Care Quality Commission

Caring Homes Healthcare Group Limited

Ferfoot Care Home

Inspection report

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22 September 2016

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

Summary of findings

Overall summary

Ferfoot Care Home provides accommodation and nursing care for up to 52 people. At the time of our inspection, 45 people were resident at the home.

This inspection took place on 19 September 2016 and was unannounced. We returned on 20 and 22 September 2016 to complete the inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager is responsible for the day to day management of the home and was available throughout the inspection.

At the last comprehensive inspection on 15 and 18 May 2015, we identified the service was not meeting two of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because potential risks to people's safety were not being properly identified and addressed. In addition, people's care was not being planned in a way that ensured their needs were met. At previous inspections in April and August 2014, there were also shortfalls in care delivery. Following each inspection, the provider sent us an action plan, which detailed how improvements would be made. At this inspection, there remained breaches in regulation within these areas.

Not enough staff were available to meet people's needs safely and effectively. Staff were not always aware of people's whereabouts and some interactions between people were not witnessed. This increased the risk of interactions escalating and people experiencing harm. A high number of people presented with behaviours that challenged and there were many incidents between people. Some people were consistently walking around the home in an agitated state. Not all were properly supported by staff. Management plans were in place but these lacked detail and did not inform staff of the support people required. Not all staff were confident in effectively managing people's challenging behaviour.

The complexity of people's needs was not reflected in the assessment or care planning processes. People were not sufficiently supported to minimise their risk of pressure ulceration and specific areas of care were not effectively undertaken and clearly documented. Those people who required assistance were not supported to drink sufficient amounts at regular intervals. People's fluid intake was not adequately monitored, which increased the risk of dehydration. People were happy with the food they received but accurate records were not maintained when minimal amounts were eaten.

There were positive comments about the staff but interactions with people varied. Some were positive, showed a caring approach and demonstrated staff knew people well. Other interactions however, showed staff's stresses and frustrations. Some practices did not promote people's privacy and dignity. This included a person's catheter bag being visible and a person urinating in the garden. During the inspection, a group of

people went out in the organisation's minibus and some people enjoyed external entertainers. Other people received little interaction and stimulation.

Not all areas of the home were clean and good infection control practice was not always followed. There was a strong unpleasant odour in the entrance area, lounge and some corridors. There were a range of audits to monitor the safety and quality of the service but these were not always effective in identifying and addressing shortfalls. The number of incidents, accidents and infections were regularly calculated. However, further investigations were not undertaken to minimise the number of these occurring. People and their relatives knew how to make a complaint and were encouraged to give their views about the service.

Staff received informal support and more formal supervision to discuss their performance. Staff felt well supported and told us the training they received was good. Records showed staff were up to date with the training, which was deemed mandatory by the provider. Emphasis was given to "Living in My World" training which explored the experiences of people living with dementia. Whilst training was regularly undertaken, a social/health care professional felt additional training in people's care needs would enhance the care people received.

During our inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for which we are taking action and will report on this when it is concluded. Two of these breaches were repeated from the last inspection as sufficient action had not been taken to address the shortfalls. The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were a high number of people who displayed unpredictable, challenging behaviour, which was not always safely managed.

There were not enough staff to meet people's needs safely and effectively at all times. Medicines were not always safely managed.

Not all areas of the home were clean and infection control practice was not always followed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not ensure people had enough to drink and their fluid intake was not adequately monitored. This increased people's risk of dehydration.

Staff felt well supported and told us the training they received was good. Not all staff were confident to manage people's challenging behaviour effectively.

People were supported by a range of professionals to meet their health care needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Interactions with people were variable. Some were positive and showed a caring approach, whilst others indicated a sense of stress and frustration.

There were some practices which consistently promoted people's privacy and dignity. Others practices and interactions, compromised such rights.

Is the service responsive?

Inadequate

The service was not responsive.

Care was not always planned and delivered in a way which ensured people's safety and wellbeing.

People were not sufficiently supported to minimise their risk of developing pressure ulceration.

Focus was given to social activity but some people received little interaction or stimulation.

Is the service well-led?

Inadequate

The service was not well led.

Sufficient action had not been taken to address and maintain improvement in relation to the previous identified breaches in regulation.

Whilst there were a range of audits to monitor and assess the quality of the service, these were not fully effective, as shortfalls were not being addressed.

People and their relatives were encouraged to give their views about the service.

Care Quality Commission

Ferfoot Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 19 September 2016 and was unannounced. We returned on 20 and 22 September 2016 to complete the inspection. The inspection was undertaken by one inspector with support from another inspector on the second day, one specialist advisor on the first day and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

In order to gain people's experiences of the service, we spoke with 18 people and six relatives. We spoke with the registered manager, a senior manager, 12 members of staff and a health/social care professional who has contact with the service. Following the inspection, we received feedback from four health/social care professionals via email. We spent time observing the way staff interacted with people and looked at the records relating to care and decision making for eight people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also looked at documentation in relation to the management of the home. This included staff supervision, training and recruitment records, quality auditing processes and policies and procedures.

Inadequate

Is the service safe?

Our findings

At the last comprehensive inspection on 15 and 18 May 2015, we identified the service was not meeting Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because systems for assessing and managing risks did not always ensure action was taken to keep people safe. The provider sent us an action plan, detailing how they would address this. During this inspection, there continued to be shortfalls and systems were not sufficiently robust to ensure people's safety.

People's safety was not assured. This was because the management of people's behaviours, which were associated with their health care conditions, were not adequately managed. The registered manager told us "the list was endless" in relation to those people who could present with challenging behaviour. Incident records demonstrated the number of incidents that had occurred. Examples of such behaviours were seen during the inspection. This included one person who was very agitated and shouting loudly, on our arrival at the service. They were leaning over another person and close to their face. The registered manager or staff did not intervene until we prompted them to do so. They said the person was used to such behaviours, so it did not upset them. The person continued to be very agitated and consistently moved around with their arms ahead of them, bumping into furniture and other people. These actions were potentially harmful and intrusive and there was a risk they could be misinterpreted by others. The person repeatedly banged on the tables and on windows. On one occasion, they spilt a drink as a result. A member of staff removed the drink but did not talk to the person. They told other staff members not to leave the person with a drink. This was not followed, as approximately an hour later whilst the person continued to be agitated, they were left with a hot coffee.

Later in the day, in a communal lounge, another person tried to take a person's drink. They then attempted to give the person their cake by putting it to their mouth. The person retaliated by shouting and pushing them away. Staff were not in the vicinity so did not witness this incident. This did not enable them to intervene and de-escalate the situation. Shortly afterwards, in the same lounge, another person "squeezed" through the gap between two people's armchairs. As they did so, they heavily nudged both people. Another person was seen to repeatedly "lash out" at staff and on one occasion, lunged towards another person. The person screamed although was not physically injured. Another person became agitated at another and shouted accusations at them, whilst in the dining area.

Clear management plans were not in place to meet the complexity of people's needs and their challenging behaviour. For example, the management of one person's agitation was described as "staff to reduce triggers" and "needs staff intervention" with the triggers being "continence support" and "agitation from others". The information was not specific and did not provide staff with sufficient clarity to support the person effectively. Later in the person's records, there was an assessment which showed clear details on how to help manage the person's behaviours and what triggered these. The information, which had been provided by a health care professional, had not been incorporated into the person's care plan. Another care plan did not show what triggered the person's behaviour, how the behaviour presented or how staff should manage this. This did not enable staff to manage the person's behaviour in a safe, consistent manner.

One person displayed inappropriate behaviour, whilst talking to us. Their short term care plan made reference to such behaviour and a daily record stated they had been inappropriate towards a member of staff. The record stated "please monitor" but there was no evidence of this. The information within the care plan or daily records was not specific and did not clearly identify the risks involved. This did not enable adequate control measures to be put in place to safeguard the person or others.

People gave us variable views when we asked them if they felt safe living at the home. One person raised concerns about other people and their behaviours. They said they did not like those who presented challenging behaviours as they had previously been involved in an altercation and had been hit. Another person told us "the people here are noisy. I find it distracting and distressing". Other comments included "yes I feel safe sometimes, and sometimes not" and "they won't dare shout at me, but yes, only one of the residents was aggressive and we had a fight. He was quite a bully but in the last year he's really aged". One person told us "I've seen residents fighting with each other so I called the staff and they sorted it out. They're not well, some of the residents here".

Other people told us they felt safe. Their comments were "yes I do feel safe here. I was in the army and you learn to look after yourself" and "of course I feel safe here. It has a good atmosphere in here".

One person told us of an incident involving a member of staff which had recently occurred. The person was upset and said the staff member had made them feel frightened. We asked the registered manager if they were aware of the incident. The registered manager told us they were in the process of reporting the allegation to the safeguarding team. We confirmed they should do this as soon as possible.

Not all areas of the home were clean and infection control practice was not always followed. There was a strong, unpleasant odour in the entrance area, the lounge and some corridors. The registered manager told us they were aware of this but explained there were people who urinated inappropriately on the carpets. They said they had submitted a request to the organisation's head office to replace the carpets with laminate flooring, as this would enable more effective cleaning. Other carpets particularly in the corridors, on the stairs and within communal areas were stained. There was debris on the floor in both lounges, in the passenger lift and on the frames of small tables and dining room chairs. Some of the surfaces of the armchairs in the lounge were worn and could not be wiped clean. Other chairs felt "sticky" and were not clean. The room which stored people's medicines was dirty, with dust on all surfaces and spillages over the floor. The bins in this room were over-flowing and in a shower room, used paper towels were around the bin. There was a trolley in another bathroom. The trolley had a razor, a shoe and plastic aprons left on the top of it. Within the laundry room, there was a high level of dust and debris behind the washing machines. There was a basket of combs and hairbrushes. The registered manager told us the combs were clean and awaiting return to their owners. A person's dentures were left on a shelf in the laundry room. A member of staff told us they were waiting for the dentures to be claimed as no one knew who they belonged to.

All communal bathrooms, toilets and sluice rooms were clean. However, there was no disposable protective clothing in one sluice room. A member of staff entered a bathroom to collect some disposable gloves but the box was empty. The bathroom was untidy with disposable aprons over the floor. Disposable protective clothing was stored on a toilet cistern in another bathroom. Light pulls were stained brown and toilet brushes were standing in water and contained brown debris.

One person felt nauseous and had vomited in the dining area. The person was supported to another area but there was little attempt to clean where they had been sitting. Staff had given the person a bowl which they vomited into. This was placed on a dining room table. The table was not disinfected when the bowl was removed. About thirty minutes later, we informed staff that some bodily fluid remained on the floor. Staff

responded but used one bucket of water, which diluted the bodily fluid and spread it across the floor. The member of staff who had been assisting the person removed their tabard and took the bowl, which the person had been using, into the kitchenette. They placed the tabard in the kitchenette and then took the bowl elsewhere to be emptied. This increased the risk of contamination.

People's medicines were not safely managed and there were areas which would benefit from improvement. Staff had not consistently signed the records to show they had applied people's topical creams as prescribed. One person had a particular topical cream in their room but this was different to that which was stated on their cream application chart. The instructions indicated the cream was to be applied to the person's arms and legs, twice a day. Staff had not recorded they had done this. One person was prescribed a transdermal patch to be applied to their skin. Records showed there was inconsistency when documenting the removal and reapplication of the patch. The patches were not applied consistently at the same time within the 72 hour period. This compromised the effectiveness of the medicine. Another person's medicine profile stated they had no known allergies. However, the medicine administration record identified the person was allergic to penicillin. Not having consistent information about people's allergies to medicines increases the risk that they might be given a medicine to which they were allergic. Within one record, it was identified a person had become particularly agitated and challenging in their behaviour. Information showed this had been potentially linked to the person not receiving a particular medicine for three days. A member of staff told us this was because there had been problems with the prescription and the home had therefore 'run out' of the medicine. Staff were aware of the process to follow if people required their medicines to be crushed. However, records did not always provide evidence that the person's GP had authorised this practice prior to administration. This meant there was a risk these medicines would be ineffective.

There were clear organised systems in place regarding the receipt, storage and disposal of medicines. However, a thickener to minimise the risk of people choking on their drinks, was kept within an unsecured cupboard in the communal kitchen area. This increased the risk of the substance being tampered with or taken in error.

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

Shortly before the inspection we received concerns about staff shortages. At various times throughout the inspection, people were walking around the home in an agitated state and staff were not present. Whilst it was recognised people had not been commissioned to receive one to one staff support, the lack of staff presence and oversight, did not ensure people's safety. Some people went into bedrooms, which did not belong to them. One person walked into another person's room and urinated in their waste paper bin. Staff cleaned the area but the person who the room belonged to, remained upset. Another person was walking along an upstairs corridor and said they were lost. They were disorientated and could not find their room. As staff were not in the vicinity, we used a call bell to summon staff assistance. Staff responded quickly, greeted the person in a positive manner and explained to the person that their room was downstairs. However, without our interaction, there was a risk the person would not have received this assistance. Another person was upstairs as they had had their hair done. They were agitated and unable to communicate their needs. No staff were in the vicinity of the person. The hairdresser was alerted to the sound of broken glass. They found the person in the corner of the hairdressing room with glass at their feet. This impacted on the person's safety.

At approximately 17.00 on the first day of the inspection, one person was repeatedly rattling the door to the garden. Other people were walking around the lounge in close proximity to others. These people were

agitated and unsettled and the noise level had increased because of people shouting. One member of staff was administering medicines, whilst another was walking with a person who was very agitated. Two other staff were assisting people with their personal care in their bedrooms. This meant there were no other staff available to support or supervise those people walking around. This shortfall increased the risk of people's agitation and challenging behaviour escalating, which compromised people's safety.

Shortly before the inspection, we received two concerns about inadequate staffing levels. The information stated staffing shortages impacted on people's safety and did not ensure people were sufficiently supported to eat and drink adequate amounts. During the inspection, two staff told us there were enough staff to support people effectively. One of these staff said this was because staff had a good routine, which enabled all work to be completed. Other staff said they did not feel staffing levels reflected the complexity of people's needs. They said staff were often "stretched" and they found it difficult to provide the care they wanted to give. They said this was particularly apparent when people were agitated and displaying challenging behaviours. One member of staff told us they found it hard to give time to those people less mobile and less challenging, as other people demanded their time. They said staffing levels often restricted people's choices such as when to have a bath or shower. They told us "it's like today. It's been really busy so we wouldn't have been able to help anyone with a bath. It would leave us too short on the floor". Another member of staff told us they felt many people needed one-to-one care, which impacted on their time with others. They said staffing shortages also made it difficult to keep up with record keeping. They told us "one of the problems is we don't get chance to write daily records. The residents come first and it's hard to balance it". Two relatives told us they believed the home was short staffed. Their comments were "they get very busy and side tracked" and "it can be very difficult. There's lots to do. They do their best". One health/social care professional shared similar views. They told us they believed the staffing arrangements were insufficient to meet the needs of those people supported. They said the home was often "short staffed" which impacted on people's care.

The registered manager told us staffing levels were maintained at eight or more care staff and the senior team during the day. They said at night, there were four care staff. The registered manager told us staffing levels were allocated using the ratio of five people to one member of staff rather than consideration being given to people's care needs. They said the numbers of staff were sufficient and better than many other similar care homes in the area.

We were informed in August 2016 that there were occasions when staffing levels had fallen below the provider's recommended staffing ratio. Concerns were raised about the care provided and the associated risks with insufficient staffing. We looked at the staffing rosters for those days. The staffing rosters showed only four, five or six staff working on these days. However, we were informed by the registered manager that on these occasions, staff from the home's sister home were called upon to maintain numbers but had not been added to the staffing roster.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us managing staff sickness was sometimes a challenge but the home was always appropriately staffed. They said staff "pulled out all the stops" when there was staff sickness. In addition, they said ancillary staff such as housekeepers had completed all training so could assist with caring responsibilities if required.

People told us when they used their call bell, staff responded to them quickly. This was seen during the inspection. However, one person told us "I think there's adequate staff but not always, like today. They know

he has trouble cutting up his food and they just put it in front of him without cutting it up". Another person told us they felt staffing numbers were sufficient. They told us "the staff work shifts so you see lots of different staff. I do think they have enough staff here, as I'm never rushed to do anything".

Staff administered people's medicines in a person centred way. They offered them to people in a small pot or on a spoon. Some people had their medicines placed directly in their hand. Staff gave people time to take their medicines and ensured they were safely swallowed before continuing with the round. Staff appropriately asked people if they wanted any medicines, which were prescribed to be taken when required. Staff had signed the medicine administration record when people had either taken or declined their medicines. This enabled the medicines effectiveness to be accurately monitored. Staff were knowledgeable about the medicines they administered. There were regular audits of the medicine administration systems and staff had their competency in administering medicines assessed.

Organised recruitment procedures were in place, to ensure people were supported by staff with the appropriate experience and character. Two staff confirmed their recruitment procedure was robust. They said they completed an application form and supplied the names of two referees who could provide details about their past performance and character. The staff confirmed they had a formal interview and could not start work until a Disclosure and Barring Service (DBS) check was undertaken. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people. This enables safer recruitment decisions to be made. Records demonstrated the clear recruitment procedure staff described.

The fire door in the laundry room was inappropriately held open by a bucket. This did not enable the door to be automatically and safely closed in the event of a fire.

We recommend that the service seeks advice and guidance on current fire safety guidance.

Requires Improvement

Is the service effective?

Our findings

Not all people were supported to have regular or sufficient fluids. This increased their risk of dehydration. One person remained in bed throughout the inspection. Their drink was located on their chest of drawers, away from their bed. It was of a thick consistency due to having thickener added. At various intervals during the day, the drink remained in the same place with a teaspoon standing up in it. The fluid did not reduce. The person's care plan stated "encourage fluid intake". Another person had a jug and glass full of blackcurrant coloured squash. The drinks were located on an over-bed table but this was away from the person and not within their reach. Later in the day, the black currant coloured squash remained on the table and another jug and glass of orange coloured squash had been added. The content of either squashes did not reduce as the day went on. At 11.35, we asked another person if they had recently had a drink, as their glass and jug were not within their reach. They told us they had not had a drink since breakfast and would like one. The person quickly drank a whole glass of coloured juice, without stopping. They then asked for some more and drank another two thirds of a glass. The person's records showed they had a history of dehydration. The person had not been supported to have regular drinks to minimise this risk. A social/health care professional told us they had previously experienced people not being supported to drink adequate amounts. Two relatives raised similar concerns before our inspection.

Staff were not effectively monitoring people's food and fluid intake. One person's care plan stated "I need to be monitored with my fluid intake as I will often throw my drinks away. I should have at least 1500mls per day". This person was at risk of dehydration and recurrent urinary tract infections. However, there was no documentation in their daily care records to evidence this was being monitored. Another person's care plan stated "encourage fluid intake - staff to monitor output and changes in colour /odour which may indicate [urinary tract infection]". Records did not show this was taking place. Within people's care records, staff had documented intake as "poor", "average" or "good". This was subjective and did not show accurate information. This could not be used for effective monitoring purposes. Staff and the senior manager told us fluid monitoring charts were not used unless instructed by a GP. A memo to registered managers from the senior manager confirmed this instruction. The memo stated the reason for this was because the completion of the charts was always identified as a shortfall during CQC inspections. The home's fluid balance policy stated "if there are any deficiencies in their ability to gain fluids independently, then a care plan, risk assessment and fluid balance chart should be put in place for the resident". The policy continued to state staff should discuss the person's ideal amount and "fluid intake should be monitored accurately". This was not being followed.

At 10.45 on the first day of the inspection, one person was in bed. A crash mat and a pressure mat, which activated the alarm system when stepped on, were next to the person's bed. There was an over-bed table on the other side of the room, which had a plate with two pieces of toast on it. The toast had not been eaten and did not look as though it had been touched. A member of staff took the food away and said the person did not want it. The person's daily records stated "had poor food and fluid intake today". The information was not specific and did not reflect the person's actual intake. In addition, the records did not show additional attempts had been made to encourage the person to eat. Another person was losing weight. Their weight had reduced from 86.05kg to 72.20kg over a period of five months. The care plan had not been

amended to accurately reflect the actions staff were required to take to support the person with their weight loss. On the day of the inspection the person's daily records stated their intake was poor. Adequate systems to monitor food and fluid intake were not in place. Another care plan stated the person should have an adequate diet and staff were to encourage "an adequate diet daily". Information did not show what this meant in practice or whether it was being achieved. There was a memo dated 8 August 2016 from a senior manager that stated "where a person has compromised nutritional intake, the time and amount eaten should be maintained". This instruction was not being followed.

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

People had a choice of three meals at lunchtime, one of which was a vegetarian option. One member of staff told us an alternative dish would be provided, if a person did not like the main meal choices. The evening meal consisted of a hot meal or sandwiches followed by a dessert. There were lists in the kitchen which showed people's food preferences and medical needs. The majority of food was cooked "from scratch".

People were generally positive when talking about the meals. One person told us "the food is gorgeous, really good and we get a good choice". Another person told us "the food here is very good and there's always a choice. At night I always keep a tin of biscuits in my room. Supper is at 8pm". Another person told us "the food is about average. It's edible and yes we do get a good choice on the whole. I eat what's put in front of me and if I don't like it I won't eat it. I do feel hungry between meal times but just wait till the next meal". One person told us a member of staff made them a sandwich when they were hungry.

The registered manager had an understanding of the Mental Capacity Act (MCA). They said they had undertaken training in the MCA and liaised with the local authority, if they had any queries or needed advice. A social/healthcare professional confirmed this after the inspection. They told us they were working closely with the registered manager in completing MCA and Best Interest paperwork. The MCA provides a legal framework for acting and making decisions on behalf of individuals who may lack the mental capacity to do so for themselves. The Act requires as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS). The registered manager had appropriately submitted applications to authorise restrictions for some people. These had or were being processed by the local authority, the supervisory body. However, people had a standard generic care plan in place regarding consent and decision making. There was little evidence of best interest decisions, decision specific capacity assessments and DoLs applications within people's records.

Staff were aware of the process to follow if people required their medicines to be given covertly. Covert medicine administration involves disguising tablets or liquid medicine in food or drink without the person's awareness. However, whilst staff were aware of the need to gain authorisation from the person's GP, documentation was not always available to show this had been undertaken.

Staff told us the training provided was very good. One member of staff told us they felt the training they had received, supported them to provide care in line with people's needs. They told us they were supported by management if they requested training, which was not routinely offered. For example, one member of staff told us they had requested training in end of life care, when they were supporting a person with this stage in their life. Staff told us the "Living in My World" training was excellent in helping them understand people's

experiences of living with dementia. Records showed staff in all departments undertook this training. The registered manager told us they felt this was important as all staff worked with people closely and needed to have this awareness.

Staff told us they found people's challenging behaviours sometimes difficult to manage. One member of staff told us "we haven't been told or shown what to do. It's really difficult, as we go on what we think". Another member of staff said "we haven't had training on the aggressive side of things. It's hard". One member of staff told us they regularly got hit, kicked, thumped or bit by people. They said this had resulted in injuries such as bruises or scratches. The member of staff told us it was "expected" when working with people living with dementia and considered "part of the job". This was not an appropriate view. The registered manager confirmed there were times when staff experienced aggression from people. They said staff were always encouraged to report any such incident and complete an incident or accident form. The registered manager told us all staff had completed training in how to manage challenging behaviour so were not sure why they had raised this with us. Records we were provided with did not show challenging behaviour as a "stand alone" training course that was regularly undertaken. Courses which were viewed as mandatory by the provider included moving people safely, infection control and safeguarding. Records showed staff were up to date with these training courses.

The registered manager told us they operated an "Employee of the month" scheme in order to recognise achievement and value the staff team. They told us there was a rolling staff roster to ensure people had consistency in the staff supporting them. They said one team generally worked a series of "long days" from 8am to 8pm, whilst the other team had their days off. This was then alternated. Staff told us this system worked well and each team became close and supported each other well. They said in addition, they received formal support and supervision from their supervisor. This involved discussing their work, any training needs and future development. Staff told us they found this system helpful although would raise any issues informally, if they had a problem. They said they did not need to wait for their formal supervision session. The registered manager told us formal supervision was on-going but they did not have a schedule of sessions to demonstrate this. They said this was because the previous schedule they had, did not work. One member of staff told us they received a good induction and felt supported in the first two weeks of their employment.

Staff and the registered manager told us people received good support from a range of healthcare professionals. They said GPs visited routinely on a weekly basis and when called. Community nurses visited daily to support some people with their clinical needs such as the administration of insulin, catheter management and the completion of dressings. The registered manager told us 25 per cent of people were supported by regular visits from the Home Liaison Team. On the second day of the inspection, a member of the Home Liaison Team visited a person, in response to concerns we had raised as part of the inspection. After the inspection, one social/healthcare professional told us the registered manager always sought appropriate assessment and support from health care colleagues.

We recommend that the service ensures their procedures are in line with the MCA Code of Practice.

Requires Improvement

Is the service caring?

Our findings

Staff interactions with people were variable. Some interactions were undertaken in a friendly and caring manner. These approaches were particularly observed where people were more able to communicate and interact with staff. Staff showed they knew these people well including their backgrounds and previous occupations. Conversations included humour which people responded to well.

Other interactions were not so positive. One person was very agitated and grabbed a staff member's arm. The staff member "rolled" their eyes and continued walking with the person although did not engage with them. Another member of staff spoke very loudly to people. They told us many people were very hard of hearing so they often needed to do this. They said they sometimes got used to speaking loudly even when they did not need to. Another member of staff asked a colleague for assistance to support a person who was feeling nauseous. The staff member was brusque and said "no, I'm going on the trip". They continued walking and did not engage further.

One person asked a member of staff what they were carrying and said "let's have a look". The staff member responded by saying "just a minute X, hang on. I'll just put these things away and I'll be back". The member of staff put clean bedding that they were carrying away, returned and said "what can I do for you X?" They had not taken into account what the person had wanted.

Practices did not always promote people's privacy or dignity. A member of staff assisted a person to have a drink with a straw but did not talk to the person or explain what was happening beforehand. Another person had a catheter and their leg bag which collected their urine, was clearly visible below their trousers. Staff had assisted the person but had not moved the leg bag so it was appropriately covered. Another person repeatedly raised their trousers above their knees, whilst they were seated. Staff did not support this person to maintain their dignity. Another person had tipped their hot drink onto their plate, which contained their biscuits. This was in front of them but staff had not intervened. Another person was trying to drink but they had their cup resting in a dish. They struggled to lift both items and place the cup to their mouth. As a result, they spilt some of their drink on the floor. Staff cleaned up the spillage and took the crockery but did not ask the person if they wanted anymore to drink.

There were incontinence aids on show in some people's rooms. These had not been stored discreetly to promote people's dignity. At 5pm, one person's bed had been stripped and was bare. The duvet and pillows had been placed in the person's chair. This did not look pleasant or enable the person to have a lie down, easily sit in their room or receive visitors in a dignified manner. One person urinated in the garden but staff were not in the vicinity to intervene. On discussing this with the registered manager and senior manager, they told us this behaviour was a regular occurrence. They told us it was linked to the person's earlier life and culture. Whilst noting the explanation, the practice did not promote the person's dignity.

The majority of people had a picture of something that was important to them on their bedroom door. Some pictures showed animals or a football team. This showed a person centred approach and assisted people to locate their rooms more easily. However, some rooms did not look as if they were occupied. They

had no name or a picture displayed on the door. One member of staff told us this was because people removed them and the pictures then got lost. A more robust system to address this had not been implemented.

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

People told us staff consistently knocked on their bedroom doors before entering. We saw this in practice and as they did so, staff said their name and informed the person of what they wanted. This included "hello X. It's X. I've brought your tea". Some staff made pleasantries such as "your hair looks nice X" and "I like your jumper". One member of staff described the weather to a person and said how it made them feel. Another member of staff supported a person to be less anxious by gently stroking the person's hand and asking them what they wanted. They asked the person if they wanted to go outside or have a walk around the home. The person said they wanted to stay inside and staff respected this. Within one care plan, it was stated the person liked to have a soft toy near them for comfort. The person held a small teddy whilst in bed. Staff told us all mealtimes were "protected" so there could be a calm environment to enable people to eat without interruptions. Staff told us they administered people's medicines after their meal because of "protected" mealtimes.

Staff gave people choices and asked permission prior to carrying out care. For example, one member of staff asked a person if they would like to sit up in bed to take their medicines or whether they would like to take them later. The member of staff respected the person's decision. Another person told us they were having a 'lie in' as they liked to do this. They told us they were happy and the staff were "lovely".

One person was not so happy with the staff. They told us told us "they're alright. You might find one that snaps at you but they're alright". Other people were more complimentary. Their comments were "there's no staff that I'm uncomfortable with", "the staff are pretty good here. They can take a joke", "the staff are lovely, they really are", "the staff are good" and "I get on with the staff here. They're all right". One person told us "the staff here are very good. They try to make you feel better". Another person told us "I felt 'down' once and the staff made me feel better. There are a couple of male staff here that are really good and you can talk to. There's always there to listen".

A visitor who used to have a family member living at the home was complimentary about the service they had received. They told us their family member liked to listen to audio books but whilst they were away the CD player broke. They told us a member of staff purchased a new player, "off their own back" so their family member could continue with their interest. The visitor told us several staff went to their family member's funeral which was very much appreciated. Another relative was equally positive about the staff. They told us staff helped people celebrate special occasions. They said "they are wonderful. They always look out for [my family member] and they have rung me at home to make sure I'm alright. They look after X well. The night staff are excellent". The relative told us they gained support from the staff when needed.

Inadequate

Is the service responsive?

Our findings

At the last comprehensive inspection on 15 and 18 May 2015, we identified the service was not meeting Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because planning of care was not always done in such a way to meet people's individual needs. The provider sent us an action plan, detailing how they would address the shortfalls.

At this inspection, there remained shortfalls in the planning and delivery of some people's care. For example, records showed one person was hot and being "regularly checked" by staff. The following day, records stated they "seemed a little quieter than usual" and two days later they were "feeling unwell". There was no information to specify what support the person received in response to these observations. The GP was called three days after initial concerns were identified. The records did not show an outcome of the visit or whether any actions were required. There was no follow up information to show how the person's health continued to present. The person had a catheter and required their catheter bag to be changed once a week. Records did not show this was being undertaken. Without this information, there was a risk the catheter bag would not be changed, as frequently as required. This increased the risk of the person developing a urinary tract infection (UTI). Other records showed the person had a UTI which had caused them to fall.

Records showed the person should have their bowel actions monitored and any concerns were to be reported to the GP. Records did not show this monitoring was taking place. This did not enable prompt identification of any problem, which needed to be addressed. The person required eye care on a daily basis. Records did not show this had been given. The care plan did not identify if the person managed their eye care independently or if they required staff support. A letter following an appointment with an ophthalmologist stated the person's eye was weeping. The person's care plan did not state what action had been taken to address this.

Another person was sitting in their room. The top half of their body was dressed but they just had their underwear on their lower body. They told us they had fallen and suffered grazing to their knees and legs due to dragging themselves back to their chair. They said they had chosen not to get fully dressed as they were waiting for the GP to visit and their wounds made clothing difficult. At 11.00, the person was told the GP would be visiting the following day. Their wounds looked sore and moist. We asked a member of senior care staff about the person's fall and the injuries they had suffered. They were not aware of this information. A body map did not illustrate all of the person's wounds. Staff had documented "red marks to knees" on the accident form. This was not an accurate reflection of the severity of the wounds. The person told us they did not want to eat or drink and were feeling hot. Care records did not demonstrate a thorough assessment had been undertaken in response to these identified needs. The person's mobility fluctuated due to their health condition. Records showed the person had a fear of falling and was at high risk of falls. However, there was a blank temperature, pulse and respirations (TRP) form and the falls assessment document had not been fully completed. We prompted staff to gain treatment for the person's injuries, as this had not been undertaken in a timely manner.

Records showed another person had very complex needs and displayed behaviours such as shouting, crying out and hallucinating. There was no evidence of a detailed assessment of their behaviour and as a result, their care plan did not reflect the complexity of their needs or the support required. There was conflicting information about the person's sensory impairment. This included whether they wore glasses or not and the impact of only having vision in their right eye. On one occasion a member of staff approached the person from their left side. The person appeared startled and anxious with this interaction. Staff did not always respond to the person in a manner that would address the route of their distress. For example, such responses by staff were "I need to do this X" and "'where do you want to go?" The person was not able to hold a conversation or communicate why they were so distressed but records showed the person was able to communicate vocally and verbally. This was not an accurate reflection of their needs.

Records showed one person was at high risk of pressure damage. This had increased to a very high risk but the person's care plan had not been updated as a result. Information stated the person needed assistance to move their position every two hours to minimise the risk of pressure damage. This was not undertaken as on the first day of the inspection, the person remained in the same position for a period of six hours. One member of staff did not know how often the person should be repositioned. They told us the person's chart, which demonstrated this information and showed when they had been repositioned, was kept in the care office. This was not accurate, as a senior member of the care team and the senior manager told us repositioning charts were not used unless requested by a GP. They said people's care and repositioning would be reported on in the person's daily records. Staff had used phrases such as "turned regularly" and "pressure areas checked on every care intervention". This was not specific and did not show the required frequency or inform staff when they needed to support the person next. This did not enable responsive, appropriate care which met the person's needs.

Staff told us this person was nursed in bed, as they were contracted and could not sit in an ordinary chair. One record showed staff had placed a support in the person's contracted hand to minimise the risk of their nails embedding into their palm. Records did not show this was consistent practice and there was no information in the person's care plan about the management of their contracted limbs. Within an evaluation record, there was an instruction about the person wearing specialised boots as their heels were looking vulnerable. The records did not inform staff if the boots were still being used. They were not part of the person's care plan. Another record stated the person needed support to change their continence aid "regularly". This did not inform staff how often this intervention was required. Information stated the person was prone to urinary tract infections but there was no information in the care plan about how to minimise this. There was no information about the monitoring of the person's fluid output although this was stated in the care plan, as required. The person was described as being "very confused" with no verbal communication, unable to make choices, use their call bell or engage in social activities. Information did not detail what support the person required in these areas. There was limited information about the person's wishes regarding their end of life care other than they had a pre-paid funeral plan.

Another person looked very unwell but was seated in the lounge. A member of staff told us the person had been assisted to get up, washed and dressed by the night staff. They said the person would be assisted to use the bathroom after lunch and then would remain in the lounge until taken to bed. This meant they had been sat in the same position for at least six hours. The person had declined any food or fluid during the morning. Staff told us this was because they had a specific health condition which the GP was aware of. The health condition was not detailed in the person's care plan. There was no indication that the care plan had been updated to reflect the person's changing needs. Their end of life care plan stated they did not want to go to hospital but no other wishes were identified.

After the inspection, a social/health care professional told us they felt the care records were repetitive in

places and the care plans were not very user friendly. They said this meant there was a risk that duplicated information might not be accurately reviewed causing conflicting messages for staff. In addition, the social/health care professional told us the impact the care plans had on care delivery could be questioned. This was because essential information risked being missed and the person centred knowledge of staff was not always reflected in the documentation.

During the inspection, those people who were most dependent, frail and had increased cognitive impairment, received little intervention other than task related care. There was very little by way of meaningful verbal or non-verbal interaction. On the first day of the inspection, people were very much unoccupied. Some people walked around, often agitated, whilst others remained seated but did not engage in any meaningful activity. The registered manager told us this was because the staff allocated to provide social activities were not on duty. On the second day of the inspection, a group of people went out using the home's minibus. However, those people who remained in the home were again largely unoccupied. There were some items in the corridors such as ladies scarfs, which provided visual and touch stimulation but those people who were seated did not have access to these items. Some staff walked through the lounges without maximising opportunities for people. After the inspection, a social/healthcare professional told us people were often sat in the lounge/dining area falling asleep. They said they had not seen any activities taking place at the times of their visits. Another social/healthcare professional told us "background" music was not often age appropriate and at high volume. In addition, they said TV programmes were used to "entertain" people and these were again often loud and not always appropriate viewing.

This was a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the last day of the inspection, arrangements had been made for entertainers to visit the home. Staff told us this was a regular occurrence which people enjoyed. Some people confirmed this. Such comments were "I like singing when the singers come in here", "they get a choir in and some singers. That goes down well" and "we can do chair exercises and I like singing. We have an entertainer and we have quizzes at weekends when it's quiet". Another person told us they liked reading and reading the newspapers. One person told us "I go to all the quizzes and puzzles but not the music from the wars. We go out as we have a loan vehicle that takes us out. At weekends we have a quiz on a Sunday morning but most weekends, not much happens". Another person told us they regularly went into town for shopping or a coffee.

The registered manager told us it was important for people to be involved in the local community. They said people regularly went out to places of interest, shopping or to the local pub for a meal. Staff confirmed this. One member of staff told us they aimed to base social activity on people's interests and their life history. They gave an example of one person being accompanied to the docks as they liked boats. Other examples included posting a letter or going to a supermarket, choosing an item and paying for it at the checkout. The member of staff told us activities in the home included folding laundry, pairing socks, making sandwiches and baking. They said they were in the process of putting up a washing line so people could hang out their laundry.

People and their relatives told us they would talk to the registered manager or the staff if they had concerns about the service. One person told us "yes of course I would talk to the staff if I had any concerns. They are very good". A relative told us "I have invitations to meetings but I don't always go. If I have a problem, I see the manager. I had a problem [recently] and she [the registered manager] acted on it". Another relative told us they had recently met with the manager to discuss their concerns. Staff told us they aimed to address any concerns as they arose. They told us they regularly saw people's relatives and had established good relationships with them. This enabled any concerns to be raised informally through general conversation.

There was a detailed complaints procedure, which detailed how complaints were to be managed. A record of the formal complaints that had been made was securely stored in the office. Information showed complaints were taken seriously and appropriately investigated. After the inspection, a social healthcare professional confirmed this. They told us the registered manager "took the concerns seriously and responded in a timely manner". They continued to state the registered manager "completed a full and comprehensive investigation to ascertain the cause of some of the allegations and I can feedback that she engaged well in conversation and was cooperative with the request".

Inadequate

Is the service well-led?

Our findings

Since July 2013, the service has been inspected on five occasions. Breaches have been found on each occasion. For example, during the inspections which took place in April and August 2014 and May 2015, care documentation did not fully detail people's individual needs or give staff sufficient information to enable them to support people safely and effectively. Following each inspection, the provider sent us an action plan stating how they would make improvements. Whilst some action was taken, compliance with regulation was not maintained. Similarly at this inspection, there remained shortfalls in the planning and delivery of people's care. This did not demonstrate the service was well-led.

There were a wide range of audits to monitor the quality and safety of the service. However, these were not effective as shortfalls were not being identified and addressed. For example, the infection control audit identified carpets were in a good state of repair. This was not the case as many were stained and worn. The registered manager confirmed the unpleasant odour was related to some people urinating on the carpet. They said this was a regular, on-going problem but this had not been identified in the audit. The laundry wall was damaged where the door handle had been pushed against it. This meant the wall could not be properly cleaned and the area of damage collected dust and debris. Similar damage was noted in a person's bedroom, as it appeared the bed had been pushed against the wall. The infection control audit had not identified this damage. The quality monitoring systems had not identified the gaps in people's care plans that we identified in the course of the inspection.

There was limited evidence to demonstrate "lessons learnt" were a key aspect of the management of the service. The registered manager had identified the number of accidents, incidents, safeguarding referrals and complaints that had taken place, on a monthly basis. However, records did not show that action had been taken about this. For example, there were a large number of incidents which increased people's risk of harm but strategies had not been considered to minimise future occurrences. The records demonstrated a number of people had experienced chest or urinary tract infections but investigations had not taken place to ascertain why this was so. Staff had identified a number of bruises on one person and had documented this on a body map. However, records did not show an investigation into how the bruising had occurred. This was particularly important as the person was nursed in bed and not independently mobile. The registered manager told us they would look into the potential causes of the bruising.

After the inspection, one social/healthcare professional told us the registered manager had a positive, open dialogue with the safeguarding team. They told us about one situation where the registered manager was proactive in getting the person appropriate support and safeguarding other people following admission. However, between November 2015 and September 2016, there had been 34 safeguarding alerts. 19 of these involved incidents between people, with one described as a "serious assault" and another "hospital admission required". There was no evidence the registered manager had assessed these incidents to look for patterns and trends that may enable them to prevent similar instances from occurring in the future.

People and their relatives were enabled to give their views about the service they received. There were regular meetings although these were not always well attended. One person told us about the meetings.

They said "they post them up on the door so we know". Records showed surveys had been sent to people to gain their views. There was positive feedback about the staff and mealtimes. Action plans however, were not in place to show how more negative feedback was to be addressed. This included suggestions for the improvement of the home's décor.

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

The registered manager told us they had a "wish list" to make the environment more pleasing for people. This included a coffee, bar and sweet shop area. They said they would like to make the environment more "user friendly" for those people living with dementia. The registered manager told us this would involve greater use of colour, texture and pictorial formats. Records showed the registered manager's wish list although there were no clear plans with dates, to show the completion of this work.

There were variable views about the registered manager and the overall management of the home. One relative told us they did not feel there was always a management presence, particularly at weekends. A social/health care professional gave us similar views. They told us staff were often under pressure and management oversight was not always evident. The registered manager told us they predominantly worked in the week although visited at weekends for auditing processes.
One relative said "I can always get to talk to the manager and she's always there for us". Another relative told us "I think the manager is doing a good job. She's always there to talk to". Other comments were "she is very approachable. She always sorts things out straight away. Head Office is always helpful too" and "the manager is lovely. She always makes sure I'm okay and gives me a cuddle". A member of staff told us the registered manager was "easy to approach and relaxed but will sort any problems out". They continued to tell us the registered manager was "supportive to staff by asking, have you tried this approach?" They said the registered manager always put the resident's needs first. After the inspection, a social/health care professional told us the registered manager came across as professional and knowledgeable.

The registered manager told us the ethos of the home was to "give people the best quality of life and let people be themselves". They said they wanted the home to be homely and not institutionalised with people following their own choices of what they wanted to do. They said this included people walking around in their pyjamas if they wanted to or not having a shave, if they chose not to. Staff gave us similar views when asked about the ethos of the home. One member of staff told us they enabled people "to do what they wanted to do". Another staff member told us "we aim to provide a good standard of care but most importantly, it's their home and they can do what they want". They told us they always gave people choices such as when they wanted to get up and what they wanted to wear.

The registered manager told us they kept themselves up to date with current guidance by attending conferences and meetings, undertaking training and searching the Internet. They told us they were passionate about providing personalised care and had a special interest in supporting people living with dementia. They said they had recently developed awareness sessions for family members and friends of people living with dementia. The sessions were aimed to encourage people to share experiences and develop strategies to successfully manage potential difficulties.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The planning and delivery of care did not ensure people's needs were effectively and safely met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Practices did not always promote people's privacy and dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's safety were not being adequately identified and properly addressed. Regulation 12(2)(a) and (b). Not all areas of the home were clean and good infection control practice was not always followed. Regulation 12(2)(h). There were some shortfalls in the management of people's medicines. Regulation 12(2)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Not enough staff were deployed to meet people's needs safely and effectively. 12(2)(a) and (b).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audits were not effectively identifying and addressing shortfalls in the service.

The enforcement action we took:

We imposed a condition to ensure the provider made improvements.