The Cottage Nursing Home Limited

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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?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

This inspection took place on the 22 January 20215 and was unannounced.

We carried out an unannounced comprehensive inspection of this service on 10 November 2014. A breach of legal requirements was found. As a result we undertook another comprehensive inspection on 22 January 2015 to establish what improvements had been made to the service.

The Cottage Nursing Home Limited is registered to provide accommodation and care for up to 53 older people, ranging from frail elderly to people living with dementia. At the time of this inspection there were 44 people living at the service.

At this inspection the service did not have a registered manager; however they did have an interim manager in post. A registered manager is a person who has registered

Summary of findings

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.

During our inspection in November 2014 we found that people's safety had been compromised in a number of areas; not all staff were able to demonstrate that they knew how to identify or respond to abuse appropriately; parts of the home had not been adequately cleaned or maintained and there were poor arrangements for the management of medicines that put people at risk of harm. Bedroom doors had been wedged open and this put people at risk if there was a fire in the home.

We had concerns about the arrangements in place for obtaining and acting in accordance with the consent of people.

Records did not demonstrate that people had access to health care professionals to meet their specific needs. Care records and risk assessments did not accurately reflect people's current care needs or offer guidance for staff as to how people should be cared for and supported.

People were not provided with choices of food and drink and meal times were rushed. Staff support for people in relation to their nutritional needs was not carried out with sensitivity and staff showed little respect towards maintaining people's dignity.

Staff were not always patient and many did not take time to listen and observe people's verbal and non- verbal communication.

We found a deeply embedded culture which included a lack of respect, dignity and compassion for people. Care was not based around the involvement of the individual, but was task focused, and we observed people's safety was compromised by poor practice.

Records we looked at demonstrated people's concerns and complaints had not been dealt with appropriately. We were unable to find any information in a format that was suitable for people who were using the service to use in relation to making a complaint.

There were no systems in place to adequately monitor the quality of the service.

During this inspection we found that staff were able to demonstrate how to respond to allegations or incidents of abuse.

We found that overall, improvements had been made to the management of medicines. However, we found some gaps in the recording of medicines.

People's safety continued to be compromised by the on-going practice of wedging open fire doors.

We found that improvements had been made to reduce the risk and spread of infection. However, there were still some areas that needed to be addressed.

We found there were sufficient staff available to meet people's individual care and support needs. Safe and effective recruitment practices were followed.

Improvements had been made to training and supervision for staff. However, staff had not been provided with sufficient training to ensure they were able to care for people safely and to perform their roles and responsibilities.

People's consent to care and treatment was sought in line with current legislation. Where people's liberty was deprived, Deprivation of Liberty Safeguards [DoLS] applications had been approved by the statutory body.

People were provided with a balanced diet and adequate amounts of food. However, people were not always offered a choice of food and drink; people who needed assistance to eat their meals were not always provided with support in a sensitive and unrushed manner and drinks were not readily available.

Improvements had been made to the environment. However, there remained a lack of signage for toilets and bathrooms to make them recognisable for people using the service. We have made a recommendation about providing a supportive environment for people with dementia care needs.

People told us their healthcare needs were met and care records confirmed that people had been visited by healthcare professionals such as the dietician, district nurse and GP.

People were not always looked after by staff that were caring, compassionate and promoted their privacy and dignity.

Summary of findings

Complaints had been dealt with in a timely manner and were well recorded.

No improvements had been made to the Quality Assurance systems to assess and monitor the quality of service.

We identified that the provider was not meeting regulatory requirements and was in breach of a number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 is not safe.

Systems for the management of medicines had improved. However, we found some areas of poor practice in the recording of medicines.

People's safety continued to be compromised by the on-going practice of wedging open fire doors.

People were protected from avoidable harm and abuse by staff who knew how to report concerns.

There were sufficient staff available to meet people's individual needs and keep them safe. Effective recruitment practices were followed.

Is the service effective?

Requires improvement

The service is not effective

We found some improvements to the staff training programme. However, essential training continued to be lacking in many areas.

People were not always provided with choices of food and drink to meet their diverse needs. Some staff did not always support people with eating and drinking with sensitivity and respect.

Improvements had been made in relation to meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.(DoLS)

People were supported by staff to maintain good health and to access health care facilities when required.

Is the service caring?

Inadequate

The service was not caring.

We found that people were not always treated with compassion, kindness, dignity and respect.

People were not always supported to express their views and be actively involved in making decisions about their care, treatment and support.

Care was often task focused and did not always take account of people's individual preferences and did not always respect their dignity.

Is the service responsive?

Requires improvement

The service was not responsive.

Improvements had been made to the assessment and care planning process. However, people did not always receive personalised care that was responsive to their needs.

Summary of findings

People sat for long periods of the day with little interaction.

We found improvements had been made to the way the home responded to concerns and complaints.

Is the service well-led?

Inadequate

The service was not well-led.

The service did not have a registered manager in place and this was having an impact on the leadership and direction for people living in the service and staff.

People were put at risk because there were no systems in place to assess and monitor the quality of care provided to people, or to manage risks of unsafe or inappropriate treatment.

Staff attitudes and the day to day culture at the service included a lack of respect, dignity and compassion for people.

The Cottage Nursing Home Limited

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.

The inspection took place on 22 January 2015 and was unannounced. The inspection team comprised of three inspectors.

Prior to this inspection we reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law. We used a number of different methods to help us understand the experiences of people living in the service. We observed how the staff interacted with people who used the service. We observed how people were supported during breakfast, the mid-day meal and during individual tasks and activities.

We used the Short Observational Framework for Inspection (SOFI). SOFI this is a specific way of observing care to help us understand the experience of people who could not communicate with us verbally, due to their complex health needs.

We spoke with five people who used the service. We also spoke with the interim and assistant manager, four relatives of people who used the service, two nurses, six care staff and two members of the housekeeping team.

We reviewed care records relating to five people who used the service and four staff files that contained information about recruitment, induction, training, supervisions and appraisals. We also looked at further records relating to the management of the service including quality audits.

Inadequate

Is the service safe?

Our findings

When we inspected the service in November 2014 we identified issues with the medication systems and processes in use at the service. We found that the requirements for giving people their medicines covertly had not been followed. There was poor recording of medicines and the practice of crushing people's tablets with a pestle and mortar put people at risk.

This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During this inspection we found that overall improvements had been made. However, we observed some gaps in the recording of medicines.

We spoke with a nurse specialist who was visiting the service to review people's medicines and the procedures for administering covert medicines. They told us, "All the nurses have been given advice and information about covert medicines. They are changing their practice."

We checked the medication administration record [MAR] sheets for twenty people. We found that for two people the record had not been completed appropriately. Their tablets were still in the monitored dosage system blister packs. The reason why they had not been given the medicines had not been recorded. We observed one person's MAR sheet that had handwritten entries recorded. The entries had not been countersigned by a second staff member to minimise the risk of error when transcribing in line with current best practice guidance.

We found that the service had obtained support from other health professionals to ensure that people's medicines were administered safely. For example, on the day of the inspection a GP and nurse specialist were visiting the service to review people's medicines. This was to ensure that people received their medicines safely, in line with current legislations and best practice guidelines.

We saw that those people who received medicines covertly and did not have capacity, best interest assessments had been undertaken and Deprivation of Liberty Safeguards [DoLS] applications had been made to the statutory body to administer their medicines covertly. We observed staff using a tool designed specifically for the crushing of medicines, when people were having their medicine s administered covertly.

We found that people's prescribed medicines had been reviewed or were in the process of being reviewed. For people who had been prescribed PRN medicines [medicines to be administered when required] there were protocols in place that reflected when these should be given.

We saw that all medicines were stored appropriately. The temperature of the room where the medicines were stored was checked daily to ensure they were stored in the right conditions. Controlled medicines were stored in double locked cupboards in line with best practice guidance.

We spoke with the manager who said that medication audits had not yet been implemented so mistakes or omissions were not being identified.

This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During our previous inspection we found that people were not protected against the risks associated with unsafe or unsuitable premises. This was because fire doors were wedged open with wooden wedges or bedroom furniture.

This was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this this inspection we found that people's safety continued to be compromised by the on-going practice of wedging open fire doors. We found that seven bedroom doors were wedged open with wooden wedges or bedroom furniture. We also saw two corridor doors that had been wedged open with disposable latex gloves and doors in some communal areas were also wedged open. We saw people sat within two lounge areas with doors wedged open. These were fire safety doors with a self-closing mechanism which enabled the door to close when the fire alarm was raised. Wedging the fire doors open meant that people may be put at risk if there was a fire in the home.

Inadequate

Is the service safe?

This was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found there were no effective systems in place to reduce the risk and spread of infection. We found that areas of the home were not being cleaned sufficiently and carpets and chairs were stained and dirty. There was a strong odour of what appeared to be urine throughout the home and there were poor hand hygiene facilities.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

During this inspection we checked to see if improvements had been made. People told us they were happy with the cleanliness of the home. One person said, "They are always cleaning." A relative said, "I always see them cleaning. They are very thorough. My [relative's] room is always clean."

We spoke with members of the housekeeping staff. They told us they divided the home into four areas and we saw the cleaning schedules and rotas for all four areas. These were checked by a supervisor to ensure appropriate cleaning had taken place. We checked five bed mattresses and found them all to be clean; however, some of the bed linen used was torn. There were stains on the pillow cases and sheets.

We observed the housekeeping staff using colour coded mops to clean the home. One housekeeper told us that the blue mops were used for the bathrooms and bedrooms. However, we saw one housekeeper using a blue mop to clean the walls and banisters in the communal stairway.

We found some staining to the carpets under people's beds and also within the communal lounge area. This was being spot cleaned on the day of our inspection. Generally, the bedrooms and communal areas were clean, and there was evidence of on-going cleaning. We found a hoist sling was stained with what looked like faecal matter. We asked one staff member if people had individual slings for moving and handling. They told us that they shared them between people. This increased the risk of cross contamination and was not good infection control practice.

We observed that some of the tiles in the bathroom areas were falling off the wall and there were areas where sealant required renewing in between the tiles. This made the areas difficult to clean effectively.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

At our previous inspection we found that people were not safeguarded against the risk of abuse. We were concerned about staffs' level of understanding of their roles and responsibilities to safeguard people in the home, and the action they would take if they had any concerns about potential abuse or people's safety. We also found that the manager had not taken appropriate action to ensure that incidents or safeguarding concerns were reported to the relevant authorities for consideration and potential investigation.

This was in breach of regulation11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations2014.

At this inspection, we checked to see if the service had made improvements. One person told us, "The staff look after me, so yes, I do feel safe." A relative said, "The home provides good care and is one of the better homes in the area. I feel that my [relative] is safe here." Another relative commented, "I am very happy with the care my [relative] receives. I believe people are safe here. It's got a bit better lately."

We spoke with staff about keeping people safe. They told us if they suspected any abuse they would report it to the nurse or the manager. Staff told us they did not often get feedback when safeguarding matters were reported which did not help them to learn lessons from past mistakes. Staff said they were aware of the whistle blowing policy.

We found that the home had been working closely with the local authority and had identified safeguarding people as a priority training area for staff. We saw dates displayed in the office for staff to attend this training. In addition, we found that safeguarding incidents had been reported appropriately both to the local authority and the Care Quality Commission (CQC).

Inadequate

Is the service safe?

There were enough staff to meet people's needs. One person told us, "You have to wait sometimes for them [staff]) to see to you. They work hard and get to us when they can." A relative told us, "They are sometimes short of staff but they get the job done." A second relative said, "If there are not enough staff they always get agency workers. I am very happy with the care my [relative] receives."

Staff told us there were shortages of regular staff. We found there had been a high turnover of staff [eight had left in recent months]. We saw if there was a shortage of staff the home would use agency staff. We were told that the service would ask for staff that were familiar with the service and the people who lived there. This meant that people had some consistency of staff which was considered by the staff we spoke with helpful in a dementia service.

The assistant manager told us that the staffing numbers were made up of two trained nurses and eight health care assistants throughout the day. They said, "If the home is short we would use agency workers to make up the numbers. We always ask for staff that are familiar with the service users and the home." The manager told us that she was currently reviewing the skills mix of staff to ensure that staff with the right competencies and qualifications, experience and knowledge were employed. The service was in the process of recruiting care staff, including a clinical lead nurse and a registered mental health nurse.

The manager told us that the service did not use a specific tool to assess the dependency levels of people's needs. However, the staffing numbers were consistent. We looked at the staff rota which reflected that there were eight staff members on each shift during the day. This was in addition to the house keeping staff and kitchen staff. We found that the staffing numbers provided were adequate to meet people's identified needs.

We looked at the recruitment files for two staff members who had been recently recruited. We found that the service ensured that the appropriate documentation such as references, proof of identity and Disclosure and Barring [DBS] certificates had been obtained before staff were employed.

Requires improvement

Is the service effective?

Our findings

At our last inspection on 10 November 2014 we found that the training and development systems in place were ineffective and failed to ensure that staff received the training they needed to care safely and appropriately for people in the home. We found that new staff did not receive a comprehensive induction and most staff had not received or been enabled to keep up to date with the providers mandatory training program.

This was in breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During this inspection we checked to see if improvements had been made. Two relatives told us that they felt their family member was well cared for. One person said, "I believe my [relative] is well looked after. The staff know my [relative] and what they need." A second relative commented, "I think things are improving slowly. Some old staff have left and it seems much better." Another relative said that because of the use of agency staff not everyone who cared for their family member knew how they liked to be cared for. We were told by a fourth relative that they felt the staff were appropriately trained to meet their [relative's] needs. They said, "Staff keep me informed if there are changes. My [relative] fell last night and they telephoned me and made me aware."

One staff member told us, "I have undertaken training in dementia awareness and safe handling of medicines." They told us they were due to receive training in challenging behaviour on 9 February 2015. They said, "The training is beginning to pick up." Another member of staff said, "Training is getting better and we have also had our first supervision which we didn't get before."

The assistant manager told us that previously supervision had been irregular. However, since the commencement of a new management team all staff had received at least one supervision since our last inspection. The manager said appraisals were due to take place and staff knowledge and skills were being updated. This meant that the service had plans in place to develop staff knowledge and skills.

The manager had implemented an induction programme and told us that all new staff would, in the first instance, complete a day's induction training. They would be made aware of the service's policies and procedures and the organisational structure. Staff would then be allocated to shadow an experienced staff member for one week. This would be reviewed and evaluated with the individual. If the staff member did not feel confident working on their own after shadowing, this could be extended. In addition, the manager said that all new staff were expected to complete a 12 week common induction training programme. This was a recognised national induction training programme.

We found that nine of the 34 health care assistants had completed moving handling training. The manager told us the home had been working closely with the local authority and had identified three priority areas for staff training and this included moving and handling training. We saw dates displayed in the office for staff to attend this training.

There were gaps in fire, first aid and basic food hygiene training. Two of the seven nurses and one of the four kitchen staff had completed fire training. We saw that plans were in place to ensure that all staff were provided with this essential training. We saw that safeguarding, moving and handling and dementia awareness training were the first courses to be completed by staff. We saw that dementia training was taking place the day following our inspection. Although we found some improvements to staff training, the training provided was insufficient to ensure that staff were able to care safely and appropriately for people.

This was in breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At our previous inspection we found that people were not offered a choice of food and drink; people were at risk of not receiving enough to eat and drink and staff did not provide effective support to meet their needs and preferences. People were not supported with their food and drinks in a sensitive manner and meals were often rushed. In addition, accurate records were not available of people's dietary intake and this placed them at risk of receiving inadequate food and drink.

This was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During this inspection we checked to see if improvements had been made. We observed breakfast and lunchtime

Requires improvement

Is the service effective?

meals. People told us the food they received was good. One person said, "It is ok, yes I get choices." Another person commented, "The food is nice. Not too bad at all. "A third person told us they had previously lived in another care home where the dining tables were laid with cutlery, napkins and condiments. They said, "I would like to see that here."

We noted that some staff offered people a choice, for example, at breakfast some staff asked people if they wanted Weetabix or porridge. However, we also observed several staff not offering people a choice of food or drink. Some staff interacted well with people and took their time to support them. Other staff demonstrated poor interactions, assisting people with their meal in silence and in a hurried manner. The menus did not offer people a choice of food and were not available in a suitable format for people using the service. Staff did not always tell people what they were eating or what had for their meal.

We noted that fluids were not accessible to people. They had to wait for a drinks round to take place. One person told us, "I'm so thirsty and hungry." We requested a drink for this person from staff which was eventually given and recorded on the fluid intake chart.

We saw the person responsible for the maintenance of the home cleaning the carpet with a carpet cleaner at the same time the nurse was administering medicines and people were eating their breakfast. The carpet cleaner was noisy which meant people were not able to eat their breakfast in a relaxed and comfortable environment.

We looked at the care records for five people using the service. We saw a lack of consistent recording in relation to nutrition and hydration. For example, in one person's file their nutritional assessment had not been reviewed since November 2014. In a second file we saw advice from a health care professional that the person should be encouraged to drink 1.5 litres of fluid a day. We looked at the food and fluid intake charts for this person over a six day period. On three days there was no recording of fluids past twelve mid-day. In a third file we saw the person was to be encouraged to drink 'copious amounts of fluid'. There were gaps on the fluid intake chart for this person.

This was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At our last inspection we found that the environment was not supportive for people with dementia care needs. There was no signage for toilets and bathrooms to make them recognisable for people using the service. There were no features for interest, different settings or welcoming dining areas and the furnishings were sparse.

This was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

During this inspection we found that some improvements had been made to the environment. We saw that some inappropriate seating had been removed. Furniture had been arranged in way that encouraged people to interact more with each other. A dining room had been created to encourage people to eat their meals at the dining table. There remained a lack of signage for toilets and bathrooms to make them recognisable for people using the service.

At our last inspection we found that the service had not been meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People had not been asked for their consent to care and decisions had not been made in people's best interest. This meant that the human rights of people who may lack mental capacity to make particular decisions had not been protected.

This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During this inspection we found that improvements had been made. We found that the home had been working closely with the local authority to ensure they followed the correct procedures. We saw that where people lacked capacity, a mental capacity assessment had been completed and Deprivation of Liberty Safeguards [DoLS] applications had been made to the statutory body. This meant that people who lacked mental capacity were safeguarded and their human rights protected because the service was following the MCA Code of Practice.

We spoke with people and their relatives about how their health care needs were met. One person said, "They look after me. I have seen the doctor and I know they will do their best."

Requires improvement

Is the service effective?

A relative commented that they were satisfied that the health care needs of their family member were met. Another relative told us that they felt the staff were appropriately trained to meet their [relatives] needs. They said, "Staff took my [relative] to the dentist as they had toothache. They let me know what's going on and also there was an optician here and they got new specs."

Staff told us they supported people to attend required appointments when needed. We saw that many people using the service had recently had their medicines reviewed. Staff also told us that they made referrals to relevant healthcare professionals should the need arise.

Care records showed that people had been visited by the dietician, district nurse and GP. We saw that one person had attended an optician's appointment and another person had been seen by the dentist.

We recommend that the service considers the NICE guidelines, 'Dementia: Supporting people with dementia and their carers in health and social care' in relation to providing a supportive environment for people with dementia care needs.

Inadequate

Is the service caring?

Our findings

At our last inspection on 10 November 2014 we found that staff did not involve and treat people with compassion, kindness, dignity and respect. Staff did not have an understanding of how to promote respectful and compassionate behaviour towards people using the service.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9(3) (a)(g) and 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We checked to see if improvement had been made. One person told us, "A lot of staff have left. Most of the staff here are kind and caring but you always get a few who are not." A staff member told us, "I love working here. We are like a big family."

We saw that staff attended to people in a timely manner. We were talking with one person who pressed their emergency call bell because they required some assistance to sit up. Staff arrived promptly within two minutes to provide support.

We observed staff providing care and support and interacting with people. There were varying interactions with people. We saw one staff member dancing with someone and singing. We observed a staff member who gently persuaded a person who liked to walk, to sit in a chair and have some food. This took time and the staff member spoke with patience and kindness. We saw a person holding a teddy bear who was being transported in a wheelchair. Interactions between the person and the staff were positive. Staff had difficulty with the foot pedal on the wheelchair. One of the staff members went to look for a foot plate to make transporting safer. They told the person where they were going.

Just before lunch was due to arrive most of the staff were grouped around the small kitchen area talking together. There was little interaction with people using the service. Many people were left for periods of time without support from staff; when they did attend to people some staff were not communicative and did not always engage positively with people. We observed that some staff did not always listen effectively to what people wanted and did not engage with them on a meaningful level.

We observed staff supporting people at meal times. Some staff interactions were positive and supportive. However, we observed limited conversation and very often we saw staff talking across people. We observed one person who had become agitated and aggressive to staff when brought to the dining table in their wheelchair. Staff did not appear to know how to deal with this behaviour and eventually walked off leaving the person sitting far away from the table. We also saw an incident where a person sat in another person's favourite chair. They became agitated and staff did not appear confident to deal with this.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9(3) (a)(g) and 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At our last inspection we found that people were not always offered choices about their care. Daily routines were not always person centred but were task-led. People's care needs were not carried out in line with their preferences.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9(3) (a)(g) and 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We checked to see if improvements had been made. Relatives told us they had been involved in some decisions about their relatives care but had not been involved in the whole care planning process. For example, one person told us they had been asked about their [relatives] medicines and this had been discussed with them. They also told us that their [relative] required two people to take them to the toilet. They didn't know if this was happening and it had not been discussed with them.

The manager told us they were in the process of improving the information contained in the care plans and once this had been completed, reviews would then start taking place involving people using the service and their relatives.

We saw that some staff involved people in simple day-to-day decisions. For example, we saw a staff member ask someone where they wanted to sit. They also asked the person if they wanted to wear their slippers, to which they replied, "No." This involvement in decision making depended on the staff member providing support.

Inadequate

Is the service caring?

We overheard staff having a conversation about who needed support with feeding, where other people could hear. One staff member asked one person if they would like breakfast. They replied, "No" and the staff said, "Well I will give it to you anyway." We observed staff often talking across people they were supporting with meals, to talk with other staff members.

We were unable to find any information available about advocacy services. Advocates are independent of the service and support people to communicate their wishes. We were told that no one who lived in the home currently had an advocate. This meant people may not be aware of advocacy services which were available to them.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9(3) (a)(g) and 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At our previous inspection we found that people's privacy and dignity were not always respected. In addition, people could not be confident that information about them was treated confidentially and respected by staff.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9(3) (a)(g) and 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We checked to see if improvements had been made. Relatives told us their family members were treated with respect. One relative said, "Yes my [relative] is treated with respect. The staff are very polite."

Staff used terminology such as, "You are my angel" and "My darling." One staff said, "You next" to someone during a meal time and addressed them by the wrong name. This was not respectful of people and did not promote a feeling of positive care. At times staff spoke with people in a childish manner. For example, "You want sugs in that?"

Some aspects of the home were not conducive to people's dignity and privacy being maintained. For example, one of the toilets was barely large enough for a hoist to enter and we observed staff taking someone into the toilet on the hoist, with the door being left open as they attempted to help them onto the toilet. No privacy barrier was used to promote dignity or privacy. There were no quiet spaces or lounge areas for visitors to meet with their family members. We saw numerous relatives visiting on the day of our inspection and observed that there was no privacy for them when talking with their relative. We observed that staff did not always knock before entering people's rooms.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9(3) (a)(g) and 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Requires improvement

Is the service responsive?

Our findings

At our last inspection we found that people did not receive personalised care that was responsive to their needs. People's needs were not met in a timely manner and often people's needs were not met at all.

This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During this inspection we found that some improvements had been made. One person told us, "I can sit where I like. I prefer to stay in my room and the staff pop in to check on me. I prefer it like that."

Two staff we spoke with said that practices at the home were slowly changing and improvements were being made. For example, one staff said, "We are now doing things for people as and when they want them, not just because we have to get things done. Its more about the person than it was before."

At our previous inspection we found that staff commenced getting people up at 06:00am whether they wished to or not. A staff member told us, "The new manager has stopped that. If people are awake they are asked if they want to get up. If people don't want to get up their wishes are complied with." They continued, "One person likes to get up at six and likes to go to bed at 10.00pm, and that's what we support them to do." This meant that people were being empowered to make decisions about their care and that their views were acted upon.

We observed two staff hoisting a person from their wheelchair to an arm chair in the lounge. Staff did not communicate with the person and did not explain to them how they would carry out the activity. We observed the same staff hoisting a second person. One staff member said, "Lean forward." They did not tell the person what they were doing. We saw three occasions where people were taken to the toilet with no explanation by staff of where they were going. They had not been asked if they wanted to go to the toilet.

Care plans did not reflect how people would like to receive their care, treatment and support. The manager told us that care plans were currently being updated to contain more information about people and how they wanted to be supported. At the time of our inspection only two care plans had been reviewed and we looked at these. We saw that family members had been asked for information about people's personal histories, interests and past hobbies. The two care plans included more detailed information about people's care and treatment and were written in a way that promoted individualised care. The manager told us that a senior staff member had been allocated the task of updating all care plans and this was a priority area for improvement.

We observed that people sat for long periods throughout the day with little or no interaction. We did not observe any opportunities for people to follow their interests and take part in social activities. We were told that the activities coordinator had recently left the service so few activities were taking place. We spoke with the manager who told us they were planning to provide training to a staff member who had shown an interest in activities for people with dementia. The manager also told us that the activities coordinator who had left was returning to the service. They said they wanted to provide a full programme of activities to meet all people's needs.

We were unable to find any information about choices in relation to who provided people's care. We saw female service user's having personal care provided by male staff. We did not observe people being asked before care was provided, if they objected to this.

We found that improvements were being made to the assessment and care planning process. However, care plans were not reflective of people's preferences, and our observations demonstrated that people did not always receive personalised care that was responsive to their needs. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At our last inspection we found that the service did not routinely listen and learn from people's experiences, concerns and complaints. In addition, we found that concerns raised by people who used the service or others, had not been investigated thoroughly and recorded.

Requires improvement

Is the service responsive?

This was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked to see if improvements had been made. One relative told us, "I have raised a couple of issues with the new manager and they have been sorted out."

A staff member commented, "I have confidence that this manager would deal with any concerns or issues straight away."

The manager told us that they had met with relatives and a lot had been discussed in relation to the way the service was run and about care provision. The manager told us they were planning regular meetings for people using the service and relatives. We saw that the service had held a 'meet and greet' for relatives to meet the management team and to raise any concerns. We saw that another had been arranged and was advertised throughout the home. They told us, "It's early days yet but we plan to involve families as much as possible."

We saw that complaints had been dealt with in a timely manner and were well recorded. However, there was no information available in a format that was suitable for people who were using the service, to use in relation to making a complaint. Overall, the service had made significant improvements to how they dealt with complaints and concerns raised by people.

Inadequate

Is the service well-led?

Our findings

At the previous inspection on 10 November 2014 we found that the provider did not have effective systems in place to regularly assess and monitor the quality of service. There was poor communication between staff, record keeping was not accurate or up to date, medication systems and infection control systems were not effective and staff training had not been kept up to date.

This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked to see if improvements had been made. We found that care records were often incomplete and inconsistent. For example, we found people's nutritional charts had not been reviewed on a regular basis and fluid intake charts had not been fully completed. There were no audits conducted of care records to identify gaps and omissions in recording.

We found that Infection Control audits were not undertaken to protect people from the risk of infection. Also we were told by the manager that Medication audits were not taking place which meant people were not protected from the risk of unsafe medication management.

We found that the practice of wedging doors open with wooden wedges or bedroom furniture had continued. We found that audits in relation to the safety of the premises had not been conducted and this placed people at risk.

Systems in place for recording accidents and incidents were not always linked to people's individual care plans. This meant there was not always a clear record of any incidents that had occurred. We were unable to find evidence that the service carried out an analysis of incidents and accidents to identify any patterns and take the appropriate actions. This does not ensure people are protected against the risks or unsafe care.

We found that some staff were not aware of the services vision and values. Therefore, people were not always treated with respect, dignity and compassion.

We found the arrangements to ensure staff were appropriately supported to deliver care and treatment to an appropriate standard, by receiving essential training, continued to be lacking in many areas. For example, there were no staff with first aid training. Staff told us that the frequent change in managers made them feel frustrated. There was no visible leadership to inspire them to provide a quality service. There was a lack of support and uncertainty among the staff.

We found that people, relatives and staff were not consulted regularly about the delivery of service. Records we looked at were not person centred, and we were unable to find information about how staff communicated with people who were unable to communicate verbally. We found that there were no quality assurance systems in place to monitor the quality of the care provided.

This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The registered person failed to provide people with a choice of suitable nutritious food and drinks; and failed to ensure that people were supported to eat and drink in a sensitive and respectful manner.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered person failed to ensure that people were treated with respect and dignity.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **People were not protected against the risk of unsafe care and treatment that included the unsafe management of medicines, inadequate systems to protect people against the risk of the spread of infections and by failing to ensure persons' providing care or treatment to people have the qualifications, competence, skills and experience to do so safely.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered person failed to ensure that the care and treatment provided to people was appropriate and met their needs and preferences.**