Hill Care Limited

The Laurels and The Limes Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This was an unannounced inspection which meant the staff and provider did not know we would be inspecting the service. The inspection took place on 2 November 2016.

The service was last inspected on 13 July 2015. At the last inspection we found the service was not meeting the requirements of the following regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 Safe care and treatment, Regulation 17 Good Governance and Regulation 11 Need for consent. As a response to the last inspection the registered provider sent a report to the Care Quality Commission of the action they would take to become compliant with the regulations. The registered provider told us they would complete all the action to achieve compliance by the end of 2015.

The Laurels and the Limes is a nursing home that provides care for up to 88 people. The service operates from two separate buildings on the same site in the south of Sheffield. The Limes building is purpose built. The majority of bedrooms are single and some have ensuite facilities. There are well maintained gardens and car parking is available. At the time of the inspection there were 53 people living at the service. The Laurels building is a residential unit primarily used for people living with dementia. At the time of the inspection there were 14 people living in the Laurels. The Limes building has three floors and a lower ground floor where the service's kitchen, laundry and staff rooms are based. At the time of the inspection there were 39 people living in the Limes.

There was a registered manager 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection we saw the registered provider had not ensured DoLS authorisations had been obtained for some people living at the service. We saw that sufficient improvement had been made for to achieve compliance in Regulation 11, Need for consent.

We checked that improvements had been made in the safe handling of medicines. We saw that insufficient improvement had been taken to achieve compliance. We found the service continued not have appropriate arrangements in place to manage medicines to ensure people were protected from the risks associated with medicines.

The outcome of the inspection identified the service continued to be in breach of two regulations of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014, plus a further three breaches were identified. These findings showed the registered provider's processes to monitor and improve the quality of the service were still ineffective in practice.

Although people told us they felt 'safe' and relatives spoken with felt their family member was in a safe place, we found that people were not safeguarded from the risk of harm. We saw the service had not always followed the local safeguarding protocols and made a safeguarding alert in line with the local multi agency agreement.

Staff recruitment records reviewed showed that information was not always obtained in accordance with Schedule 3. This meant we could not be confident that people were cared for by suitably qualified staff who had been assessed as safe to work with people.

At the last inspection we found that people's daily charts were not maintained to ensure they were accurate, complete and contemporaneous. We saw that insufficient action had been taken so that we could be confident that people's daily charts were completed accurately and were contemporaneous.

Most people and relatives spoken with told us the activities provided at the service could be improved to meet the needs for all the people living at the service.

At the last inspection we raised concerns regarding the lack of stimulation provided for people living in the Laurels. We found that insufficient action had been taken by the registered provider to ensure people living with dementia did not become disengaged with their surroundings.

People and relatives made positive comments about the staff and the manager at the service.

In the Limes building we observed a lot of laughter and friendly 'banter' between people and staff. We saw that people got on well with staff and that people's relatives and visitors were greeted in a friendly way.

In the Laurels building we observed the interaction between staff and people was centred on tasks. This lack of engagement between staff and people created an unstimulating atmosphere.

People spoken with were satisfied with the care they had received.

Relatives told us they were involved in their family members care planning and were satisfied with the care their family member had received.

In people's record we saw evidence of involvement from other professionals such as doctors, opticians, tissue viability nurses and speech and language practitioners.

We reviewed one person's Deprivation of Liberty Safeguards authorisation which had been granted with conditions in May 2016. These conditions are legally binding and had not been met. This showed there was a risk that people would not receive appropriate care and treatment to meet their needs.

We found that there was a risk that people's behaviour was not managed consistently and the risk to their health, welfare and safety was not managed effectively.

People's preferences and dietary needs were being met. We received mixed views regarding the quality of the food provided.

We saw the environment in the Limes dining area was not a calm and conducive atmosphere for people to eat in.

Accidents and untoward occurrences were monitored by the registered provider to ensure any trends were identified.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

We found insufficient improvements had been made since our last visit with concerns regarding the safe handling of medicines

Although people told us they felt 'safe', we found that people were not safeguarded from the risk of harm. The service was not always following the local safeguarding protocols.

Staff recruitment records reviewed showed that information was not always obtained in accordance with Schedule 3.

Is the service effective?

Requires Improvement

The service was not always effective.

We received mixed views from people and relatives regarding the food provided at the service.

At the last inspection we found the provider had not ensured DoLS authorisations had been obtained for some people living at the service, where there restrictions were in place for people. We saw that sufficient improvement had been made.

We found evidence of involvement from other health professionals in people's records.

Is the service caring?

Good

The service was caring.
People and relatives made positive comments about the staff and told us they were treated with dignity and respect.

Staff were able to describe people's individual likes and dislikes and their personal care needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We found the registered provider had not ensured that all the

people living at the service had appropriate care and support to meet their needs.

There was a risk that people's behaviour was not managed consistently and the risks to their health, welfare and safety were not managed effectively.

Relatives and people told us the service had responded to their concerns and taken action to address any issues raised.

Is the service well-led?

Inadequate

The service was not well-led.

During the inspection we identified two continued breaches and three new breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This showed the registered provider had failed to make sufficient improvement to reach and sustain compliance.

We found the checks completed by the registered provider to assess and improve the quality of the service were not effective to ensure people were protected against the risk of inappropriate or unsafe care.

The Laurels and The Limes 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 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.

A scheduled inspection took place on 2 November 2016. This was an unannounced inspection which meant the staff and the provider did not know we would be visiting. The inspection team consisted of two adult social care inspectors, a pharmacist inspector and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experiences had experience of older people's care services.

Before our inspection we reviewed the information we held about the service and the registered provider. For example, notifications of deaths and safeguarding concerns. We also gathered information from the local authority, commissioners and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used a number of different methods to help us understand the experiences of people who lived in the service. We spent time observing the daily life in the service including the care and support being delivered. We spoke with 21 people living at the service, ten relatives, the managing director, operations director, a senior home's manager, one regional manager, the manager, one nurse, two senior care assistants, two care assistants, one domestic worker, an administrative manager and the housekeeper who was covering the cook's vacancy. We looked around different areas of the service; the communal areas, the kitchen, bathroom, toilets and where people were able to give us permission, some people's rooms. We examined a range of records including the following: four people's care records, 13 people's medication administration records, six staff files and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

All the people spoken with told us they felt 'safe' and had no worries or concerns. Their comments included: "This was not an easy decision, but my wife and I feel so safe here; it was a good decision," "The staff make every effort to make sure you are safe," "It's feeling secure that makes this place right for me" and "I was not safe at home; me and my children feel so much better now I live here."

All the relatives spoken with felt their family member was in a safe place. Relatives comments included: "I know that my wife is safe here; I am fully involved in her care,'' "I am so confident in the staff team; safety is a priority for everyone," and "I know that my wife is safe here; they do all they can for her."

We inspected the service in July 2015 to check that improvements had been made to the management of medicines. We saw that some improvements had been made, however we found the registered provider still needed to make further improvements to ensure that people were protected against the risks associated with medicines.

On this inspection we checked to see whether these further improvements had been made. A pharmacist inspector looked at how medicines were managed for thirteen people living in the home. We found the registered provider had not made sufficient improvements since our last inspection.

We saw that the system for obtaining regularly prescribed medicines had been ineffective in practice as one person did not have a supply of one of their prescribed items; the nurses had not taken any action to reorder it, but had used another person's supply. This is poor practice and highlighted the system for ordering was not robust enough. We also saw that the home had run out of paracetamol which could be used if people living there had the occasional ache or pain that needed treating by the use of 'homely remedies'. A homely remedy is another name for a non-prescription medicine that is available over the counter in community pharmacies.

We saw there had been no improvements in the safe storage of prescribed creams, which were still being stored in people's bedrooms and bathrooms. We also saw that people had creams in their rooms which were not currently prescribed for them. Waste medication was also not stored securely. The medication room was cluttered with medication in boxes on the floor and on the window ledge; staff were unsure if the medication was to be disposed of or was part of the new monthly delivery. This meant there was a risk of the medication being inappropriately used or disposed of.

We examined records about medication and saw that in general they were completed accurately and could show that medication was accounted for and had been given as prescribed. We did find some instances of medicines being signed for, but not given and times when medicines were given, but had not been signed for. We found that records about the application of most creams were accurate, but we also found that people had creams in their bedroom for which there was no record of application. It is important that all records about medication are accurate and complete to evidence that all medication is being used as prescribed.

Four people were prescribed a thickening powder which is added to drinks and other fluids to prevent the person choking and reduces the risk of aspiration which causes chest infections and pneumonia. We found that people did not always have their drinks thickened properly. We saw that the records and information about thickening drinks were incomplete and confusing. The poor management of prescribed thickeners placed people at risk of harm.

We examined the information available to guide staff to administer medicines prescribed to be taken 'as required'. Some information was found to be excellent, however, most of the information available was inadequate and did not given clear, personalised guidance to ensure people could be given medicines that were prescribed in a way, that was safe and consistent. We saw that when a plan to support safe administration was in place they were not always followed. For example, one person was prescribed a complicated regime of laxatives. Staff did not know which laxatives to use or when to use them. As a result there was a risk of the person becoming constipated.

As the last inspection, we saw when medicines were prescribed with a choice of dose; there was still no guidance available to help staff select the most appropriate dose to give. We also saw that the dose which was given was not always recorded. This meant there was a risk that medicines were not given safely and consistently.

As at the last inspection we saw that there were still no systems in place to ensure that time sensitive medication was given safely. We saw that staff did not record the time medicines were given, such as paracetamol, which placed people at risk of being given doses closer together than was safe. We found that nurses failed to give people who were prescribed an antibiotic on an empty stomach, in accordance with prescribed instructions for best effect.

People had individual risk assessments in place so that staff could identify and manage any risks appropriately, for example, a falls risk assessment. The purpose of a risk assessment is to identify any potential risks and then put measures in place to reduce and manage the risks to the person. We saw that one person had experienced a number of falls. We saw the measures in place to reduce the person's risk of falls was an infra-red sensor and close monitoring by staff. We visited the person in their room. We found the person sitting in the dark and that the infra-red sensor had not been switched on. We asked a member of staff to switch the sensor on.

We shared our concerns in regards to the management of medicines with the manager and senior managers so that appropriate action could be taken to minimise the risk of harm.

These findings evidenced a continued breach of Regulation 12 Heath and Social Care Act (Regulated Activities) Regulations 2014, Safe care and treatment.

A recruitment and selection policy was in place, but it did not identify all the information as specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 must be available to demonstrate fit and proper persons have been employed. Schedule 3 is a list of information required about a person seeking to work in care to help employers make safer recruitment decisions.

Staff recruitment records examined showed that information was not always obtained in accordance with Schedule 3.

Our findings meant the recruitment of staff was not safe and was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, Fit and proper persons employed.

The service had a copy of the South Yorkshire safeguarding protocols. This protocol provides guidance for staff in all service sectors in South Yorkshire to make a safeguarding alert in line with the local multi agency agreement. It is important that staff follow these protocols to safeguard people from the risk of harm. We were aware that these protocols had not been followed consistently. For example, a concern in March 2016 had not been reported to safeguarding by the previous manager. The concern had been reported to safeguarding by a visitor. The regional manager became aware of the concern when they were invited to attend a safeguarding meeting. A notification was received by CQC in May 2016 by the regional manager. We examined one person's records who lived in the Laurels. We saw that two initial skin damage assessments had been completed in June 2016 and July 2016 for the person. We saw on both occasions that staff had recorded the reason for bruising as unknown. At the bottom of each form we saw that the section titled 'tissue damage notified to home manager' had not been completed. We asked the manager how staff reported these types of concerns. They told us staff would fill in an accident form. We fed back the information that there were no corresponding accident forms within the person's records to the manager and senior managers. Following the inspection, the manager contacted the local authority and sent in an alert.

This showed that people were not safeguarded from the risk of harm. These findings evidenced a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment.

We found there were satisfactory arrangements in place for people who had monies managed by the service. We examined three people's financial transaction records and the balance was correct. A receipt was given when monies were booked in by the person or by their representative.

On the day of the inspection we noted that the nurse did not finish their medication round until 11 o'clock. The regional manager and manager both told us that this was later than normal. People told us staff responded to their calls for assistance during the day and night, but sometimes they had to wait for a response. Peoples comments included: "'if you call the alarm during the night, the night staff are wonderful, nothing is too much trouble," "If I need pain relief during the night it is not a problem," "The staff come immediately whenever I use the nurse call," "If I use the buzzer it can be a while before the staff come to you," "They [staff] take ages coming if you need anything" and "It seems a long time before the staff come to you when you call for them." During the inspection it was noted that when the nurse calls were activated, on four occasions it was five to ten minutes before they were responded to. Most of the relatives spoken with did not express any concerns regarding staffing levels. One relative commented, "I notice that sometimes the staff are slow at answering the buzzer." We shared our observations with the manager and the provider's senior managers.

During the inspection we observed staff using appropriate personal protective equipment whilst providing personal care. For example, gloves and aprons. At the time of the inspection the service's housekeeper was filling in for the vacant cook post. Domestic staff spoken with told us they were short by one staff member, but staff were picking up additional hours to cover for their absence.

People did not express any concerns about the cleanliness of the building. We received mixed views from relatives regarding the cleanliness of the service. Some relatives did not express any concerns whilst others said the cleanliness in some areas were not always clean. One relative said, "Sometimes it really smells over in The Laurels, it's not as clean as in here [The Limes]."

On the morning of the inspection we detected malodours on entering both buildings; we found the malodours reduced as the day progressed. In a few people's rooms in the Limes we found there were

malodours emanating from the carpet flooring. We saw that in a few people's rooms that equipment was being stored inappropriately in their toilet area. We spoke with a domestic who told us that carpets were deep cleaned on a regular basis. In the Laurels we saw that some of the chairs and areas of the carpet in the lounge were stained. We also saw there was wear to some of the chair arms. We shared this information with the manager and the provider's senior manager so this could be addressed.

The service held regularly health and safety meetings. We saw that a range of topics were discussed including: fire risk assessment, moving and handling and the review of incidents and accidents. People's records included a personal emergency evacuation plan. Each plan described the person's moving and handling needs and took into account any sensory impairment.

Requires Improvement

Is the service effective?

Our findings

People spoken with were satisfied with the care they had received. Their comments included: "My wife and I have all our dental and optical needs sorted, it has been really good," "The district nurse comes every week, the staff are great at sorting that out" and "I am amazed at the help and support we have had with our health needs."

Relatives were satisfied with the care their family member had received. Their comments included: "[family member] always gets to see the district nurse and the optician," "My relative was in a terrible state when she first came here. She had been bed ridden for six weeks, but they [staff] have worked a miracle and got her back on her feet. They are really good and make sure she uses her frame which she sometimes forgets," "My Dad is happy, he has a whole range of health care professionals coming in, staff are great at communicating this," "'Mum could not get better care anywhere else," "I have every confidence he is getting the care he needs," "'I come every day, so I get a good idea of what's going on, the staff are great" and "My mother sees the district nursing service every Thursday."

We found evidence of involvement from other health professionals in people's records. For example, district nurse, GP and optician. However, we noted in one person's records the person's doctor asked why staff had not sort treatment for an infected area within three days of its appearance and sooner. We shared this information with the manager.

We received mixed views from people regarding the food provided at the service. Some people complimented the food whilst others felt that it was cold and did not always look pleasant. People's comments included "'I like the food, but they give me too much, I keep asking for a smaller portion," "There is a good choice of food and there is plenty," "It is alright here. Except they can't cook vegetables. Everything is cooked until its mush," "We always seem to have peas, can't we have some asparagus and celery," "They [staff] give me so much food, I only ask for small salads" and "Sometimes the food is cold, if you have to be helped with eating it is cold by the time they get round to giving it you."

We received mixed views from relatives regarding the food provided at the service. Their comments included: "The presentation of the food is the problem, it looks like slop sometimes," "Sometimes they give my wife a really big plate of food, she doesn't like it, she likes small portions" and "From what I have seen the food seems to be good."

Our observations showed the arrangements in place at meal times could be improved.

During the inspection we observed the arrangements at mealtimes in both buildings. We observed lunch being provided in the ground floor dining area in the Laurels building. The lounge and dining room on the first floor was not being used. We saw there was a choice of two options; either chicken pie and vegetables or fishcakes and chips. One person asked if there was any parsley sauce and then a number of other people also asked, but they were told there wasn't any and were offered a choice of either vinegar or tomato sauce. One person who was waiting for lunch said, "I'd like a nice cup of tea. I don't like these water things. They all

taste the same to me." We saw there were jugs of fruit juice on each table, but people were not offered a hot drink. During lunch we saw there was very little social interaction between people and staff. We saw staff come in to bring meals and beverages during the meal but they did not stay in the dining room. We saw that one person did not eat their meal. We saw staff made some attempts to encourage the person to eat, but they refused.

We observed lunch being provided in the ground floor dining room and the adjoining lounge area in the Limes. We noticed the menu displayed on the wall did not relate to the meal that was served. We saw this caused confusion to some people and family members. One relative commented: "I am not sure what the meal is today, it says one thing on the board and another on the tables". Staff told us the menu on the board was from another day. The menus that were available for people to read had very small writing and were handwritten. We saw that some people would find them difficult to read. We saw people were offered a choice of meal and condiments were available on tables.

We saw the environment was not a calm and conducive atmosphere for people to eat in. One relative said, "There are too many people in the dining room, it gets really loud at times." The atmosphere was chaotic; busy and loud. One person did not wish to enter the dining room and was very vocal about this. We saw some people reacted to the person by calling out negative comments. We saw this was not a positive experience for the individual or the people waiting to have their lunch. The person was provided lunch in the lounge area. We saw the person was settled in that environment and ate all their meal. During the meal we saw some people repeatedly left the dining area and staff immediately returning them. We saw staff were calm and patient whilst encouraging people to the dining table. We saw that some people were supported to eat by staff in both the dining and lounge areas. Staff supported people in a calm and relaxed way, quietly engaging and encouraging them to eat. We noticed that at the end of the meal that some people had left drinks. It is important that people are encouraged to take fluids whenever possible.

We spoke with the housekeeper who was covering for the cook vacancy. They told us that one of the housekeeping staff was training to be the assistant cook. They provided us with details of people who had allergies or required a specialist diet and/or soft foods. For example, fork mashable, pureed, diabetic and vegetarian. They told us that one of the choices for the lunch time meal had changed because the service had not being delivered any corned beef. The housekeeper told us that people's preferences were obtained at breakfast the previous day. We saw that some people may find it difficult to remember what they had chosen, particularly if they were living with dementia.

During the inspection we observed staff obtaining consent from people before providing personal care. We saw people's choices were respected.

The Mental Capacity Act (MCA) 2005 is an act which protects and promotes the rights of people who are unable to make all or some decisions about their lives for themselves. It promotes and safeguards decision-making within a legal framework.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

At the last inspection we found the provider had not ensured DoLS authorisations had been obtained for some people living at the service, where there restrictions were in place for people. For example, a person being restricted from leaving the building when they wish to do so. We saw that sufficient improvement had

been made. However, in one person records we were unable to locate a copy of the mental capacity assessment undertaken prior to the application being made to demonstrate the MCA code had been followed. The manager informed us that it may have been archived. It is important that a full audit trail is in place to evidence that the MCA code has been followed. □

Most staff spoken with were positive about the change in management. Some staff expressed concerns about the changes. Staff comments included: "The new manager is making a big difference," "It worries us all about the management changes over the months," and "Staff morale has really picked up since [manager] came."

Staff told us they attended supervision sessions and felt supported. Supervision is regular, planned and recorded sessions between a staff member and their manager to discuss their work objectives and wellbeing. An appraisal is an annual meeting a staff member has with their manager to review their performance and identify their work objectives for the next twelve months. The manager had a staff supervision and appraisal schedule in place. The manager told us that staff received a supervision from their supervisor. If concerns were raised and could not be dealt with by the supervisor they were escalated to the manager. We noted in one person's supervision that a serious concern that could lead to a disciplinary had not been dealt with by the manager. The manager provided us with background information and told us that they were aware of the concerns. We discussed with the manager, the lack of supporting information of the seriousness of the concern to demonstrate it had been investigated and acted on appropriately.

The manager used a staff training spreadsheet to monitor the training completed by staff. We looked at staff records and saw staff received training relevant to their role. The training provided covered a range of areas including the following: moving and handling, safeguarding, health and safety, infection control, fire awareness and equality. We noticed that the spreadsheet indicated that some staff refresher training was overdue. The manager provided us with copies of training that was planned. However, we saw the systems in place to ensure staff received training needed to be more robust to ensure training was delivered prior to it becoming overdue. We reviewed the quality audit completed by the regional manager in September 2016 and saw that the completion of staff training was being monitored to ensure action was being taken to bring it up to date.

Good

Is the service caring?

Our findings

In the main reception area of the Limes, there was a range of information available for people and/or their representatives. This included: Age Concern, Alzheimer's Society, dignity and respect and advocacy services.

People told us they were treated with dignity and respect and made positive comments about the staff. People could choose where they wished to spend their time. Some people chose to spend time in their rooms and to have their meals in their room. One relative said, "[family member] goes to bed exactly when she wants, she also gets up when she wants."

Our observations showed that people were treated with dignity and respect. Staff respected people's privacy by knocking on doors and calling out before they entered their bedroom or toilet areas. We saw one example where staff had not waited for an answer and entered one person's room whilst they were being supported with their personal care. We heard them apologise to the person.

In the Limes we observed a lot of laughter and friendly 'banter' between people and staff. We saw that people got on well with staff and that people's relatives and visitors were greeted in a friendly way. Peoples comments in the Limes included: "I come and go as I please, they have no problem with that, I love a walk around the grounds every day, whatever the weather," "I am so happy that the staff are so friendly," "A woman made me and my family a drink in the cafe area, it turned out to be the area manager, how nice," "They have taken the time to get to know just what we like," "Some staff go above and beyond the call of duty to make us happy", "'The staff are smashing, they look after us so well," "'I have not been here long, but with the help of staff I soon felt at home," "'The staff have got to know us so well, they know just what we like" and "The night staff are wonderful, they go to so much trouble."

In the Laurels building we saw that the interaction between staff and people was centred more on tasks and we saw there was less interaction between staff and people. We saw that staff were pleasant and polite, but we saw they were not actively engaging with people. People spoken with told us that staff were kind, respectful, polite and observed their rights and dignity. People's comments in the Laurels building included: "They [staff] look after me really well. They are nice staff and I am very safe here," "They are alright, but I've nothing to compare it with. I just don't want to be here" and "I feel safe with them. They are friendly."

Relatives spoken with also made positive comments about the staff. Their comments included: "They [staff] make our Mum's life so special," "The staff [in the Limes] are so dedicated," "The staff are so caring and kind," "I have no problems with the staff here, they are very friendly and always make me welcome," "The staff have developed a real personal relationship with mum, she loves it," "They [staff] offer me a meal every time I come, it makes me feel a part of the home," "They [staff] work so hard to keep mum happy," "The staff here are absolutely marvellous" and "They [staff] are all so kind to [family member]."

Staff spoken with were able to describe people's individual needs, likes and dislikes and the name people preferred to be called by. There were end of life care arrangements in place to ensure people had a

comfortable and dignified death. There were two nurses working at the service who were the nominated end of life link person.

Requires Improvement

Is the service responsive?

Our findings

People had a written care plan in place. We saw that people's plans covered a range of areas including: oral care, person cleansing and dressing, sleeping and communication. We found that people's plans were personalised but not yet person centred. For example, we saw people's life stories were not detailed. Understanding a person's life story can have a very positive benefit for people living with dementia. People's backgrounds are very important to understand particularly if people are unhappy or become distressed. Particular activities or the approach by a member of staff may trigger behaviour related to events in someone's past.

The manager told us that senior staff filled in a spreadsheet to confirm that a monthly care plan evaluation had been completed. We reviewed the form completed by staff at the end of October 2016. The form requested staff to complete the following sections: date plan evaluated, dependency score, Body Mass Index (BMI) and malnutrition universal screening tool (MUST) scores, any infection, any pressure damage and equipment in the person's room.

At the last inspection we found that people's records, particularly their daily charts were not maintained to ensure they were accurate, complete and contemporaneous. It is important that an accurate record of the care and treatment provided to a person is kept. On the day of the inspection we visited one person in their room in the Limes at 11:43am. We checked their daily charts and noted that staff had recorded at 9:00am that the person wanted to stay in their bedroom. We saw the person had a table directly in front of them with two glasses of water on it and access to a call bell. We noticed the person had not been provided with a hot drink. People in the lounge area had been provided with a hot drink during the morning. We visited the person again on two occasions. We saw no wellbeing checks had been recorded on their daily charts or a hot drink provided. At the last visit the person told us they wanted a drink and were thirsty. Whilst we were with the person a staff member arrived at 12:57 with the person's lunch. We shared this information with the manager. Later in the day we were shown a copy of the person's daily charts by the regional manager. We saw that staff had recorded hourly checks retrospectively on the person's records. We could not be confident that the person had received any checks. In the nurses and senior meeting dated 24 October 2016 it had been noted 'nurses and seniors to ensure that staff are pushing fluids as we have a high number of urinary tract infections (UTI) and this needs to be reduced'. One of the people who had experienced a UTI was this person.

On the day of the inspection the activities board in the Limes stated there was to be an entertainer that day. Later in the day we found out that this was from another day. The activities worker was not working on the day of the inspection. We saw people waiting for their hair to be done in the Limes Building.

Most relatives spoken with told us the activities provided for their family member could be improved. Some relatives said that the activities provided could be more varied. Relatives felt that the activity workers were very friendly people, but they did not always understand the needs of the people living at the service or those people living with dementia. Relative's comments included: "The activity people are lovely people, but I don't feel they fully understand the needs of the people here," "The activity organisers are not very

dynamic, but I think it might be the care staff that are doing some of the activities" and "I feel that the activities are not always suitable for everyone." One relative described how the inclusion in activities had a positive impact on their family member and helped them settle in.

People living at the service told us the activities at the service could be improved. Peoples gave us suggestions on how the activities could be improved: "I would love it if they could arrange for a local art group to visit us," "I wish there was more involvement from the local churches, I am sure they would be willing to come in," "I would love to go for a ride out into the countryside," "I have not been out since I came to live here in June," "I am sure we would all be willing to pay for trips out," "I don't like bingo and they play it so often," and "They need to ask us individually what sort of hobbies and activities we would like to do."

Accessing the outdoors is an important aspect of maintaining people's wellbeing.

At the last inspection we raised concerns regarding the lack of stimulation provided for people living in the Laurels. The Laurels primarily supports people living with dementia. We spent time observing the interaction between staff and people at different times of the day in the Laurels. A few people chose to stay in the room. One person said, "We don't go into the lounge. We have our books and I like colouring in and doing dot to dots." We saw the interaction between staff and people centred around tasks and that staff were not actively engaging with people. For example, we saw people sitting in the lounge area with a range of dolls and teddy bears and a musical film was being played in the background. However, we saw nobody interacting with these items or actively watching the television. People told us they were bored. Their comments included: "We sit here (lounge) and then they [staff] take us in for dinner and then we come back" and "I am just bored. I've asked if anything is happening this afternoon and they (the staff) said I don't think so." The staff told us there were no activities due on the day of the inspection. One staff member said, "There is an activities person who comes over from the Limes and does things like singing." We asked staff to suggest any activities that might be appropriate to stimulate people. They told us they could not think of any.

We found that insufficient action had been taken by the registered provider to ensure people living with dementia did not become disengaged with their surroundings. It is important that people are provided with meaningful activities, linked to hobbies and interests that the person enjoyed before a diagnosis of dementia. Some of the most beneficial activities can be simple, everyday tasks such as setting the table for a meal or folding clothes. They can help a person with dementia feel connected to normal life and can maximise choice, conditions and control.

We reviewed one person's DoLS authorisation which had been granted with conditions in May 2016. These conditions are legally binding and have to be met. The person's conditions included: undertaking life history work with the person and their family to identify key past events, hobbies and interests that are important to the person. The person needed to be communicated with regularly so they felt valued. To provide evidence that supports social active engagement even if the person refuses to engage. To support the person in areas they know they may be interested in such as events at the Crucible (theatre). We reviewed the person's records. We saw their social history held some information regarding their past, but we saw there was no evidence that work had been undertaken with the person's family to identify key past events. We saw no evidence that supported social active engagement or that the person had been supported to attend events they may be interested in. We spoke with a senior member of care staff. They were unable to provide any information to support these conditions had been met. This showed there was a risk that people would not receive appropriate care and treatment to meet their needs. We shared this information with the manager and registered provider's senior managers.

We reviewed one person's records who had behaviour that challenged. The person was living with dementia. We saw there was guidance in place for staff on how to respond to challenging behaviour. However, we noticed there was no process in place to look for patterns in a person's behaviour and when aggressive behaviour occurred. For example, this could be verbal aggression, noting down everything that was going on at the time that could have triggered the behaviour. This told us there was a risk that people's behaviour was not managed consistently and the risks to their health, welfare and safety was not managed effectively.

These findings evidenced a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person-centred care.

The complaints process was on display. The service kept a complaints log. The regional manager reviewed the services complaints activity as part of their auditing processes. People and relatives knew how to complain and they told us they would inform staff if they were unhappy with their care. Peoples comments included: "I would say if I wasn't happy, in fact I have done, [manager] sorted it out" and "I would tell [manager] if anything was wrong." Relatives comments included: "[family member] has no problems, but I would pop in a see the manager; her door is always open" and "I will always make sure [family member] is safe, I would stop at nothing in complaining."

Inadequate

Is the service well-led?

Our findings

Since our last inspection in July 2015 there had been changes in the management at the service. One of the registered provider's senior managers had been managing the service at the last inspection. A manager had been appointed but they left in May 2016. The regional manager had changed for the service in 2016. The current manager started working at the service in May 2016 and had registered with the CQC.

The manager was aware of their responsibility to inform the CQC about notifiable incidents and circumstances in line with the Health and Social Care Act 2008. Our records showed the previous manager had not always followed the local safeguarding protocols and reported concerns. The previous regional manager had notified CQC about the incidents when they had been made aware of the concerns. The provider's nominated individual provided us with details of the action taken to ensure this did not occur again.

At our last inspection we found the registered provider had not ensured there was an effective system in place to regularly assess and monitor of the quality of the service provided. The registered provider submitted an action plan following our inspection which detailed the actions they intended to take in order to achieve compliance. Our findings showed the registered provider had failed to take sufficient action to achieve compliance with two of the regulations that had been previously breached. During this inspection we also identified a further three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This showed the systems in place to regularly assess and monitor of the quality and safety of the services provided were still ineffective.

The Laurels building was managed by a unit manager and we found the manager was not as visible to the people living there. People did not know who the manager was. People told us resident meetings were not held at the Laurels and they were not invited to meetings held in the Limes. It is important that the views of all the people living at a service are actively sought. The feedback received from people living in the Laurels and our observations showed a contrast to people's experience of living in the Limes.

At the last inspection we raised concerns regarding the lack of stimulation provided for people living in the Laurels. The Laurels primarily supports people living with dementia and the registered provider's website describes it as offering 'expert dementia care'. We found that insufficient action had been taken by the registered provider to ensure people living with dementia did not become disengaged with their surroundings. We reviewed the quality audit completed in April 2016 completed by the previous regional manager. The audit included an action plan. Under the section in relation to the activities programme the regional manager had recorded the following: 'no dementia activities in programme', 'only limited activities available' and 'tends to focus on same people'.

We saw evidence that medication checks had been completed at the service since the last inspection. The most recent audit was completed on 26 October 2016. However, our findings during the inspection showed the system for monitoring the management of medicines were not robust. It is essential to have robust monitoring in place in order to identify concerns, to make improvements and changes needed, sustain

those improvements to ensure medicines are managed safely. We found the register provider had failed to make sufficient improvements in the management of medicines at the service. We are concerned that some of the concerns found at the last inspection were also found at this inspection.

These findings evidenced a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

Most people spoken with living in the Limes building knew the manager by name. Their comments included: "I think the new manager is wonderful," "[manager] comes to see us and asks if everything is alright," "The manager is a marvellous woman, nothing is too much trouble," "We can talk to her [manager] about anything" and "[manager] tells me that she has an open door policy and we can go to her at any time; that's so reassuring." People told us that resident meetings were held at the Limes. One person said, "I have been to a residents meeting, it was good."

A few relatives felt unsettled as the management structure had changed again. Some relatives felt very involved and other less so. Relative's comments included "I am fed up of the changes in the management; as long as they don't close the home, that's my fear" and "The management changes are ongoing, I hope this settles down."

Relatives spoken with made positive comments about the manager. Their comments included: "The new manager is making a big difference already," "The new manager has assured us that she is here to stay, I do hope she is," "[Manager] is really special, she did everything to help my mother settle in, mum thinks she is great," "I can say without a doubt that [manager] is beginning to make real changes for the better" and "This home is run well, my relative is not easy to care for."

Some of the relatives spoken with told us they had attended the meetings held with relatives. Their comments included: "It is so important as a relative to feel involved, it reassures us, [manager] is making sure that this is happening" and "It is great that the relatives meetings are at different times; I cannot come in the evenings."

The registered provider had sent out a customer survey in September 2016. We saw a summary sheet displayed in the reception area of the Limes. As a result of the survey the action the service was completing included the laundry and additional recruitment for activities. We looked at the manager's quarterly magazine dated October 2016. It included a range of topic and employee of the month for each building, dates for your diary, resident meeting timescales, staff information and development.

We reviewed the minutes of the residents meetings held in August and October 2016 and noticed that none of the residents living in the Laurels had attended. We saw that the main topic discussed in both meetings was about activities. We reviewed the minutes of the meetings held in June and October 2016 for relatives. In contrast, we saw the topics discussed were focussed on the management of the service and quality of care.

We saw the NHS infection prevention and control nurse had completed an audit in July 2016 and the service had completed an action plan to improve infection prevention control standards at the service.

We saw that the manager had been holding regular staff meetings at the service. We reviewed the minutes of the meeting completed with nurses and senior care workers in October 2016. We saw that a range of topics had been discussed including: ensuring staff used slide sheets, care plans, medication and mentoring new staff. We reviewed the minutes of the governance meeting held in October 2016. We saw that a range

of topics had been discussed including: audits undertaken, accidents, infection trends, new policies, safety alerts and staff training. The meeting also included an action plan for completion. Regular staff meetings can help to improve the quality and safety of services.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Service users were not protected against the risks of receiving care or treatment that is inappropriate or unsafe because the planning and delivery of care did not meet people's needs and ensure the welfare and safety of service users.

The enforcement action we took:

vary a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that care and treatment was provided in a safe way for service users.

The enforcement action we took:

vary a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The Provider had not ensured service users were protected from abuse and improper treatment inaccordance with this regulation.

The enforcement action we took:

vary a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 17 HSCA RA Regulations 2014 Good governance Service users were not protected against the risks of inappropriate or unsafe care or treatment because the provider did not have effective

Treatment of disease, disorder or injury	systems to monitor the quality of the service provisions.

The enforcement action we took:

Vary a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Service users were not protected because the provider did not have appropriate processes for assessing and checking that staff have the competence, skills and experience required to undertake the role.

The enforcement action we took:

vary the condition.