Bondcare (London) Limited

Derwent Lodge Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 21 November 2017 and was unannounced. This was the first inspection of the service since the current provider, Bondcare (London) Limited, became the registered owner on 4 October 2017. Previous to this the service was registered with and managed by another organisation.

Derwent Lodge Care Centre is a care home with nursing for up to 62 people. The service offers support to older and younger people with nursing needs, including people with physical disabilities. Some people were living with the experience of dementia. At the time of our inspection 32 people were living at the service. Four people were younger adults who had a physical disability. There are three floors where accommodation can be provided. However, at the time of our inspection only the ground and first floor were being used.

There was a registered manager in post. However, this person was a regional support manager and did not work full time at the service. The provider had recruited a new manager for the service who started work there three weeks before our inspection. They told us that they were in the process of applying to become the registered manager. They told us that once they were registered the regional manager would cease to be registered for the service. 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 and associated Regulations about how the service is run.

People were not always supported in a way which met their needs and reflected their preferences. In particular, their social, emotional and leisure needs were not being met. People had limited variation in their lives and were not supported to pursue individual interests. For example, we observed people spent their day in their rooms or communal rooms either asleep or sitting with no activity. Records for these people showed that this was the same each day.

Information about how people's personal care needs were met indicated that they did not have access to the care and support they needed. For example, we saw that people frequently refused to have their teeth brushed and no action had been taken in respect of this. Records also indicated that people regularly had no support to change continence pads for up to eight hours. Representatives of the provider told us they thought this was a record keeping issue. However, the provider's own governance systems had failed to identify this.

The staff did not always treat people in a kind or respectful way. There were instances where staff talked unkindly about people. The staff tended to focus on the tasks they were performing rather than the person who they were caring for. For example, we witnessed an incident where one member of staff who was supporting a person with a drink handed the cup to another member of staff and said, ''I am going on my break now.''

Some of the staff had poor English language skills and could not understand each other, the people who they were caring for or others who spoke with them. We witnessed a situation which required the immediate attention of a nurse. However, neither a care worker nor the nurse we spoke with understood what we were telling them. Therefore there was a risk that these staff would not be able to understand important information in an emergency situation. Their interactions with the people who they cared for were limited and people could not make them understand their needs.

The provider was not always working within the principles of the Mental Capacity Act 2005 because they had not always ensured that people had consented to decisions or that these were being made in their best interests.

The provider's governance systems had failed to fully identify and mitigate risks or make sufficient improvements. The provider had made improvements to the service, but these had not made sure people received personalised care which met their needs and respected their preferences. The provider's representatives told us that records of care were inaccurately completed, yet no action had been taken to rectify these.

We found breaches of five of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

People lived in a suitable environment. However, there was limited information available about the service to help people orientate themselves or plan their time. For example, menus were not on display and advertised activities were inaccurate. The environment did not reflect current best practice guidelines about dementia friendly environments. We have made a recommendation in respect of this.

People using the service told us they felt safe at the service and they liked the staff, although some people told us they felt the staff did not take time to speak with them. They received their medicines as prescribed and in a safe way, although some of the staff practices meant that there was a risk this would not always be the case. The environment was clean and there were procedures for controlling the spread if infection but the staff were unsure about some of these and therefore there was a risk that they may not follow the correct procedures.

The risks to people's wellbeing and safety had been assessed and planned for. The staff had a good understanding about how to support people to move around the home. There were appropriate procedures for safeguarding people from abuse.

The provider had assessed people's capacity to make decisions and made applications for lawful authorisation of any restrictions.

People were given the support they needed to lead healthy lives. The staff worked closely with other healthcare professionals and sought their advice when needed. They monitored people's health and responded appropriately to changes in this. People were able to make choices from a range of nutritious food and drink. The staff ensured that people maintained a stable weight and made referrals to appropriate professionals when people were considered at nutritional risk. People had access to ample amounts of fluids and the staff encouraged people to drink.

Some of the staff were polite and caring. They knew people's needs and, most of the time, they respected choices that people expressed.

People knew how to make a complaint and felt confident raising concerns.

People being cared for at the end of their lives were given the care and support they needed. There was clear information about their needs and wishes and the staff worked with other professionals to support people at this time.

The provider had undertaken a number of audits of the service and had worked closely with commissioners to identify where improvements were needed. They had started to make improvements at the service. The provider's representatives told us there had been improvements in staff recruitment, staff interactions with the people who they supported, record keeping and the overall quality of the service. When we discussed our findings at the end of the inspection visit, the manager and provider's representatives told us about some of the plans they had for addressing the issues we identified. The provider had agreed a voluntary embargo on admissions to the home until they felt significant improvements had been made.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

Some of the practices staff followed when administering medicines created a risk that things could go wrong. Although people had received their medicines as prescribed.

The staff indicated that some practices were not in line with procedures for the prevention and control of infection.

The risks to people's wellbeing had been assessed and planned for.

There were enough staff to keep people safe.

The provider learnt from incidents and made sure that improvements were made as a result of these.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The provider did not make sure all the staff had the appropriate skills to deliver effective care because some staff did not have good English language skills

The layout and design of the environment did not always enable orientation, meet best practice guidance or provide the information people needed.

The provider was not always acting according to the principles of the Mental Capacity Act 2005.

The staff worked closely with other professionals and organisations to help meet people's needs and support them with their health.

People's nutrition and hydration needs were being met.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

The provider did not ensure that people were always treated with kindness, respect and compassion, and that they are given emotional support when needed.

People were able to make choices about their care when they had the capacity to express these.

People told us they felt the staff were kind, caring and respected their privacy. Although we found that this was not always the case.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People did not always receive personalised care that was responsive to their needs.

People's concerns and complaints were listened and responded to and used to improve the quality of care.

People were given the care and support they needed at the end of their lives.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

The provider had failed to identify, monitor and mitigate risks of people receiving unsafe and inappropriate care.

The provider had started to make improvements at the service and was working with other organisations to make sure these were appropriate and met the needs of the people who lived there.

Derwent Lodge Care Centre

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 21 November 2017 and was unannounced.

The inspection was conducted by two inspectors, a pharmacy inspector, a nurse specialist advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service

Before the inspection visit we looked at all the information we held about the service. This included information sent to us by the provider as part of their registration and notifications of significant events and safeguarding alerts.

During the inspection we spoke with nine people who used the service, four visiting relatives and friends, the manager and other staff on duty who included, care assistants, senior care assistants, nurses, the chef and domestic staff. At the end of the inspection we gave feedback to the manager and two senior managers who worked for Bondcare (London) Limited.

We observed how people were being cared for and supported. Our observations included using the Short Observational Framework for Inspection (SOFI) during the morning. SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us.

We looked at the care records for 15 people who used the service. We also looked at the records of staff training and support and other records used by the provider for managing the service, which included records of complaints, accidents and incidents, quality monitoring checks and action plans. We viewed the environment and records relating to checks on this and equipment used. We looked at how medicines were stored, administered and recorded.

Requires Improvement

Is the service safe?

Our findings

People who used the service and their relatives told us they felt safe there. One person said, ''This place has saved my life.'' Another person commented, ''I feel safe. I don't have any worries about that. I suppose it's the staff that make me feel safe.'' People told us the staff were available when needed and that they were gentle and kind.

The nurses on each floor were responsible for administering medicines. Both nurses wore tabards identifying they were in the process of administering medicines and stating they should not be disturbed. However, we noted that one nurse carried a telephone with them, which they frequently answered during the medicines round. They also attended to other tasks and were regularly disturbed. This meant that there was a risk they would make a mistake. We also noted that the morning medicines round took them three hours to complete, meaning that some people did not receive their morning medicines until 11.45am. This meant that there was a risk that the length of time between different doses was not consistent or always correct.

At one point during the medicines round a nurse placed the keys to the medicines trolley on top of the trolley and left the area to go into another room behind a closed door. There was a risk that these keys could be picked up and mislaid by someone or used for unauthorised access to the trolley. In addition one nurse did not always sign the medicines administration records straight after they had administered these. They told us that they ''Wait to sign all of the charts at the end of the round.'' This practice did not follow the provider's procedure regarding the administration of medicines and increased the risk of mistakes in the records.

We discussed the above observations with the manager who acknowledged that there had been breaches of the procedure which caused potential risks. They agreed to investigate these and take action to prevent repeat occurrences.

People received their medicines as prescribed. The staff responsible for administering medicines had been trained and their competency had been assessed. We observed staff administering medicines. They did this appropriately, giving people information they needed and allowing them to take their time. They checked whether the person was in pain and responded appropriately.

Medicines were stored securely and at appropriate temperatures. The staff regularly checked the storage areas and recorded this. There was clear information regarding each person's medicines needs, including information about their allergies. There were protocols describing the circumstances when PRN (as required) medicines should be administered and the staff demonstrated a good understanding of these. There were also individual guidelines regarding how people expressed pain and when pain relief may be required. Records of administration had been completed accurately and any deviation from the prescribed administration had been recorded.

There was evidence that people had their medicines needs regularly reviewed. The staff recorded consultation with healthcare professionals regarding medicines. The staff carried out the correct monitoring for all medicines where this was required.

The provider carried out their own audits of medicines management. These were up to date. Where areas for improvement were identified action had been taken. The supplying pharmacist had also audited the service twice in 2017 and we saw that the provider had acted on their recommendations and made the required improvements.

The domestic and care staff who we spoke with indicated that the procedures for preventing and controlling infection were not always clear or followed. For example, one member of the housekeeping staff told us that they had been advised to use the same mops for cleaning bedroom floors and toilet floors. They told us that they did not think this was good practice but that this is what they had been told. We spoke with some of the care staff about the cleaning schedule for slings (used with hoists). They told us that there was no cleaning schedule and that slings were cleaned if they became ''smelly.'' We told the manager about these discussions and they agreed to look into the practice around these areas and make sure procedures were being followed to minimise the spread of infections and to keep equipment clean.

People told us that the service was clean and fresh. We observed this to be the case on the day of the inspection. Unpleasant odours were attended to promptly. We saw staff cleaning the service throughout the day. The staff wore appropriate personal protective clothing (such as aprons and gloves) when providing care and when cleaning. They disposed of these appropriately. Cleaning products were stored securely. The staff told us they had received training in the prevention and control of infections. Bathrooms and toilets were equipped with soap and paper towels. Anti-bacterial gels were strategically placed in communal spaces and corridors.

We found that a small number cords for call bells in toilets and bathrooms had been tied so that they did not reach down to the floor. This meant that there was a risk that if a person fell to the floor they would not be able to reach them. The call bell in one person's room had been placed beyond their reach. The person had the capacity to use the bell in an emergency. However, the majority of call bells were positioned appropriately so that they could be reached by people in needs. There were risk assessments and plans for people who did not have the capacity to use call bells. These included the frequency of checks by staff to make sure the person was safe.

The manager told us that when Bondcare (London) Limited had started managing the service they had found that a number of contracts with other organisations regarding maintenance and the environment had ceased and they were in the process of reviewing these arrangements. They told us that they had carried out an audit of the environment to make sure it was safe and were continuing to review the health and safety arrangements of the building.

There were individual personal emergency evacuation plans for each person. These described their needs and the support they required in event of an emergency evacuation. These had been reviewed in July 2017 and were available for the staff working on each floor to access along with the fire procedure for that floor.

The risks to people's wellbeing had been assessed and planned for. The staff had created individual risk assessments for each person where risks associated with mobility, skin integrity, nutrition, falls, allergies, continence, medicines, and mental and physical wellbeing. The plans included actions for the staff to help prevent the risks of harm to the individual. The risk assessments linked into care plans.

The staff demonstrated a good awareness about how to move people safely. We observed how people were supported to move around the home. The staff supported people appropriately, taking their time and considering whether the person was safe and pain free. The staff told us they had received regular training in this area. We saw that equipment, including as hoists, profiling beds, air mattresses, was in good working order and had been regularly serviced. Care files included a quick reference summary of the equipment each person needed.

Some people were at risk of choking. There was clear information about the safe and appropriate consistency of food and drink for these people. The staff followed guidance to ensure people received the correct consistency. When the staff supported people to eat and drink they did not rush people and they made sure people were seated in a suitable position to reduce the risk of choking.

There was clear information about the risk of falling for each person. The staff were able to explain how they supported people to reduce the risk of falls. Following a fall or accident the staff had reassessed the risks for that person and consulted with other professionals to make sure the person was receiving the best support to meet their needs.

The provider had procedures for safeguarding people from abuse and whistle blowing. Information about these was available for the staff and they had received training in this. The provider had responded appropriately to allegations of abuse by taking action to protect the person and by working with the local safeguarding authority to investigate the concerns. There were records to show what action had been taken to reduce the risk of further harm.

There were enough staff employed to keep people safe. The service was not fully occupied and the provider was not accepting admissions at the time of the inspection. The manager told us that staffing levels would be increased when new people started to move to the service. People living at the service and their relatives told us they thought there was enough staff. They said that the staff were busy and ''rushed about'' but they felt people's needs were being met.

The provider had successfully recruited to all the nursing positions in the service which meant they could provide a continuity of nursing care. The manager told us that there were about three care worker vacancies and they were in the process of recruiting for these. They said that they had reduced reliance on agency (temporary) staff and the majority of work was provided by their own staff. There were vacancies for activities coordinators and maintenance workers. The manager told us that staff from the neighbouring care home (also run by the provider) were helping cover these vacancies until successful recruitment. The manager confirmed they had recruited a physiotherapist who would work full time at the service to support the nurses and care workers in meeting people's needs. This person was due to start work shortly after our inspection.

The provider had systems for learning from incidents. All incidents and accidents were recorded. The records included evidence of action taken at the time and any further action required. The manager was able to describe how a recent incident had led the provider to review the equipment used in one person's room. They had purchased additional equipment which sensed movement in the room and alerted the staff to this, to help prevent the risk of falls. As part of the learning from this incident the provider had started to assess the needs of other people and had purchased these sensors for others where needed. In another example the provider had agreed to share the recommendation of a safeguarding investigation with their other services to ensure all services were following best practice. The staff took part in daily meetings to discuss any incidents and how they should respond to these. The provider shared updates on national good practice guidance and alerts with the staff so that they could learn from incidents outside of the home.

Requires Improvement

Is the service effective?

Our findings

The provider did not make sure all the staff had the appropriate skills to deliver effective care because some staff did not have good English language skills. This meant that they could not always understand the people who they were caring for, other staff or instructions. During the inspection we witnessed an incident where a person's oxygen supply had been dislodged. We explained this to a care worker who did not understand what we were telling them. We also explained this to the nurse who did not understand us. The care workers told us that they relied on the nurses to tell them about people's needs and how they should meet these. However, one care worker told us that one of the nurses on duty could not speak English. We observed that some staff did not interact or communicate with the people who they were caring for and some did not answer or respond appropriately when people spoke with them.

We spoke with individual staff about some key procedures in the home, including safeguarding people and the Mental Capacity Act 2005. The provider's records showed that the staff had received training in these areas. Some of the staff could not understand what we were asking them.. Their answers indicated that they had misunderstood both us and the training they had received in these areas. This represented a risk to people's welfare and safety as they may not be able understand or communicate effectively if someone was unwell, distressed or needing assistance. There was no evidence that the provider had assessed the competencies of the staff to make sure they understood and communicated effectively in English. We discussed this with the manager and the provider's representatives.

The staff told us that the majority of training they had undertaken was on line. Some staff said that they did not like this because there was no one to ask questions of or check the meaning of something they did not understand. There was no evidence the provider had tested individual staff competency or knowledge following the training and therefore they could not assure themselves that the staff had fully understood the information provided in the training.

The staff told us that they did not have regular individual meetings with their manager and they had not had their work appraised. Two members of staff who had been in post for over a year told us they had never had a review or appraisal of their work and had never been invited to attend an individual supervision meeting to discuss their work. Therefore they had not had opportunities for a formal review of their work and any needs they had. The provider did not have a record of the formal assessment of the skills and competencies of these staff.

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

The manager told us that they were in the process of arranging individual supervision meetings with all staff. They told us they had met with four members of senior staff before our inspection and were aiming to meet with all the staff shortly afterwards.

The provider had a record of the training all the staff had undertaken with the previous provider. They told

us they were in the process of inviting the staff to renew their training using their systems and training providers. During the feedback at the end of the inspection we discussed this with the manager and the representatives of the provider. Their plan for training was in line with good practice guidance and with the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty 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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The staff had undertaken assessments of people's capacity and recorded these. However, the information for one person was inconsistent, stating in one document that they had capacity, and in others that they did not. A record of a decision not to attempt to maintain the person's life in the event that their heart stopped, a Do Not Attempt Resuscitation (DNAR) decision, for this person stated they had capacity but had not been involved with this decision. The records indicated that the person's representatives had not been consulted about this decision either. This meant that the decision had only been made by professionals and did not include the person or their representatives and may have been against their wishes or what they considered in their best interests.

A number of people had their medicines administered covertly (without their knowledge). This practice had been agreed by a multidisciplinary team with reasons for the decision recorded. However, we noted that the person's family or other representatives had not been asked for their views. Therefore the provider had not ensured that all aspects of the person's best interests had been considered when making this decision.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

With the exception of these examples, we saw that people and their representatives had been consulted about decisions with regards to people's care. Where people lacked capacity the provider had made applications to the local authority for DOLs authorisations. The manager showed us they maintained a record of when applications had been made, authorised and when they were due for renewal. This meant they could make sure they had legal authorisation for any restrictions placed on people.

The staff had undertaken assessments of people's care needs in line with current legislation, standards and evidence based guidance. People and their families had been involved in discussions when the assessments were being made. Their choices and preferences were recorded within these assessments. The provider employed nurses who carried out assessments each month reviewing people's current needs and any changes to their health status, weight, nutritional intake and care needs. The assessments were clearly recorded and the staff used risk rating scales to determine whether changes to the care plans were needed. We saw that the staff had responded appropriately to changes by updating care plans, contacting other care professionals when needed and discussing the changes with all the staff involved in the person's care.

Some of the people who lived at the service had dementia. The layout and design of the building did not fully meet the recommendations of best practice guidance about environments for people living with

dementia. For example, some of the walls were painted in bright colours but there was limited information to help orientate people to find their way around the building. Bedroom doors were labelled with a picture of the person and their name, but there were no other features to help people to locate their rooms. Doors to bathrooms and toilets were labelled to help people to identify these.

Some people had personalised their bedrooms with their own belongings and furniture. Other rooms were brightly decorated and the furniture was generally clean and in good condition. The provider had recently purchased new chairs for the communal rooms. There was a well-equipped activity room and sensory room which had been left open so people could access these, although they were not encouraged or supported to. Good practice guidelines about environments for people living with dementia refer to interactive features in the environment and items which people can use, engage with or look at. These types of features were limited at the service.

Information for people was limited. For example there was a notice board advertising activities, but this did not accurately record the activities which were organised on the day of the inspection. There was a notice board showing the date, weather and season but no other information such as menus, information about the home or information about other services people may wish to access. Some people who we spoke with told us they would like more information available which they could access when they needed.

The corridors and communal rooms were free from hazards and there was ample space for people to move around the home. There was a lift to enable people to transfer between floors.

We recommend the provider consult recognised good practice guidance for improving the environment to help orientate and support people living with the experience of dementia.

The staff at the service worked effectively with other organisations to make referrals when people's needs changed and to make sure people received the right care and treatment. There were regular visits by the GP to the service and the staff kept a record of any information they wanted to share and had shared with the GP about people's conditions or needs. There was evidence that the staff had worked with external professionals including the palliative care teams, tissue viability nurses, speech and language therapists and dietitians to assess people's needs and plan individual care and treatment. Contact with other professionals was recorded. Advice and guidance from other professionals had been included into care plans.

People using the service told us that they were able to see healthcare professionals when they needed. One person said, ''We have regular visits from dentists and the optician. The district nurse comes to me twice or three times a week.'' Another person commented, ''I can have a doctor if I need one; staff can look after things most of the time.''

People's healthcare needs were recorded within their care plans. The staff monitored people's wellbeing and vital signs regularly and recorded changes in their conditions. The staff had responded appropriately when people became ill. For example, they had contacted GPs and/or other healthcare professionals to inform them about changes to someone's health. They had been timely in requesting medicines for people who were ill. We saw details of a recent incident where a person had experienced a seizure. The staff action showed that they had followed the guidelines for this type of incident and had worked with other professionals to make sure the person was safe. Some of the people living at the service had a history of drug and alcohol dependency. The staff had successfully worked closely with other professionals to give these people the support they needed to recover from their addictions.

The people who we spoke with had mixed views about the food at the service, although they mostly thought

it was good. There was an appropriate menu offering people choices at mealtimes. Meals were freshly prepared at the service by catering staff. The systems in the kitchen were well organised and ensured that food storage areas were clean and appropriately maintained. The chef told us they knew people's needs and whether they had any special dietary requirements. However, they did not have written information about this within the kitchen, apart from a record who people who were on fortified diets, therefore there was a risk that temporary catering staff would not have the information to hand.

People's nutritional needs had been assessed and care plans included information about dietary needs and any nutritional risks. There was evidence the staff had made referrals for healthcare professional input when people had been assessed as at risk. Throughout the day we saw the staff offered people fluids and recorded their fluid intake. People were offered a range of different hot and cold drinks, as well as fruit. We looked at the care records of some people who were considered at risk of dehydration. The records indicated that they were offered regular fluids, however not all records included a daily target amount, therefore the staff could not assess whether they were meeting this target or not.

During lunch service on the day of the inspection some people were offered a choice of food, although the staff did this verbally rather than by showing people the choices. The staff did not always explain what the meal options were other than repeating the name of the dish; for example, they asked people if they wanted ''Chicken pie'' or ''Mince.'' Therefore people who had limited understanding or auditory processing needs may not have the information they needed to make an informed choice. Other people were not offered a choice of meals and were just given a meal ready plated by the staff.

Snacks outside of mealtime were available at certain times of the day and if people asked for them. We saw a record showing that sandwiches and a hot drink were offered during the evening to people who wanted these.

Requires Improvement

Is the service caring?

Our findings

People who used the service told us that the staff were kind, although many of them commented that the staff did not have time to listen to them or stop and talk. One person said that the staff had a good sense of humour and they liked this.

However, we found that the provider did not ensure that people were always treated with kindness, respect or compassion. Throughout our visit we saw examples of the staff treating people disrespectfully. At one point a member of staff was supporting someone to have a drink. The person was unable to hold the cup themselves. Whilst the person was between mouthfuls the member of staff handed the cup to another member of staff and walked out of the room stating, ''I am going on my break now.'' They did not talk with the person they were supporting. In another example, the staff wanted to support one person to leave the room. In order to do this they moved another person who was seated in a wheelchair without warning the person, asking their permission or having any interaction with the person before or after this.

We witnessed occasions, where the staff spoke inappropriately to people or in a disjointed way which did not make sense to the individual. For example, one member of staff walked into a lounge where a person was sleeping. They said loudly, ''Wakey wakey [person]'' and then walked away. A short time later they returned and said, ''Alright there sleepy, you had a good nights' sleep last night, why are you tired now?'' They did not have any other interaction with this person at this time and left the room straight after saying this. At another time a member of staff asked a person, ''What is the matter with you?'' They did not do this in a comforting way, or in a caring tone. They stood next to the person, made their comment and then walked away before the person had an opportunity to respond. In a third similar incident a member of staff asked a person, ''Are you playing up today?''

We heard the staff asking people questions about their wellbeing and not waiting for an answer or responding to the person's answer. For example, the staff asked people if they were hungry or thirsty but did not wait for a response and had walked away before the person had an opportunity to respond. In one instance a member of staff asked a person, ''Do you have a headache?'' The person indicated they did. The member of staff then told the person it was lunch time and did not respond about the person's headache. We overheard a number of times when the staff walked into a room and said a person's name or ''Alright [person]?'' Then walked away or gave their attention elsewhere. In one instance a member of staff was writing records. They spoke out people's names as if checking who they were writing about. When the people concerned looked at the member of staff they did not get a response because the member of staff was concentrating on what they were writing.

We overheard the staff talking about people in front of others or sometimes loudly from a corridor when we were in an adjoining room. For example, we over heard a member of staff say about a person, ''She doesn't want to talk to me today.'' We also heard a member of staff say about a person, ''[Person] is always sleepy.''

The staff spoke with each other about supporting people and the tasks they were performing in a way which

did not show people due respect. They did this in loud voices which could be heard by the person they were speaking about and others. For example we heard conversations between staff which included, ''[Person] and [person] need feeding'', ''Let me start feeding [person] now'', ''What are we going to do with [person]?'', ''Shall I feed [person] or [person] first?'', ''Let's get the bibs out of the way then'', ''Has [person] done a mess'' and ''Who are you going for?''

The staff did not always show that they had thought about care from the person's perspective. For example, one member of staff sat next to a person and sighed as they sat down. They supported the person to eat their meal and sighed frequently during this. Another member of staff supported a person to have a drink. Their only interaction with the person was telling them to open their eyes and mouth, which they told them repeatedly. This member of staff stood next to the person and continuously tapped a spoon on the person's cup between offering them mouthfuls. We saw a number of staff using a spoon to scrap food or drinks off people's chins and reoffer this to them when they were supporting them to eat and drink.

The staff left people they were supporting to talk with other staff or attend to another task without telling the person what they were doing. When the staff finished supporting people with food they stood up and walked away without speaking with the person. Some staff also placed protective aprons on people before they ate or drank without asking their permission or consulting with them. The staff who told people what they were doing did so as they were placing the apron on the person not before. When one person spilled a drink on the floor, three members of staff stood closely around the person discussing with each other how they would clear it up. None of the staff offered the person comfort or reassurance. At one point a staff member walked into a room told a person they were going to wipe their nose, did this and left again without any other conversation.

The above evidence showed a culture of task based care where the staff did not think about how the people they were supporting would feel. We discussed this with the manager and provider's representatives who agreed that this way of supporting people was not acceptable.

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

The provider's representatives told us that they had seen examples of the staff being caring and kind. They said they had witnessed staff holding people's hands and initiating songs and dances with them. Although they told us they also recognised the staff appeared to feel that they could not sit down and spend time with people talking with them.

We saw that the staff were generally patient when providing care and allowed people to take their time when eating and drinking.

People who were able to express choices had these respected. They told us this was the case. For example one person said, 'If I don't feel like getting up, I can have breakfast in bed. The Staff don't seem to mind if I want to stay in bed.'' Another person told us, ''I can make choices about what to eat and what to wear.''

We saw that when people expressed a choice the staff supported this. For example, we saw that some people asked to be taken to different rooms and they were able to do this. Other people told the staff what they wanted to eat and drink and this was respected.

The records of care indicated that the time people rose in the morning and went to bed varied and this indicated that they were able to express a choice about this.

People told us that the care workers respected their privacy when providing care. One person said, ''Carers always shut my door when I need privacy.'' People who were able to were supported to be independent if this is what they wanted. For example, one person told us that they were encouraged to wash themselves.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive personalised care that was responsive to their needs.

Some people living at the service expressed themselves in ways that were challenging for the staff. For example, they shouted, swore or injured themselves. There were people who were anxious and agitated and showed this by shouting at others. The service was not meeting people's needs when this was the case. We witnessed a number of incidents where people shouted and became verbally and physically resistant to the care being offered. The care plans describing these needs did not always give clear information about how the staff should respond. For example, one person's care plan set out that staff should test to see if the person had an underlying physical need (such as an infection or constipation) but did not give clear guidance on how the staff should support the person at the time.

Where care plans did give guidance the staff did not follow these. For example, we saw that one person's care plan included the action that staff should respond to one person if they became agitated with a calm voice. We witnessed an incident where this person became upset. Three members of staff stood close to the person, who was seated, discussing what they should do. When they spoke with the person it was not in a calm way but in a series of quick and rapid questions, including, ''Do you want a drink?'', ''Are you cold?'', ''Shall I get you a jumper?'' and ''Do you want to go into [another room]?'' The questions were asked straight after each other by a combination of the three members of staff with no opportunity for the person to respond. As a result the person became more agitated. The staff response was to remove the person from the communal room they were in.

Later we witnessed another incident where a person was refusing the assistance of a staff member who was supporting them with a meal. The staff member and another staff member (who was supporting someone else) talked about how to respond. The person was not given any reassurance and the staff agreed that the person should be taken out of the room as they thought they were disturbing others. The person's care plan did not indicate that this was the best response to such an incident, and the action of the staff did not calm the person or support them to express how they were feeling.

The staff did not give adequate support to people who they knew could become agitated before incidents. For example, one person's care plan described how they could become agitated but that they enjoyed certain interventions and activities. During our inspection visit they were not offered these and the staff did not provide the person with anything to do or occupy themselves with. Staff interactions with the person were limited. The person became agitated and the staff spent time responding to this, however, they showed limited understanding that the right support before the incident where the person became agitated may have prevented this. In addition, they did not provide any support with activities or social interactions after the person had calmed down. Therefore the person was at risk of frustration and boredom which may have led to further incidents of agitation.

The staff did not demonstrate an understanding of people's frustration and agitation or how they could

support people so they did not experience these emotions as often. The staff told us that one person who lived at the service, ''Swears a lot so [person] stays in their room because it upsets others.'' When we spoke with the staff supporting this person they did not recognise that finding alternative ways to engage with this person may enhance the person's quality of life.

People's personal care needs were not always being met. One person told us, ''I've not had a bath or shower since I came, I've been here 18 months. [The staff] just don't care.'' Another person who had lived at the home for over a year told us they had been offered two showers in that time. One person told us that they could not hear because they could not put their own hearing aid in and the staff did not help them with this. They said, ''No one helps me.'' Another person who told us they were fairly independent explained that the staff did not offer them any assistance with personal care because they thought they could do everything for themselves. They said that they could not take a shower independently and felt they could not ask the staff to assist them with this because they were ''busy helping other people.''

We looked at a sample of records which the staff used to record the support they had given people with washing, dressing and personal hygiene. Only one of the 11 records for personal care support in November 2017 showed that the person had been offered a shower or bath. None of the 11 people were confined to bed. The records for six people indicated that they had consistently refused support to clean their teeth or with oral care. There was no record of action taken when people consistently refused personal care.

Records of care provided for four people during November 2017 indicated that continence pads were not changed on most days for up to eight hours. This meant that there was an increased risk of infection and skin breakdown as well as the person feeling uncomfortable.

People using the service told us they did not have support to meet their social, emotional and leisure needs. One person explained, ''Most of the carers are very busy, they don't have the time. I wish they could talk with me as I don't get any conversation stuck in this room. They don't care about me.'' Other comments included, ''I never see the staff they just bring me my meals and that is it'', ''I don't want to bother them so I don't ask for help and they leave me alone'', ''I'm just bored and lonely, just someone to talk to would be nice'', ''There's not much going on so I don't bother to find out'' and ''The staff don't have time to do things with us.''

One member of staff on the ground floor told us, ''All the residents are in bed so we don't have activities for them.'' Other comments from the staff included, ''We try to do activities but it is very rare'', ''The staff don't really have the time to do activities. I go and talk to them sometimes and put the TV on'' and ''We don't do anything here because we never have time.''

During our inspection visit there were limited organised activities. On the ground floor none of the staff offered support for people to pursue interests during the day. On the second floor we observed that one person spent the morning colouring, which they appeared to enjoy. A member of staff read a news article to two different people but there were no other activities during the morning. The staff placed books and a toy in front of two people, but neither person showed any interest in these and the staff did not support them to use these. Music was playing in one lounge, although people were not given a choice about this and the staff changed the music which was playing without consultation or warning. One member of staff chose a pop music station in the dining room when people ate lunch. They did not consult people about this, and none of the other staff offered an alternative.

We did not witness, but we heard, an organised activity in the afternoon which included a game and some music in one lounge.

The records of support which people received each day indicated a similar pattern of limited stimulation and variation. For example, hourly observations by the staff for six people indicated that the only activity apart from personal care or eating that anyone took part in was a one hour slot when one person was recorded to have watched television. The record for one person who was not confined to bed indicated that they had spent six hours between 11am and 6pm the day before our inspection asleep. We observed that they spent the majority of the day of our inspection asleep. Another person's records showed that they had been asleep from 10am until 5pm on one of the days during the week of our inspection. We observed that this person also spent the majority of the morning asleep on the day of our inspection along with three other people seated in the same lounge. In another lounge four people spent the majority of the morning asleep. The staff interactions with these people was limited to bringing drinks and food.

The staff visited people who spent the majority of the day in their rooms only when providing care, drinks, food or medicines. One person who was seated in a lounge asked a member of staff if they could go to bed because they were tired. The person could not get to their room independently. The member of staff told them they would ask another staff member to support them but they did not. The person waited for 20 minutes until we intervened and asked the staff to give this person the support they had requested.

The above evidence showed that the service did not effectively respond to people's needs or offer them care which met these needs and reflected their preferences.

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

People using the service and their relatives told us that they had been involved in planning their care. One person told us, ''Care plans and reviews are undertaken regularly and I know I can ask and the problem is quickly sorted out.'' We saw that care plans gave clear information about how people's physical care and healthcare needs should be met. The care plans included information about people's preferences. However, there was limited information on how people's emotional, social and leisure needs should be met. The provider was aiming to improve this and had started to introduce new care plans which included a more personalised plan based on people's interests and social needs. One visitor who we spoke with told us that they felt the service was very good and that their relative's needs were well met.

The provider had a system of reviewing people's care on a monthly basis. They had a ''resident of the day'' form which gave consideration to people's holistic needs and was designed to involve different departments at the service, such as the chef, nurses, maintenance team, activities coordinators and housekeeping staff. We found that these had not been consistently used and that the majority of reviews only considered some aspects of the person's care.

The provider had an appropriate complaints procedure which was available for people to view. People using the service and their relatives told us they knew how to make a complaint, although some people told us they did not want to ''bother'' the staff with their concerns.

The provider maintained a record which showed how complaints had been investigated and responded to.

People were given the care and support they needed at the end of their lives. Their wishes and preferences had been discussed with them in advance so that care plans could reflect these. One visitor told us that their relative had been close to death on a number of occasions and the staff had given kind support and knew how to care for the person when the time came. Another visitor we met told us their relative was receiving end of life care. They said, ''The staff have done all they can.'' A recently bereaved visitor explained how the

staff had supported their relative and them during the end of the person's life and since. They said, ''The staff have been very kind.''

We saw that care plans were in place for people receiving support at the end of their lives. There was evidence the staff had worked with other healthcare professionals, including palliative care nurses, to make sure people had a pain free and dignified death.

Requires Improvement

Is the service well-led?

Our findings

The provider had systems for identifying, monitoring and mitigating risks. However, they had not taken enough action in respect of some of these risks. For example, we identified that the staff were not always meeting people's needs and did not always treat people with respect. The staff did not always follow the provider's procedures and the governance systems had not identified or monitored this. We found that the records which showed the support people had received with their personal care indicated that they were not offered support to meet their needs. The provider's representatives told us that this was a record keeping error. We were unable to verify whether this was the case or not. However, there had been a failure of governance to either ensure people's personal care needs were being met or to ensure the staff maintained accurate and contemporaneous records in respect of each person.

We found a number of other areas where improvements were needed and which had not been identified by the provider's governance systems. For example, the staff who spoke with us about infection control indicated that the procedures to prevent the spread of infection were not being followed and we found that people's social, emotional and leisure needs were not being met. The staff administering medicines did not also follow the medicines management procedures and as a result placed people at risk.

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

People who lived at the service and their relatives had mixed views about the overall service. Some people felt that the service they had received was good. However, others felt that they did not always get the care and support they needed. They told us that they did not feel they had the opportunities to share their views about the service. For example one person told us, ''I have never been asked to attend a meeting and I don't remember being asked my opinion about anything.'' Another person said, ''I don't bother, I went to a meeting once and they didn't seem to listen to me so I won't go again.'' However, people acknowledged that there had been changes of the provider and managers of the service. They did not know whether this would make a difference yet. We saw evidence that there had been some meetings for people who used the service and their relatives. Minutes of these showed that some action had been taken following their requests, for example purchasing new furniture for the communal lounges.

The staff we spoke with were positive about the new provider. They felt that improvements had been made and further improvements would take place. Some of the comments from the staff included that they liked the new paperwork and the recruitment of new staff. They also felt that the new provider was ''stricter'' and that this was a good thing because it would improve the quality of the service.

The manager told us that they were in the process of asking people and their relatives to complete surveys about their experience. We saw a draft survey form which the manager told us would be sent out to all stakeholders shortly after our inspection.

The new provider had a clear vision of the improvements they wanted to make. The provider had a team of

senior managers and quality assurance staff who regularly visited the service to carry out their own audits and had created action plans to make the improvements they had identified. Some of the improvements had already started to take place. For example they had started to introduce new records, such as revised care plans, risk assessments and their own policies and procedures. The provider had recruited new staff and was continuing to do so. Through their initial assessments they had identified that it would be beneficial to employ a full time physiotherapist to work at the service. This member of staff was due to start work shortly after our inspection. The provider had also reviewed staff training needs and had a plan to provide the training to meet these needs.

The provider had employed a manager who had been in post for three weeks at the time of our inspection. They were in the process of applying to be registered with the Care Quality Commission. There was a clear management structure at the service, including a deputy manager and other senior members of staff. The manager told us that the provider's representatives had been very supportive. They also told us about some ideas they had for improving the service which included implementing daily ''Manager's walk-arounds'' where they completed a quick daily audit of the service. They had started to do these, and we saw the records of these. They explained that this had been a useful way of identifying where improvements were needed.

The manager told us that they regularly met with the local authority and Clinical Commissioning Group. They had involved these organisations in their discussion about improvements and had taken on board their suggestions. In addition, the provider had placed a voluntary embargo on admissions until they felt they had made the improvements that were needed.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not make sure that care and treatment of service users was appropriate, met their needs and reflected their preferences. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not ensure that service users were treated with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had not ensured that care and treatment of service users was provided with the consent of the relevant person. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

Treatment of disease, disorder or injury	The registered person did not effectively operate systems and processes to: Assess, monitor and improve the quality of the service or assess, monitor and mitigate risks to the health and safety of service users. Regulation 17(1) and (2)(a) and (b) To maintain accurate, complete and contemporaneous records in respect of each service user. Regulation 17(1) and (2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not always ensure that: Sufficient numbers of suitably qualified, competent and experienced persons were deployed to meet the regulated activity. Regulation 18(1) Persons employed received appropriate support, training, supervision and appraisal to carry out the duties they were employed to perform. Regulation 18(2)(a)