Care Quality Commission

Summerfield Care Limited

Summerfields Care Home

Inspection report

Summerfields House,
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Morecambe
LA3 3NL
Tel: 01524 425184

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This unannounced inspection took place on 10 & 22 April 2015.

Summerfields Care home is situated in Morecambe and is registered to provide care and accommodation for up to 33 people living with Dementia. All accommodation is offered on a single room basis. The home has a variety of communal areas for people to use. There are passenger and stair lifts for ease of access between floors. There were 22 people living at the home at the time of inspection.

A registered manager was in post at the time of the inspection. 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 service was last inspected in April 2014. The registered provider did not meet all the requirements of the regulations at that inspection as they had breached

Summary of findings

regulation 19, complaints. We used this inspection to review what actions had been taken and found that the provider had put systems in place to ensure that complaints were appropriately received and managed.

Feedback received during this inspection from people using the service was positive. All of the people we spoke with confirmed that they were happy living there and the service being provided. Feedback from family members and friends of people who lived at the home was also positive. Families stated that they were happy with the service provided. Relatives said that the staff were caring and that people's needs were generally met.

Although people who lived at the home said that they felt safe, we noted that safety of the people was sometimes compromised. We found that people were not always kept safe as deployment of staffing meant that there was not always oversight of people in the main lounge area. We identified a high number of people were injured following falls when staff were not present. Poor deployment of staff sometimes led to disorganisation and a lack of consistency of support for people.

Processes and systems were in place to protect people from abuse. Staff were aware of how to report abuse and whistle blow. The provider had a robust recruitment system in place.

People were not safe from risk of injury as the registered manager had failed to ensure that the environment in which people were living was adequately maintained. We found slip, trip and fall hazards in one lounge, poor lighting in communal areas and windows without restrictors. We noted an electrical inspection assessment had found the electrics were unsafe but there was no evidence that this had been actioned. These environmental hazards posed a risk to people who lived at the home.

People were not protected from unsafe care as adequate processes and systems were not in place for the management of medicines. The numbers of trained staff available to administer medicines was inadequate. We found that best practice for administering medicines were not always followed.

It is a requirement of the Care Quality Commission (Registration Regulations 2009) that the provider must notify the Commission without delay of any serious injury to a service user or any abuse or allegation of abuse in relation to a service user. This is so that we can monitor services effectively and carry out our regulatory responsibilities. The registered manager had not notified the Commission as required.

Mandatory staff training was not completed by all staff members to ensure they were equipped with all skills required to do their role. Staff were not aware of the Mental Capacity Act (MCA) (2005). Ongoing support to staff was provided through quarterly meetings with the registered manager.

Although care plans and risk assessments were in place for each person we found paperwork was often incomplete. This made it difficult to follow and assess the effectiveness of the care being provided.

We observed mixed interactions between staff and people at the home. Some staff demonstrated behaviours which showed that they treated people with compassion. On other occasions we noted staff failing to engage with people and meet their needs.

Care provided was often delivered as a means to meet staffing need rather than the people who lived at the home. We observed people being denied choices because staffing levels dictated how the service was run. People were unable to have baths because of a lack of staffing and people were delayed from going to bed when they requested to do so.

Feedback from staff was mixed. Overall, staff said that morale was low and there was a lack of leadership within the home. A recent restructure within the home had caused disparity between staff and confusion over accountability and roles and responsibilities. Despite morale being low, staff described working with the people who lived at the service with care and commitment.

We found that there were a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what actions we have asked the provider to take at the back of the full version of this report.

We found that the environment was not dementia friendly for people with dementia. There was a lack of appropriate signage to promote independence of people

Summary of findings

living with dementia and the provider had done little to make the environment wholly inclusive. We have made a recommendation about using good practice guidelines to improve the service.

On the day of inspection activities were planned but were cancelled at short notice, this meant that people spent time sitting in the lounge with no activities. There was evidence that activities did take place in the home as we noted people's drawings and hand crafted vases that had been made by the people who lived at the home. We have made a recommendation about using best practice guidelines to promote and increase appropriate activities for people living with dementia.

The registered manager used a variety of methods to assess and monitor the quality of the service. These included quarterly satisfaction surveys and 'relatives meetings'. Overall satisfaction from relatives and people who lived at the home was seen to be positive.

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 was not always safe.

People told us they felt safe living at the home but we found that the registered manager did not have adequate systems in place to ensure people were safe at all times. Staffing levels did not always meet individual need. People at risk of falls were not appropriately risk assessed and monitored.

Suitable arrangements were not in place to ensure that the environment was adequately maintained to prevent people from being harmed.

Suitable arrangements were not in place to ensure that best practice guidance was followed and medicines were safely administered.

Recruitment processes were in place to protect people from abuse. Staff had a good knowledge of what constituted abuse and how to report it. All staff said that they would not hesitate in reporting abuse.

Is the service effective?

Requires improvement

The service was not always effective.

Mandatory training was not completed by all members of staff. Ongoing training and support was not always provided.

People who lived at the home spoke highly about the quality of food and had a choice about what they wanted to eat. People's nutritional needs were sometimes met.

People who lived at the home were encouraged to retain their own GP when they moved into the home and had access to good health care.

Is the service caring?

Requires improvement

The service was not always caring.

People who lived at the home, family members and visitors were all complimentary about the staff but this was not consistent with what we saw at times. Although we observed some positive interactions where staff treated people with patience, warmth and compassion, we also observed staff not responding appropriately to people who lived at the home. Privacy and dignity was not respected at all times.

Visitors were welcomed at the home and had ready access to visiting relatives. Staff made an effort to ensure people had privacy when people had visitors.

Is the service responsive?

Requires improvement

The service was not always responsive.

Summary of findings

Care planning systems were not always complete and accurate. Health needs were not always addressed within care records. Risk assessments were sometimes incomplete and ineffective.

People were not always at the centre of their care. Wishes and preferences were not always met. Staffing levels sometimes determined the quality of care provided.

Although people were not engaged in any activity on the day of inspection, there was evidence that activities took place within the home. However these were not always dementia friendly activities.

The registered manager had a thorough complaints procedure in place and responded appropriately to complaints from relatives. Feedback from people who lived at the home was positive and no-one had any complaints.

Is the service well-led?

Requires improvement

The service was not always well led.

The service had not always reported and responded to safeguarding incidents, serious injuries and deaths of people who lived at the home.

A recent restructure had caused disparity between the team and morale was low. There was not a clear and accountable management system in place at all times.

The provider had systems in place to monitor and assess the quality of the service. Feedback from respondents were generally positive.

Summerfields 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 was an unannounced inspection carried out over two days on 10 April and 22 April 2015. The inspection team was made up of two adult social care inspectors and an expert by experience (ExE.) An ExE is a person who has personal experience of using or caring for someone who uses this type of care service. The lead adult social care inspector returned to the home (unannounced) for a second day to complete the inspection process.

Prior to the inspection taking place, information from a variety of sources was gathered and analysed. This included notifications submitted by the provider relating to incidents, accidents, health and safety and safeguarding concerns which affect the health and wellbeing of people who lived at the home.

We undertook this inspection in response to some concerns we had received in relation to the care being provided at the home and to check whether the provider had made improvements to ensure they were now meeting their regulatory requirements.

To gain a balanced overview of what people experienced when using the service, we also contacted the Local Authority safeguarding team, the local authority contracts team and Healthwatch to obtain their views regarding service provision.

Information was gathered from a variety of sources throughout the inspection process. We spoke with ten staff members at the home. This included the Registered Manager, seven members of the care staff team, and two ancillary staff.

We spent time with the people who lived at the home to see how satisfied they were with the service being provided. We observed interactions between staff and people to try and understand the experiences of the people who could not verbally communicate. We observed care and support being provided in communal areas around the home and spoke in private to three people who lived at the home.

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 spoke with five relatives who were visiting the home on the day of inspection.

As part of the inspection we also looked at a variety of records at the home. This included the care plan files belonging to five people who lived at the home and recruitment files belonging to five staff members. We viewed other documentation which was relevant to the management of the service.

We looked around the home in both public and private areas to assess the environment to ensure that it was conducive to meeting the needs of the people who lived at the home.

Inadequate

Is the service safe?

Our findings

We spoke with three people who lived at the home. They told us they liked living there and that they felt safe. One person said, "I feel safe here and have no need to complain."

We also spoke to relatives and visitors who all said that they were happy with the service provided. One relative said, "I feel safe with my relative here because they were falling a lot in their own home." Although relatives and people at the home felt that people were safe this did not always reflect our findings.

We spoke with staff to assess their knowledge of what constituted abuse and how to report it. Staff had a good knowledge of abuse and who to report it to. One staff member said, "If I thought someone was being abuse, I would go to the registered manager or the top man. We have policies in place to help."

We spoke with relatives of people who lived at the home about staffing levels. Two relatives informed us that they felt that staffing levels were not always sufficient to meet need. One relative said, "They are unable to handle [relatives] moods. This may be because they don't have time to get to know some of the service users."

We looked at staff rotas and spoke with the registered manager about staffing arrangements. The registered manager described the staffing levels at the home as flexible and said that despite a decrease in people who lived at the home, staffing levels had remained the same. The registered manager informed us that there were six staff on shift during the morning, this reduced to five in the afternoon and two staff on waking nights with an additional member of staff on standby in a sleep over room.

On the morning of inspection there were only four staff on duty when we arrived. This meant that the provider was not meeting its staffing level as discussed. A staff member told us that because there had not been enough staff on shift that morning some people had been unable to have a bath. On the day of inspection staffing levels were not sufficient to meet the needs of the people who lived at the home.

The registered manager said that staffing was a problem that week as it was half term and a number of staff had booked annual leave. We asked about procedures for covering for staff absence and we were told that agency staff would be used for night shifts but these were not permitted for day shifts. When cover could not be found within the staff team day staffing levels fluctuated. This meant that appropriate systems were not in place to ensure adequate staffing to meet people's needs at all times.

The registered manager told us that following a restructure senior staff were employed to deputise when the registered manager was not there. One staff member confirmed that at times there could be gaps when no seniors, no staff trained to administer medicines or the registered manager on duty. One staff member said, "I am never sure who is in charge."

Staff deployment was not organised effectively to ensure that people's needs were met at all times. At lunch time we noted people asking for assistance. Staff were moving in between people offering support and not sitting constantly with people to ensure all needs were met. Staff confirmed that they were often required to come in on their days off to administer medicines. The registered manager had not ensured that there was a suitable number of trained staff on duty at all times.

Throughout the day we observed a lack of staff oversight within areas of the home. We observed people being left unattended for long periods of time in the main communal lounge. People could not always summon help in an emergency as call bells in the main lounge were not accessible to all people using the lounge. We observed one person who had difficulty mobilising trying to stand up unaided from their seat and another person calling for assistance to use the toilet. On both occasions an inspector had to intervene and seek staff to come to attend to people's needs.

We looked at accident reports and noted that there was a high number of unwitnessed falls during the day in the main lounge. This meant there was no member of staff present at the time of the incident. One person experienced nine unwitnessed falls during the day through the months of January and February 2015. Another person experienced four unwitnessed falls in January and one person was admitted to hospital following an unwitnessed fall in March. This demonstrated that staff deployment was not effectively organised to ensure there was a staff presence as oversight of people in the lounge areas.

Inadequate

Is the service safe?

We asked a member of staff how they ensured that people were safe. They told us that it was difficult to ensure everyone was safe as people could walk freely around the ground floor communal areas. There were five staff present during the afternoon to the 21 people who lived at the home. Because of the layout of the home and additional duties placed upon the afternoon staff, these five staff members had to supervise five communal rooms as well as carry out tasks of cleaning, cooking and bathing. This meant that staff presence was limited at times. We spoke to the registered manager about the staffing levels and they agreed that due to the environmental lay out of the home it was difficult to deploy staff appropriately to ensure people are monitored effectively.

On the day of inspection we observed two people asking to go to bed but they were told that they would have to wait. We asked a staff member about this and we were told that they could not go to bed early as, "they would just get up early and it would be disruptive to night staff." We addressed this with the registered manager who informed us that they did not have enough staff on during the day to allow all people to go to their bedrooms. The registered manager said that she could not be assured of the safety of people in their bedrooms with the current staff levels.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (staffing) because the provider had failed to ensure that suitable numbers of trained staff were on duty at all times.

We asked the registered manager about how falls were monitored and what risk assessments were in place for people who were at risk of falls. The registered manager said that they did not have a specific risk assessment for this. On the second day of inspection we spoke with the registered manager to express our concerns about the ways in which falls were being managed, particularly in relation to two people who had frequently fallen within the last three months. The registered manager informed us that they had now assessed these people and had addressed these risks by moving them to a different lounge where there was continuous supervision. Although this had now been risk assessed, it had not happened in a timely manner.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Good governance) as the registered manager had failed to assess, monitor and improve the safety in relation to people who lived at the home in a timely manner.

We saw people's medicines were checked and confirmed on admission to the home. To ensure that the correct medicines were administered to the correct person there was a photo of each person within the medicines administration files. Medication records showed that records were completed every time after medicines had been prescribed by the staff member who administered the medicine. We observed one person refusing their medicines, the staff member tried hard to encourage the person to take the medicine but the person refused. The staff member appropriately discarded the medicine and recorded on the Medication administration record that the person had refused the medicines.

We found best practice for administering medication was not always followed. Medicines were not always appropriately administered and stored. We observed a staff member taking medicines from the medicines cabinet and then leaving the trolley open and unsupervised for over five minutes on three occasions. This meant that medicines were not kept securely at all times. We observed one person's tablets being administered from the staff member's hand. This posed a risk of cross contamination. We also found one person's prescribed ointments in a communal bathing area which indicated that it was accessible to other people for whom it was not prescribed.

On the afternoon of inspection, we were informed by a staff member that there was no senior member of staff on duty 1pm until 3pm. This was remedied whilst we were there. The member of staff who came in to work informed us that she was staying on as there was no qualified member of staff on duty to administer medicines. We spoke with staff who confirmed that there was not always a trained member of staff on duty to administer medicines. We looked at the Rota which confirmed that staff came in just to do medicines. This meant that should a person require PRN (As and when required medicines) or pain relief medicines that they may not always be administered in a timely manner, as people who lived at the service may have to wait until a staff member who was trained in administering medicines was available.

Inadequate

Is the service safe?

The registered manager informed us that staff were not permitted to administer medicines unless they were trained. Medication training had been provided to 16 of the 29 members of staff. However 12 of these members of staff had completed the training more than three years ago and had not received any refresher training. This showed the provider did not always support staff with on-going personal development that is required to keep staff skills up to date.

This was a breach of regulation 12 of the Health And Social Act 2008 (regulated Activities) 2014, (Safe care and treatment) as the registered manager had failed to ensure that medicines were managed and administered safely.

People were not safe from risk of injury as premises were not adequately adapted for people living with dementia. One corridor was poorly lit and had a patterned carpet. This can contribute to confusion and accidents for people living with dementia. Signage around the home was also poor, which could contribute to confusion for people living with dementia.

The registered manager had not identified risks within the environment which had the potential to cause harm. We found that flooring in one communal lounge was uneven and there was a large dip in the floor. This could present as a slip, trip and floor hazard for all people accessing this area. A door threshold was also raised which would cause a trip hazard for people using walking frames. After the inspection the registered manager took action and closed off this room until the work has been completed.

We also found that there were a significant number of windows without restrictors fitted. This could pose a risk to someone who is confused or agitated who was attempting to leave the premises. After the inspection we spoke with the registered manager who informed us that restrictors were on order and the handyman was going to fit them within the next week.

We also found a certificate for the electrical testing dated 25th March 2015, which stated that the electrical wiring in the home was of an unsatisfactory standard. The registered manager assured us that quotes had been received to commence work and remedy this. We spoke with the contractor who we were informed was going to carry out the work and he confirmed that although the provider had verbally agreed a contract with them, they had not been given the go ahead to complete the work. At the time of writing the report this work had still not been undertaken.

This was a breach of regulation 15 of the Health and Social Care Act 2008, (Regulated Activities) 2014, (Premises and equipment) because the provider had failed to ensure that the premises were appropriately maintained at all times.

We looked at recruitment and selection of three members of staff. People were protected from unsuitable people working in the home because the provider had a recruitment procedure in place that was consistently followed. The registered manager ensured people were of good character by seeking references and exploring all gaps in employment before staff commenced employment.

Because a high percentage of staff had worked at the home for a significant duration of time, we asked the registered manager about how often they renewed staff Disclosure and Barring Certificates. We were informed that the provider does not renew DBS checks for staff. This meant that some staff who had worked for the company for long periods of time had never been asked to provide a new DBS check. The registered manager also said that they never asked the staff to regular sign disclosures to confirm that they had not received any criminal convictions. This meant that the provider could not be sure that people working at the home were of good character.

The provider had adequate systems in place to manage infection control. On the day of the inspection we found that cleanliness was of a good standard and with the exception of two bedrooms was odour free. We were informed by the local authority lead nurse for infection control that they had no major concerns with the standard of cleanliness at the home.

We recommend that the provider consults with best practice guidelines on vetting existing members of staff.

Requires improvement

Is the service effective?

Our findings

Relatives we spoke with all stated that the home provided a good service. One relative said, "My relative's needs are met by the service; they receive the support they require, because we visit so often the staff keep us informed of their condition and needs."

Although relatives said that the care they received was good, we found that effective care was not always delivered.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

We spoke with staff to check their knowledge of the MCA and how they promoted decision making for people they supported. Staff informed us that they could not remember having any training in this area. Whilst staff could talk in detail about supporting people to make choices, staff could not relate this to the MCA. One senior staff member said, "I don't know about it, I don't deal with it." This meant that staff may be making decisions on people's behalf without consulting with the code of practice, which could result in unlawful decisions being made.

The expanse of the home enabled people to move freely between three downstairs lounges, a conservatory and a dining room. However, we noted restrictions were in place to limit people's movements. The home had a key pad on the main door to restrict people leaving the premises. There were also locks on doors that restricted people from leaving the communal areas.

On the first day of inspection the registered manager told us that they had not undertaken any training and had little understanding of the MCA and their responsibilities as a registered manager. The registered manager said that she was not aware of up to date case law but thought that, "people may now need DoLs applications making." However the registered manager had not put any plans in place to make the applications. On the second day of inspection, the registered manager informed us that they had undertaken the training and recognised the need to make applications to deprive people of their liberty. We spoke to the registered manager a week later and they informed us that they had started making the applications as required. The registered manager said they were intending to complete one for each person who lived at the home and that this was a priority.

We spoke with staff to see if they were adequately equipped with the relevant skills to do their role. We received mixed views. Two members of staff saying that training was good however three other staff members felt that they were not always equipped to do their role. One staff member said, "It would be nice to have some training so that we can handle [person] more appropriately."

We looked at the training matrix kept by the registered manager which provided a centralised record of all staff training. We found that mandatory training was not completed by all staff. The training matrix showed that all staff had completed moving and handling training and fire safety training. However there were gaps in infection control, health and safety, first aid, safeguarding of vulnerable adults, diet and nutrition, MCA training and dementia awareness. 12 of the 29 staff had not received any safeguarding training. Only the registered manager had received any diet and nutrition training. The registered manager confirmed that there were gaps in the training.

Care plan assessments showed that there were two people who displayed some behaviour which challenged. Staff informed us that they had not received any challenging behaviour training. Care notes for one person showed us that in one morning, three members of staff had been physically assaulted by one person. One staff member said, "We feel we need some training in challenging behaviour. It would be nice if we had training for [person using service] They can hit out; it would be great if we knew how to respectfully diffuse the situations." Lack of training in this area breached the providers own challenging behaviour policy which stated that training would be provided to deal with such incidents.

The registered provider had recently had a restructure and had introduced senior carers into the management infrastructure. The registered manager said that these roles had been introduced to provide leadership when they were not present. There was no evidence on the training matrix

that showed that these new seniors had been provided with training to enable them to do their new role effectively. None of the senior carers had completed any management training and only five of the seniors had completed an National Vocational Qualification (NVQ) in Care. One senior told us that they had not received any additional training to equip them with the skills required to perform the role. We looked at the rota's and it showed that seniors were in charge for four and a half days per week.

This was a breach of regulation 18 of the Health and Social Care act 2008 (Regulated Activities) 2014 because the registered manager had failed to ensure that there was sufficient qualified, competent, skilled and experienced staff deployed to meet the needs of the people who lived at the home.

We spoke with the registered manager about staff supervision. Staff supervision is necessary to ensure that staff are given the opportunity to reflect on their work, develop their skills and to enable problem solving with another peer. The registered manager said that staff did not have regular supervisions but had regular appraisals. Staff files showed us that this was the case and staff were offered opportunities to discuss and assess their work on a quarterly basis.

Some staff members reported that the restructure had caused a breakdown in communications and contributed to ineffective care. Two other staff members said that communication was poor and, "people did not know what they were doing." Carers did not attend handovers and did not always receive full information. One staff member said, "I didn't even know [person using the service] was in hospital. Nobody told me until I read the notes."

We spoke with the registered manager about access to health care. The registered manager said that to ensure consistency, wherever possible, people were encouraged to remain registered with their own GP when they moved into the home. Although care notes demonstrated health care professionals were consulted with when people required health interventions we found that the registered manager did not always work proactively in working with other agencies. There were a number of people at the home at risk of falls but the registered manager had failed to engage with the falls prevention service.

People who lived at the home all said that the food was good and had no complaints. Relatives also said that the food was good. They said they received varied, nutritious meals and always had plenty to eat.

There was no chef on duty on the first day of the inspection but the registered manager had made arrangements for a fresh meat and potato pie to be delivered from the local butchers. People were offered a choice of sandwiches or salads if they did not like the hot meal on offer. A member of the night staff had prepared homemade soup for the evening meal. People said that both meals were good.

Although we were informed that there was no cook on duty, a cook arrived later in the day. The cook informed us that the registered manager ensured that the home has good quality food available at all times and that money for food was no object. We looked around the kitchen and found that food was in good supply. On our second day of inspection we observed a delivery of fresh vegetables being delivered. This showed us that the people who lived at the home received nutritious foods.

We spoke with the staff member responsible for the serving of meals on the day of our visit. They confirmed they had information about special diets and personal preferences. They told us this information was updated if somebody's dietary needs changed.

The registered manager had made improvements to the dining area to make it a pleasant place for people to eat. There were table cloths on tables and flowers in vases made by the people who lived at the home, flooring had been replaced and pictures had been placed upon walls.

We observed meals being provided at lunch and dinner whilst at the home. Observations showed that support over meal times was mixed. On one occasion we observed one staff member sitting down with one individual and providing quality time to support them over lunch. The staff member showed patience and understanding when the person refused to eat. The staff member tried a variety of foods to try and entice the person to eat. They sat with the person throughout the whole meal time and at the end of the meal, supported the person to wipe their face.

We also observed some poor interactions which demonstrated that supervision and assistance was not always available at meal times for people who asked for help. At lunch time we observed one person asking for assistance to eat their meal. A member of staff started to

support the person with their meal but then left the person on their own. The person did not finish the meal. Another member of staff then came along and took their plate away without asking if they had finished or if they required any assistance. Another person was awaiting a dessert; a member of staff came along and placed an empty bowl on the table whilst they attended to someone else. A member of staff then assumed that this person had already eaten their dessert.

We observed three people's dignity being compromised at lunch time. One person was struggling to eat their lunch and without assistance they were spilling food down themselves. This person resorted to using their fingers to eat the food. We also observed another two people who were struggling to eat their meals without assistance. We spoke to a staff member who confirmed that they did not use any specialist aids and adaptations to promote people's independence and dignity when eating. The staff member said that they had tried them once but had not worked. There was no further evidence that other avenues have been explored.

We asked a staff member, how they knew which person had eaten and who had not. They told us that they "couldn't be sure," who had eaten. This meant that staff could not always accurately monitor people's food and fluid intakes.

We looked at people's care records. The registered manager did not have any nutrition or hydration screening tools in place. Weight charts were completed for each person to see if any people had weight changes. Records showed us that people were weighed monthly and if there were any concerns, people were referred to health agencies for further assistance. On one occasion there was evidence that following a referral to a dietician one person had gained weight and consequently had been discharged by the dietician. This confirmed procedures were in place for this person to reduce the risk of poor nutrition and dehydration.

Although we observed people being offered hot drinks throughout the day we failed to see people being offered any cold drinks despite the weather being hot.

We recommend that the provider consults and implements best practice guidelines in relation to dementia care.

We recommend that the provider consults with and implements best practice guidelines in relation to falls prevention.

Requires improvement

Is the service caring?

Our findings

Two people who lived at the home and the relatives we spoke with thought that staff were caring. One relative said, "The staff are very kind to [relative]."

Staff spoke fondly and knowledgeably about the people they cared for. They showed a good understanding of the individual's and their support needs.

Although we received positive feedback about the attitude of staff, we observed inconsistencies in the way that staff responded and interacted with people who lived at the home.

Staff showed pride in the home and were dedicated in making the home a pleasant environment for people to live. On the day of inspection the staff were using crushed lavender to promote a relaxing smell throughout the home and with limited resources the registered manager was making improvements around the home to make it aesthetically pleasing. Staff had brought in ornaments and artefacts to make the home warm and welcoming.

We observed some positive interactions from staff members. On one occasion we observed one person who appeared upset. We observed a staff member sat with this person, singing to them in a calm manner and stroking the person's hand. This showed us that this member of staff was compassionate and caring. Some staff showed a genuine concern for people who lived at the home and this was demonstrated when they spoke with us. One staff member said, "I enjoy working here, it's like a little family, you get attached to them [the people who lived at the service.]"

We also observed some poor interactions. We observed one staff member supporting a person to walk to the dining room for their lunch. The person was walking slowly but the staff member was talking brusquely, telling them to walk faster. This showed us that staff did not always demonstrate patience, compassion and empathy.

Relatives informed us that they could visit whenever they wished and that there were no restrictions. One relative said, "We can come whenever we want but we prefer to come in the morning. We can then take my [relative] out for a drive if the weather is good." We observed one person going out for the day with a relative.

The home had several lounges for people to use when they had visitors. Staff respected people's privacy when visitors were present. We observed staff making room available for people to meet with their visitors in private. We also observed staff knocking on bedroom doors before entering.

Respecting people's dignity was not consistently applied by all staff. Although we saw good examples of dignity being protected we also witnessed incidents where people's dignity was maintained. On two occasions we observed two people sitting in the lounge wearing skirts. The skirts had raised up which meant that the people were displaying bare skin; staff did not address this and did not support the people to retain their dignity. We pointed this out to the registered manager and they said, "There is not much you can do," (to protect their dignity.)

The registered manager informed us that people who could communicate were asked informally on an individual basis if they were happy with the service. For those who could not communicate the registered manager encouraged family members to have a say about the service and how it affected the people who lived at the home. Relatives confirmed that this occurred.

We saw minutes of meetings and agendas for family meetings. The registered manager held family meetings where families were encouraged to participate in decision making. Despite their being a low turnout at these meetings the registered manager showed commitment to ensuring that these meetings took place.

We spoke with one relative who informed us that they were always kept up to date and involved in decision making processes for her relative. The registered manager was aware of advocacy services but said that no one was using one at the moment.

Requires improvement

Is the service responsive?

Our findings

One relative told us, "My [relative] could not be in a better place, it is spot on. They have really looked after him and have got him mobile again."

Although we were told that people's needs were met we found that people did not always receive consistent, personalised care and treatment.

Care plan records showed that people's preferences and choices were acknowledged before services commenced for people. There was some evidence of family input into care pare plans before people were admitted. Although people's preferences and wishes were addressed prior to admission and were documented in the persons care plan, these preferences were not always met by the provider. Care plan assessments asked people about sleeping patterns and the times at which they like to go to bed.

Not all people had a completed life history within their care records. We found two files where people's life histories had not been completed. Life histories are important aspects of a person's care plan as they give staff awareness of what has happened in people's lives and how past experiences have shaped the person into who they are today.

Information stored within people's care plans was not clear and easy to locate. The provider did not have one comprehensive filing system in place. This meant that information was difficult to find and varied according to each person.

Four of the five care plan files we looked at had incomplete documentation. One person who moved into the home six months prior to the inspection had missing information relating to their health care needs. Their past medical history had not been completed along with risk assessments for pressure care and falls. The provider had received a discharge care plan from another health care provider addressing these issues but these had not been acted upon and documented into the persons care plan notes.

Although the provider had risk assessments in place these were also not completed correctly to enable risks to be monitored. We found risk assessments that were not dated or fully completed. We found one falls risk assessment form had been completed but the person had not been given a total score which would have determined what care the person required. We also found another pre-assessment had been completed and the person had been allocated a score but there was no corresponding information which informed people how the score influenced care provision. Risk assessments did not routinely inform care plan actions.

We looked at daily care records for people who lived at the home to look at the quality of information recorded for each person. We found that care notes were not completed by each shift. We spoke with the registered manager about this and we were informed that night staff do not complete reports as people are asleep. Night staff would only complete a report if something was untoward. We also found that during the day there was sometimes only one entry, despite two teams being on shift. Notes were not person centred and were not always comprehensive. Comprehensive notes are important to ensure continuity of care for people. Poor record keeping also contributes to poor communications.

We spoke with the registered manager about the quality of the paperwork and they stated that they were aware paperwork was not always up to date; They said that they had previously expressed concerns to the provider that seniors did not have the time to complete paperwork. Lack of information in care plans and risk assessments can result in poor outcomes for people as health needs are not adequately addressed and managed.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Good Governance because the registered manager had failed to ensure that records were kept up to date and accurate.

On the day of inspection we noted that there was a lack of appropriate activities offered throughout the day as a means to occupy people. People were sat in the communal lounge, mainly asleep. There was no activities plan available to evidence that regular activities took place. We spoke with the registered manager who informed us that a drama production company were due to visit that day but had not turned up.

The registered manager said that the home often put on activities such as dominoes and colouring for people but said that these activities were sometimes limited due to staff not having the time to carry out activities. The registered manager said that they were committed to providing activities for people and told us that one person

Requires improvement

Is the service responsive?

is planning to come in voluntary to carry out a craft session one afternoon a week. The registered manager said that plans were also in place for one staff member to start completing an activities session one afternoon per week.

There was no evidence of any dementia friendly activities taking place on the days we inspected but we were told by one relative that the registered manager was trying hard to get their loved one to make a memory box. We also observed arts and crafts that had been completed by people who lived at the home. The registered manager said that they were in the process of buying new musical instruments so that they could facilitate some music sessions. We also saw evidence that a musician visited the home regularly to entertain the people who lived at the home.

People we spoke with said that their religious needs were not met by the provider. Two relatives were not aware of any churches or religious organisations visiting the home.

People were enabled to maintain relationships with their friends and family members. Throughout the day there were a number of friends and family members who visited their relatives. They told us they were always made welcome at the home. One family member said, "We are always welcomed and offered a cup of tea."

On the day of inspection, all the people we spoke with said that they had no complaints about the care. One person who lived at the home said, "I have no need to complain." One relative said, "I have never had to complain but I know how to if necessary, I would go to the manager."

We noted that the registered manager had updated their complaints policy and had displayed the new policy in the entrance for people to see. The registered manager informed us that they had now started recording low level complaints also and audited the complaints log monthly before all complaints were transferred to their sister home to be electronically stored.

We recommend that the provider consults with best practice guidelines in order to promote and increase appropriate activities for people living with dementia.

Requires improvement

Is the service well-led?

Our findings

The provider had a registered manager in place. The registered manager had worked at the home for a significant number of years and was well established. At the previous inspection, the registered manager agreed to inform the CQC of all incidents of safeguarding concerns. The Care Quality Commission places a statutory responsibility on a registered manager to inform CQC of all safeguarding concerns, serious injuries and deaths that occur within the registered location However, at this inspection we found evidence to show that the registered manager had continued to fail in reporting incidents to the CQC. Care records identified three incidents where people who lived at the home had had disagreements between themselves leading to physical altercation. We also found a further two instances of serious injuries that were not reported, as well as a death of a person who lived at the home.

Although the registered manager had systems in place for managing situations within the home, we noted that they were not always followed. This meant that risks to people who lived at the home were not always identified and managed in line with the provider's policies. We found policies in place for safeguarding vulnerable adults, training and mental capacity were not consistently applied by the registered manager.

We spoke with the registered manager to ascertain whether or not care plan audits took place. We were informed that care plan audits took place monthly. This was evidenced in people's files. However it was difficult to see the effectiveness of these audits as they had failed to identify the concerns we found at inspection in relation to missing, incomplete and inaccurate paperwork

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the registered manager had not ensured that they had maintained accurate, complete and contemporaneous paperwork relating to people who lived at the home.

Staff turnover at the home was low. Many of the staff we spoke with had worked at the home for five years or more. However due to the structuring of the management system, staff told us they were unclear who was in charge and when. The rota's showed that seniors were in place for four and a half days per week. This meant that the majority of time the seniors were in charge. The registered manager said however that she was on call outside of her working hours.

Although senior staff had been recruited there were no systems in place which designated one senior to be in charge when the registered manager was absent. Three staff informed us that they did not know who was in charge when the registered manager was not there. This meant that there were no clear lines of accountability when the registered manager was absent. Communication was also impaired because of the lack of accountability as there was not one specific person accountable for keeping the registered manager informed of all incidents in their absence.

We discussed the working culture and atmosphere within the home with staff. We received mixed information about this. Some staff said that there was a closed culture within the home in which they were not encouraged to participate in making recommendations. One person said that they had raised concerns with the registered manager about staff conduct but felt that it was not treated appropriately. Following this experience the staff member said that they would be reluctant to raise concerns again.

Other staff members praised the registered manager and described them as "approachable." Another staff member said that they did feel like they could contribute to decision making and described the home as "Not a bad place to work." Another member of staff said that the registered manager had an open door policy and said that they could speak with the registered manager whenever they had problems.

All staff said that the morale between the team was low and that this was caused by the restructure of staffing within the home, the confusion about staff roles and responsibilities and lack of recognition from the provider.

Staff said that team meetings didn't occur as frequently as they should and that when they did occur staff were not actively encouraged to contribute to the agenda beforehand or prepare for the meeting. Lack of team meetings may hinder staff and service development. This demonstrated that at times management was reactive, rather than proactive.

Information relating to the organisation of the home was difficult for the registered manager to locate as information

Requires improvement

Is the service well-led?

was stored centrally at the sister home. The registered manager said that the home did not have access to an internet. This sometimes inhibited their performance as they had to rely on a fax or staff at the other home offering support. This demonstrated that support and resources required to run the home were not always available to the registered manager to complete their role effectively. This was backed up by one member of staff who said, "the registered manager needs more support to carry out their role."

The registered manager informed us that quality audits took place on a regular basis. Quality audits were undertaken by a manager from the sister home on a monthly basis. We found that all audits were up to date.

The registered manager also sent out questionnaires to relatives on a quarterly basis to ensure that people were happy with the service being delivered. The registered manager said that comments on these forms would be used to improve service delivery. Feedback from surveys was good with relatives praising the service and the staff.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had failed to ensure that medicines were appropriately managed** 12 (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The provider had failed to adequately maintain the premises to ensure that they were safe.** 15 (c) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **the registered manager had failed to ensure that systems or processes were established and operated effectively to ensure compliance.** 17 (1) **The registered manager had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on the regulated activity.** 17 (2) (a) **The registered manager had failed to assess, monitor and mitigate risks relating to the health, safety and welfare of people using the service.** 17 (2) (b)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	The registered manager had failed to ensure that an accurate and complete record was maintained for all people using the service in relation to care and treatment provided. 17 (2) (c)
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The health, safety and welfare of people using the service were not promoted as staffing levels or deployment did reflect individual need. 18 (1) People were not protected against inappropriate or ineffective care as the provider had failed to implement and carry out effective systems to support workers, to enable them to deliver care and treatment to people at an appropriate standard. Staff had not received appropriate training or professional development. 18 (2) (a) (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.