the potential risk of people or visitors being able to access this with the registered manager. They immediately wrote a risk assessment to ensure staff were aware of the risk and had the fluid thickener moved into a higher cupboard in the kitchen so that the risks were minimised.

Medicines were administered to people as prescribed and there were clear guidelines in place for the administration of medicines given to people as and when they required them (PRN). These were recorded with medicine administration records (MAR). The registered manager told us that competency assessments for staff who administered medicines were completed either by themselves or the deputy manager, once a year. However, only three staff out of ten employed had received medicines training at the time of the inspection. Therefore, we could not be assured that if people required medicines during the night, that the staff who would administer them had received training. We saw from the staffing roster for June 2018, that for only four nights out of thirty a member of staff was on duty that was trained in medicines administration. This meant that people were at risk of not receiving medicines when they required. Medicines were not always stored safely. Medicines that required extra control by law, required additional storage and administration measures, due to the high risks they pose, had not been logged into the appropriate records system in accordance with the legal requirements. This meant that there was a risk that staff would not be aware should these medicines go missing and they would not be able to account for them. We spoke to the registered manager about this, who ensured that all these medicines were immediately booked into the medicines record system. Stock checks of medicines were completed monthly to help ensure that they were

stored safely and were always available to people. We discussed the possibility of more frequent medicines checks with a senior staff member, who agreed that the medicines that had not been recorded within the home's records, would have been identified sooner.

The temperature that medicines were stored was not being effectively monitored. Some medicines should not be stored over 25 degrees Celsius to ensure their effectiveness. However, we found that where the temperature of the medicine cupboard had been recorded, temperatures had regularly reached over 28 degrees Celsius in the preceding month. The home did not have a policy or procedure for staff to follow when the temperatures exceeded the recommended levels, which meant that some medicines may not have been as effective. This was discussed with the registered manager who reviewed the current practices around temperature records and wrote a new procedure with actions the staff should take if the temperature exceeded the recommended level. This included actions such as using a fan to cool the area where medicines are stored and monitoring the temperatures more frequently.

The failure to ensure risks relating to the safety and welfare of people using the service were assessed and managed was a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last comprehensive inspection in March 2017 we found that infection control risks had not been effectively managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the environment was clean and environmental risks had been assessed and were monitored effectively. We looked at records which showed that essential checks had been completed on the building and equipment around the home which was in use, such as a hoist and electronic call bells. This meant that people could be assured the equipment in use was safe and that call bells would alert staff when needed. The provider had a duty to maintain the health and safety of the building and we saw records that showed that gas and electrical appliances were serviced routinely. Temperature checks of all hot water outlets were also completed, and an external organisation carried out necessary checks each month, to prevent the outbreak of legionella.

The provider had a policy in place to prevent and control the spread of infection which included the reporting of infectious diseases. Staff used protective equipment such as disposable gloves and aprons when delivering personal care and we saw that these were readily available throughout the home. Cleanliness was maintained in communal bathrooms and people's bedrooms although, not all areas of the home were clean. For example, the stairs leading to the first floor were not clean. One person told us "My room is usually kept clean, I know that the floor needs cleaning, but the cleaner is on holiday." We discussed this with the registered manager who confirmed that the cleaner was on leave and the care staff were trying to fill in with the cleaning tasks as additional hours work. On the second day of the inspection the rooms and stairs were cleaner but still required further cleaning to remove all the dust and dirt. The registered manager was aware of their responsibilities in the event of an infection outbreak such as informing all visitors and being extra cautious wearing protective equipment. Staff were encouraged to have an annual flu jab and the service submitted an annual infection control statement.

The registered manager told us that there was a plan to address maintenance issues in the home. For example, we saw that an upstairs shower room had limescale on the floor and could not be cleaned effectively. The registered manager told us that this is because there was a slight leak on the shower, so water pooled on the floor. We were told that the home had a vacancy for a maintenance person to support with repairs, general maintenance and to complete audits of the home. The registered manager told us that they were in the process of recruiting to this role and hoped that this would support them to promptly address any areas that required maintenance in the home.

There were policies and procedures for staff to follow in the event of a fire and each person had a personal emergency evacuation plan (PEEP). This was to ensure that staff knew each person's needs in the event of a fire or an emergency. The PEEP's detailed the support people would need if the building needed to be evacuated. The home had a fire risk assessment and fire drills had taken place, which enabled staff to be clear about what to do in the event of a fire. Fire detection and management equipment was tested weekly and records maintained. However, we saw on the first day of the inspection that one person had a fire door to their bedroom, propped open by a suitcase. We discussed this with the registered manager who told us that they had requested someone to fit a door closer, so the door could be kept open and would automatically close in the event of a fire. It was particularly hot weather on the first day of the inspection and the registered manager told us that the person felt the room was too hot with the door closed. They had no risk assessment to consider the potential risks of this. On the second day of the inspection we saw that the door was closed but they were still waiting for an automatic door closer to be fitted.

The home had policies relating to safeguarding and whistleblowing. Safeguarding concerns were reported to the local authority and to CQC and records showed the registered manager, had worked with the local safeguarding team to undertake investigations and had taken appropriate action when needed. We spoke to three staff, who demonstrated an understanding of safeguarding procedures and what they would do to keep people safe. However, not all staff had received training in safeguarding which would help them to identify, report and prevent abuse. Out of ten staff employed at the home, only three staff had received training in safeguarding. Although the staff we spoke to told us how they would safeguard people and what actions they would take if they thought someone was experiencing abuse, we could not be assured that all staff employed had this knowledge and understanding.

The registered manager told us that they used a dependency assessment tool for each person living at the home to help them to decide how many staff were needed to support people. Staff worked twelve-hour shifts in the home and told us that they felt this worked well. Although staff did not appear to be rushed, at key times of the day there was not enough staff to meet people's needs in a dignified and respectful way. For example, at lunch time we saw that several people needed some support to eat their meal. Staff were unable to support all the people who required assistance to eat in a dignified way. We observed one person stand and walk out of the lounge, they appeared very unsteady on their feet. No member of staff was available to support them, and we had to monitor the person to make sure that they did not fall. We discussed staffing levels at key times with the registered manager, who recognised that an additional staff member during the morning and throughout lunch would enable more person-centred care to be provided. The registered manager told us that they would be seeking to recruit a new staff member to enable this to happen in the future.

The provider had an accident and incident reporting system. We the reviewed the accident and incident records made over the last year. The records showed that themes and patterns were analysed, and action taken when required. For example, one person had recently had a fall. As a result, the registered manager had requested an Occupational Therapy assessment as they had identified a pattern and felt it needed further assessment.

Requires Improvement

Is the service effective?

Our findings

People felt that the staff knew them well. One person said, "The staff know what they are doing and the way I like things done." However, new staff did not receive appropriate training to enable them to effectively support people with their needs. Providers are required to follow the standards of the Care Certificate or equivalent standards, to make sure new staff are supported, skilled and assessed as competent to carry out their roles. The Care Certificate is an identified set of standards that identifies the knowledge, skills and behaviours expected of staff working in health and social care.

Training for staff was delivered via an online platform and through classroom-based sessions. The registered manager told us that staff are required to complete all mandatory training within the first week of their employment. We saw from records that one staff member, who had been employed by the service since August 2017, had only completed one session of training and had continued to work at the home, supporting people with needs that required training to be safe and effective. The registered manager said that they were aware of the training record for this staff member and planned to take disciplinary action, however they were not able to explain why they had not acted sooner, which put people at risk of being supported by untrained staff.

The registered manager told us that staff receive an induction into their role which should include shadowing more experienced staff and undertaking mandatory training. The home had a training matrix in place to identify where staff required training. We looked at this during our inspection and the registered manager told us that they needed to update some of the training records for staff. Following the inspection, the registered manager sent us the updated training matrix. We identified gaps in training that staff would require to safely support the people living at the home. For example, out of the ten staff employed only two staff had received infection control training, three had received safeguarding training, two had received end of life care training and two had received food hygiene training. The home's training policy did not identify how frequently mandatory training should be provided and stated that they would take into account previous training that staff had undertaken in other employment. Providers are required to ensure that all staff have received adequate and up to date training to enable them to carry out their role and to keep people safe. We discussed these concerns with the registered manager who told us that staff did not always attend training when it was provided and that they would take action to address this with the staff in question.

The failure to ensure staff were supported, skilled and assessed as competent to carry out their roles was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff supervision and appraisal records reviewed were completed regularly by the registered manager or by the deputy manager and we saw records to demonstrate issues that had been discussed and documented. Supervisions and appraisals provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and consider learning opportunities to help them develop. We were told that potential new staff were shown around the home and introduced to some of the people using the service as part of the interview process. The registered

manager told us that this allowed them to observe the potential staff member's ability to engage well with people before offering them a job.

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. Decision specific mental capacity assessments had been completed and documented within people's care plans. During the care planning process, we saw that decisions had been made on their behalf. Records had been made to show how these decisions had been made and who had been consulted, as required by the MCA Code of Practice. Staff described how they sought verbal consent from people before providing care and support and care plans contained 'consent to care treatment and support' forms, which documented when people were able to give consent for decisions such as the influenza vaccine each year, and consent to discuss and share their care records.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (2005). The procedures for this in care homes are called the Deprivation of Liberty Safeguards. The registered manager had applied for authorisations under the safeguards for people where necessary and these were reviewed when required.

People told us that they felt supported by the staff. We observed staff offering people choice and supporting them to do things they wanted to. For example, one person liked to sit outside and smoke when they chose to. Staff supported the person to go into the garden and checked on them regularly to see if they required anything. We also heard staff asking people if they were ready to sit at the dining room table for their lunch and discreetly asking if people wished to be supported to go to the toilet. One person said, "The staff always ask me before they help me."

Meals were provided by an external company, who delivered people's chosen food choices daily. Staff stated that people chose what they wanted to eat the day before and had a choice of two options for their lunchtime meal. The registered manager told us that people had previously been unhappy with the food provided at the home, so they had changed to an external company to provide the food and since then, they had received no further complaints. The home provided their own choice of breakfast and tea time options. People had a varied choice and one person liked to have a cooked breakfast each day, which they provided. Everyone we spoke to said that they thought the food was good. One person said, "The food is very good, the choices are the things I like." Another person said, "There is a good variety." A family member said, "The food is very good, [person's name] enjoys their food and they always eat well." The company provided a four-week menu and if people decided on the day that they do not like something, they were offered an alternative as they ordered some extra meals or provided an option from their own food stocks.

People who had specific dietary requirements such as a low sugar diet or a soft diet, were catered for. Information about each person's specific needs were detailed in their care plan but these were not readily available to staff when they were preparing food and drinks. This meant that staff could provide the wrong diet or drink consistency to people, which could place their health at risk. We discussed this with the registered manager who acted immediately to provide a list of people's nutrition and drinking needs in the kitchen.

Some people required support from staff to eat their food with dignity and respect. We saw one staff member sat next to a person and supported them to eat. The member of staff engaged with the person,

making it a pleasant experience. However, there were not always enough staff to support all the people who required help. We observed one person with their meal in front of them, but they did not start eating it. It took some minutes for the member of staff to provide the support they required by placing a spoon in their hand and verbally telling them the food was there. The person required on-going support and after a few mouthfuls stopped eating as the staff member had walked away to support another person. After twenty minutes the staff member went back to the person and crouched down next to them. They spoke to the person but did not try to help them to eat more of their lunch before walking away again. After another fifteen minutes the member of staff returned, spoke to the person and removed the person's plate, then returned with a pudding. The person was then encouraged to eat the pudding but had not eaten their meal. We discussed our concerns about staffing levels during key times such as meals, with the registered manager. More information can be found about this in the safe section of this report.

Throughout the inspection we saw people were offered drinks and there were cold drink cannisters available for people in the communal area. People were also provided with hot drinks at regular intervals in addition to when they requested these. When needed staff made records of the drinks some people received. These records showed people were receiving drinks and their hydration needs were being met. We observed people being supported to drink by staff when they were unable to do so independently.

People's needs were not always met by the adaptation, design and decoration of premises. Some people were living with dementia and therefore, had difficulties with visual perception. People living with dementia can struggle to tell the difference between different parts of flooring, doors or walls. For example, we saw one person try to step over a dark carpet that was surrounded by lighter coloured flooring. Best practice research identifies that people living with dementia can sometimes think that dark flooring is a hole in the floor. In trying to step over 'the hole,' the person became unsteady on their feet and was at risk of falling. We discussed this with the registered manager who told us that they were aware of the challenges and that the home had refurbishment plans to improve certain areas and to consider how the environment could be adapted to improve the experiences of people living there. One of the plans was to remove the pebbles from the garden area and replace them with a product that was better suited to wheelchairs and another was to paint people's bedroom doors and toilet doors different bright colours so that people could clearly tell when they were looking for a toilet. We discussed the flooring in the communal area and the registered manager agreed to consider this as an additional part of the refurbishment.

People had call bells in their bedroom so that they could alert staff if they required assistance and pressure mats were also used where appropriate. Pressure mats are used when people have been assessed as being at risk of falling without staff support to move. They were placed in front of a chair or bed and would alert staff should the person try to stand. The home had two narrow staircases with stair lifts on them. These were seats that mechanically took people up and down the stair case when they were unable to walk. The staircases were narrowed by the use of stair lifts, which were fitted permanently to the stairways.

Prior to people moving into the home, the registered manager undertook an assessment of people's individual needs. This was to ensure the home could meet the person's needs and to assess if any equipment was required. Care files had copies of assessments in them and these showed that there had been consultation with family members and others such as health or social care staff as part of the pre-admission assessments.

People were supported to maintain good health and had access to appropriate healthcare services. Care plans contained records of visits and correspondence from health and social care professionals such as social workers, nurses, mental health teams and doctors. People's weight was monitored when needed for health reasons and care plans contained health monitoring records for specific needs, so that staff would be

able to seek medical support promptly when needed. If people needed to go to hospital, the home used a system which ensured that relevant records such as information about their care needs, communication needs and details of any medicines they were prescribed, were transferred with them. This ensured a continuity of care and the registered manager told us that she would also liaise with the hospital and provide any further information they requested.

Staff were kept up to date about people's needs through handover meetings, which were held at the start of every shift. Information provided to staff included details about people's emotional and physical health needs and meant that staff worked together to ensure that people's on-going needs were met.

Requires Improvement

Is the service caring?

Our findings

People told us that they thought the staff were caring. One person said, "I am never rushed, the staff always support me with a smile, the staff cannot do enough for me, always willing to help me when I need it." Another said, "I love it here, coming here was the best decision I made." A third person said, "The staff are great, they always go the extra mile."

We observed some staff support people in a caring manner. Family members also told us that they thought the staff were caring. One said, "I cannot fault the staff, they are very caring. I could not ask for more." Another said, "The staff are amazing. They are so good with my loved one." A staff member told us, "It feels like a family here."

However, we did not always see staff supporting people in a patient and respectful way. For example, on the first day of the inspection we saw three staff engaging in an activity with people in the communal lounge/dining room. The staff had a small blow up ball which was being thrown to people. The staff did not explain clearly to people what they were doing or when the ball was going to be thrown to them. Some of the people were living with dementia or were asleep and withdrawn from the activity and appeared distressed and confused when the ball was thrown at them. One person was heard saying, "No, I don't want the ball, go away." Nonetheless, the staff continued to throw the ball at them and were laughing and talking amongst themselves throughout the activity. The staff did not appear to recognise that people were confused and showing signs of distress by putting their hands up and saying "No." Effective communication was not used to support people to be involved in the activity and to choose if they wished to participate or not. We spoke to the registered manager about these concerns and they agreed to investigate how staff were engaging people in activities. Conversely, later the same day we saw a member of staff start the ball game again with two people. We heard them spend time explaining what the activity was and saw that people consented to join in. For example, the staff member said, "Here we are I are you ready, yes, well done." This was a much more positive experience and we saw the two people actively looking up to catch the ball and smiling throughout.

We saw varied examples of staff communicating with people. On the first day of the inspection we saw staff putting music on in the lounge area without speaking to the people who were sat there, or asking them if they wanted the music on, which music they would like or if they would prefer to watch the television. We observed a member of staff assisting a person to eat a yoghurt. The staff member did not talk to the person before giving them the yoghurt and when they had finished, walked away without saying anything to the person. In addition, we saw a person being supported to stand up. The person had a diagnosis of dementia and significant communication difficulties. The person appeared to be confused by what the staff member was doing, and the staff member did not explain to the person what they needed them to do, which caused the person to be distressed.

Care plans did not always contain the detail required to assist staff to safely meet people's needs and to follow best practice guidance. For example, we saw staff supporting someone to drink by standing over them and tipping the drink into the person's mouth. This was not a dignified way to support the person and

could have increased the likelihood of them choking on the drink. We discussed, with the registered manager who acted immediately to update people's care plans with more detailed guidance about how staff should support them.

We spoke to the registered manager about our concerns from the lack of detail for specific care and support needs and staff not always engaging positively with people and treating them with dignity and respect. The registered manager acknowledged that some staff were new and had not yet completed all the training required. However, we saw from records that the registered manager had addressed the concerns about person centred care and had written a letter all staff in January 2018 that told them that they needed to, 'take time to listen to people and give them plenty of choice with regards to their daily care or activities and make sure you respect them.' They told us that they were continuing to monitor this and to seek the views of people using the service and their relatives, to improve the care provided.

The failure to treat people with dignity and respect is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, on the second day of the inspection we observed a calm and relaxing atmosphere in the communal lounge area and saw staff speaking to people respectfully, ensuring the person knew they were talking to them by getting down to their eye level. We observed some positive interaction when staff were supporting people to look at photograph albums or giving them some hand and nail care. One staff said, "There we go is that alright, does it feel comfortable for you?" Another staff member was heard saying, "Hi [person's name] I've brought you a cup of tea, are you ok if I put it here for you?"

Care plans and confidential documents were kept securely in a lockable cabinet which staff could access. Care files contained information about people's lives and preferences. For example, people's care plans had information about their family, their past interests and who was important to them. People's care plans stated, 'staff to maintain [person's name] privacy and dignity at all times. We saw staff respecting people's privacy and dignity by knocking on doors before entering rooms and closing doors when personal care was being delivered.

People's family and friends could visit whenever they wanted to, and we saw regular visitors to the home during our inspection, sitting with their relatives and chatting comfortably with staff. Visitors were offered food and drinks if they wished and told us they felt welcomed by the staff and were able to ask questions if they needed to.

Although we were told that no one had any specific cultural, religious or personal beliefs, public holidays and birthdays were celebrated with traditional foods and activities for people to participate in if they wished to. The home also had celebrations for Easter and Christmas where family and friends were invited in to celebrate together. Where people had spiritual or religious needs and preferences, these were detailed in their care plans and met. The registered manager told us that a group of volunteers supported people to go out to church services if they wished and visited people in the home to read and give communion when requested. One person told us, "I found it hard when l first came here, but I like being able to go into the garden. People from a local church visit me and take me out. I'm going to lunch this Friday."

We discussed people's specific needs with staff and they told us that they would meet each person's individual needs, recognise ethnic diversity and their human rights. The home had an equality policy and there was training in equality and diversity for staff to complete. People's sexual needs were recognised and identified within their care plans. One person's care plan stated, ''[person's name] tells me that she likes to wear makeup and a drop of perfume' and, '[person's name] choses her own clothing for the day and she can

apply her makeup.'

The registered manager was aware of how to request the services of independent advocates if needed. Advocates can be used when people have been assessed to lack capacity under The Mental Capacity Act 2005 for a specific decision and have no-one else to act on their behalf. People who needed it were supported to contact advocacy services and we saw that at the time of our inspection, one person was using an advocate to support them to make some decisions.

Requires Improvement

Is the service responsive?

Our findings

People told us that the staff cared for them responded to their needs. One person said, ""I just have to ask, and a member of staff helps me." Another said, "I am never rushed, the staff always support me with a smile."

Person centred care is considered best practice and is a requirement of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Providing support in this way meets each person's individual needs and enables them to maintain or develop new skills where possible. Although staff were observed spending some time talking to people, at key times of the day there were not enough staff to provide person-centred care. Staff told us that mornings could be particularly busy, and they tried to find time to meet people's individual needs, but this could be challenging at times. One staff member told us, "There are not enough staff and we have become task focussed." They went on to say, "People have adapted to the staff's routines, so they get ready for bed and get up when staff are available." We discussed staffing levels with the registered manager and more information can be found about this in the safe section of this report. The registered manager demonstrated a good understanding of person-centred care and told us that that they were supporting the staff team to develop and recognise how they could offer more individualised care and support. They recognised that having more staff to do this would improve the staff teams' ability to provide this type of care.

People had person-centred care plans, which were developed with involvement from the person and their relatives where appropriate. Care plans contained individual information about what was important to the person now and what was important in their past. For example, the person's religious beliefs, spiritual activities, which school they attended, their past occupations, where they lived and community involvement. One person's care plan told us that they were 'born and baptised catholic' and they liked to 'sing songs when the vicar comes in.' Information was also recorded regarding people's hobbies and interests, special lifetime events, happy memories, and information about their family. In addition, people's care plans detailed how they liked their daily routine. For example, when they liked to get up in the morning, if they liked to take an afternoon nap and their preferred place to eat a meal. These were regularly reviewed by senior staff or the registered manager and updated if people's needs changed.

Where people and their families needed to consider end of life care, care plans contained individualised information about people's current end of life wishes and preferences. However, where people did not feel ready to discuss end of life care arrangements, this was clearly documented. For example, 'end of life is not a pathway discussed at the moment. To be discussed with [person] and their family at a later date.'

Care staff had a handover between shifts. The handover was so that important information about people's needs could be passed to the staff coming on duty. Staff told us that they felt the information passed over was clear and they looked at individual daily care records for people to quickly update themselves if they needed more detail.

We received mixed views about the activities available for people living in the home. The home previously

employed an activities co-ordinator, but the registered manager told us that they had recently left, and they were trying to recruit a new staff member for this role. Staff told us that they did not follow a timetable of activities, but tried to offer different activities depending on what people would like. One staff member told us, "It doesn't matter how hard we work, there is a lack of resources to help us to do our jobs better and provide the activities that people need." However, some people told us that there were activities going on all the time. One person said, "There are always activities going on, but they don't force you to participate." Another person said, "The staff do their best, I could not fault them, but they don't have time to sit and chat." As detailed in the caring section of this report, activities were not always suited to people's individual needs. For example, where people were living with dementia, activities that may be calmer and suited to their specific need, considering any sensory impairment had not been planned.

The registered manager told us that the home has links with the local church community, with a vicar visiting once a month and volunteers who come in to read to people. At Christmas they had people come in to sing carols and they tried to have some musical entertainment from the community twice a month. We observed visitors and family members coming into the home and being welcomed by staff.

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way that they could understand. It is now the law for the NHS and adult social care services to comply with the AIS. We discussed the Accessible Information Standard (AIS) with the registered manager. The registered manager said they offered choice to people and used visual prompts where possible. For, example showing people different items of their clothing, so they could see and choose which they want to wear. The registered manager said they were looking to develop visual food choices by having picture and photographs that people could use to assist them to make a choice, but this has not happened yet.

The home had a complaints policy and a copy was given to people and their relatives when they moved to the home. We saw records of where complaints were made, and the registered manager had responded and taken action. For example, people had previously made complaints about the food and consequently the registered manager had changed the way in which food is provided. One family member confirmed that they knew how to complain if they needed to. They said, "The only issue I have is about some furniture in [relative's] room. I have asked if it can be replaced and have been told that the home plan to replace it. I will monitor it for a couple of weeks to give them chance to replace it." The registered manager told us that they regularly spoke with people and their families to check that they were happy with the service, meaning they could resolve any issues before the need for formal complaints were made.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had quality assurance processes in place, but these were not robust. Quality assurance processes should identify any environmental risks, risks to people and consider staff responsibilities and training. The provider had not carried out audits of the service to identify where the service required improvement and to implement and sustain improvement effectively. Since our last comprehensive inspection in March 2017 there had been no improvement in the level of service provided and some areas had deteriorated. Our findings from previous inspections have shown a history of non-compliance with the regulations. At this inspection we identified five breaches of the Health and Social Care Act 2008 regulations; one of these was a repeated breach from the last comprehensive inspection of the service. Breaches of regulations had been identified at every comprehensive inspection of the service since its first comprehensive inspection by the commission in 2016. This demonstrates the provider has failed to take sufficient action in response to shortfalls previously identified. As at other inspections, a number of the shortfalls relate to matters which have been brought to the provider's attention on previous occasions. These relate to key aspects of the service, such as staffing, training, safe care and treatment and good governance. At our last inspection, in March 2017, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had failed to ensure adequate systems and processes were in place to assess, monitor and mitigate the risks associated with infection control. During this inspection we found that the concerns previously identified at inspections since 2016 had not been sufficiently addressed and managed. The provider had failed to operate an effective quality assurance system. Although the registered manager conducted a range of audits of key aspects of the service these had not been effective in maintaining improvement where it was required.

The failure to operate effective systems to assess, monitor and improve the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager in place who was responsible for the day-to-day running of the service. They had previously been employed as an external consultant by the provider to support improvements of the home. People and their families told us they knew how to contact the registered manager and felt that they did a good job. One person said, "The 'boss' is very good, they keep things moving the way I like." A family member told us that the registered manager kept them informed of what was happening and said, "I always receive a phone call if there is an issue or something has happened." Staff told us that they enjoyed working at the home and felt supported by the registered manager. One staff member said, "The manager is always available to help and to talk to when needed." Another said, "I like working here, everyone is supportive."

Reviews of people's care plans when their families could be invited in if appropriate, were not being held regularly. The registered manager was aware that reviews of care plans should involve the person whose plan it is, and their families or friends, if they wish them to be invited. However, this had not yet been implemented and the registered manager said they discussed any important changes with people and contacted families if needed.

There was a clear management structure in place consisting of the provider, a registered manager and a deputy manager. The provider was not present in the home for the inspection. The registered manager told us that they felt supported by the provider and the provider's representative who are available at any time. The registered manager told us how they were able to identify where improvements were needed and had support from the provider to achieve this.

The registered manager told us that either themselves or the deputy manager were on call should staff need guidance or additional support in the evenings or at weekends. The registered manager also carried out spot checks. This is so that they could monitor how staff work when they were not around, and we were told that these spot checks could also happen at night time.

Staff meetings, which are an opportunity for management to inform staff of developments, praise positive work and discuss any concerns together, had not been held regularly. The registered manager told us that they had arranged staff meetings but had not done so lately as staff did not attend. We viewed records of previous staff meetings and saw that issues where improvements were needed had been addressed with staff. At the last staff meeting arranged in January 2018, only one staff member attended. As a result, the registered manager had written a detailed letter explaining all the things that they had planned to discuss with the staff, and each staff member had signed to say they had received the letter. For example, the letter identified that people did not always feel able to ask staff for support when they needed it. The registered manager explained to staff that, 'Our aim is to provide person-centred care and in order to do so, our residents must be at the centre of our care.' We discussed how information could be shared with staff and any concerns addressed and the registered manager said they were considering the best way to share information, which they felt could continue to be in a letter format. Staff told us that they could talk to the manager when they wanted to and we saw that they were provided with regular supervision, where information and ideas could be discussed.

The provider used surveys to identify areas where improvements could be made, which were sent out twice a year. The surveys had been given to people and their relatives. The results of these had been used to make changes and develop the home. For example, several concerns were raised about the food being provided, so the registered manager had arranged for an external company to provide the food to improve the quality. In addition, the results of the survey were used to evidence the need for areas of refurbishment and to replace furniture in some of the bedrooms.

The provider also held meetings for people who lived at the home and their families. However, the registered manager told us that these were not well attended so they also spoke to people and had regular phone conversations with their families. There was a 'visitor's questionnaire' in the main reception area of the home and a book for 'complaints, compliments and comments.' The registered manager told us that they looked at these and would contact people directly to speak to them about any issues that were raised. We spoke to family members who told us that they felt that they were kept fully informed about what was going on in the home and with their relative. One family said, "I always receive a phone call if there is an issue or something has happened."

The provider had statement of purpose that identified the home's vision and values. People were given a service user guide on moving into the home. This explained what the registered manager and staff would provide and the facilities available for people. The provider had detailed policies and procedures in place, which were produced by an external company and updated when required. Policies were kept in the registered manager's office but were accessible to staff.

Providers are required to act in an open and transparent way when people come to harm. This includes a

requirement to provide information, including an apology, in writing to the person or their representative. We saw that the provider had a duty of candour policy and the registered manager told us that letters would be sent out to people if this was needed following an incident or complaint.

The registered manager told us that they kept up to date with best practice guidance and safety alerts by receiving emails from organisations such as CQC, the Alzheimer's' Society, Care Management Matters and the Medicines and Healthcare Products Regulatory Agency. This meant that the registered manager could keep up to date with the latest research and practice guidance and they told us that they used this to develop the home and the service staff provide to people. The registered manager also told us that they had links with a local group of care staff who support people living with dementia. We were told that this group looked at how care homes could improve to be more 'dementia friendly.' However, these links with local and national agencies had not prevented the concerns we found during this inspection.

The registered manager told us that they had positive links with the local authority, local health teams and other stakeholders. They worked closely with their external health colleagues such as community nurses, physiotherapists, occupational therapists and doctors, who all came into the home to provide a service to people when requested.

The home's last inspection rating was displayed in the home and there was a link to CQC's rating on the home's website. There was a complaints procedure, and this was available for people to see on the wall next to where the rating was displayed. The provider had a whistle-blowing policy, which provided details of how staff could raise concerns if they felt unable to raise them internally. Staff told us that they were aware of the different external organisations they could contact if they felt their concerns would not be listened to.

The provider had a business continuity plan. The plan contained clear detail regarding the action to be taken in the event of specific incidents, such as a power supply outage. Information was clear for emergency contact information, guidance on prioritising risks and support from local authority social care in the event of an incident.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person was not ensuring that people were always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person has failed to ensure that risks relating to the health and safety of people using the service were assessed and action taken to mitigate identified risks to ensure the safety of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person has failed to have systems or processes to assess and monitor the service and effectively ensure compliance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person had failed to ensure safe recruitment practices.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The registered person has failed to ensure that there were sufficient numbers of skilled staff to ensure they were able to carry out their responsibilities.