Alpha Care (Caterham) Limited

# Coombe Dingle Nursing Home

**Inspection report**

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## Ratings

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

## Overall summary

Coombe Dingle Nursing Home provides nursing care and treatment for up to 42 people, most of whom are living with dementia. The home is divided across three floors. On the day of our inspection 31 people were living in the home.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. The registered manager was present during our inspection.

We carried out this inspection on 22 September 2015. This was to follow up on three breaches in regulation from our inspection in January 2015. As there had been a period of time between inspections we carried out a fully comprehensive inspection on this occasion.

# Summary of findings

People lived in an environment that was not well maintained or clean. Staff did not follow suitable infection control procedures and the provider had not made the improvements required of them from the last inspection.

Safe medicines management procedures were not always followed by staff and we found this was a continued breach of regulation from our last inspection. People had access to external health services however we found people may not always be provided with responsive care by staff.

Staff had not followed legal requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) in respect of restrictions or decisions made on behalf of people.

Up to date, contemporaneous and accurate records for people were not held which meant new or agency staff may not be working to the latest information. Staff had not taken the time to read care plans or information about people in order to get to know them to ensure they provided appropriate care and support.

Quality assurance checks were carried out by staff as well as the provider and feedback was sought from relatives. However, we found these checks had not identified areas that required improvement and the provider had not acted on areas we had identified at our previous inspection in relation to the ensuring they were providing a high quality, safe service.

Staff provided activities for people, however people who spent a lot of time in their room did not receive much social interaction from staff at times. Staff were not observed as always being proactive in engaging with people. Staff did not always treat people as though they mattered or with respect and people's privacy was not always upheld.

People were not offered a choice of meals in a way they would be able to understand and people who required a pureed food did not get a choice. Although people's dietary requirements were known by staff some information was contradictory or not provided to the chef in a way they would be able to easily identify these people.

Staff were not provided with training specific to the needs of people. Despite staff telling us no-one living in the home had capacity we found staff did not have a good understand of dementia and had not been given access to training.

Complaints procedures were in place and we saw most complaints had been resolved. One complaint was on-going as the complainant was not happy with the initial response from the registered manager.

There were a sufficient number of staff deployed in the home. We did not see people wait to be assisted and observed there was always someone around for people who were sitting in the lounge area.

We did observe some staff displaying kind, compassionate care to people and it was clear staff knew visitors to the home well. A complaints procedure was available for people or relatives if they had any concerns.

Staff had identified risks for people to demonstrate people were safe living at Coombe Dingle and we saw evidence staff had received manual handling training since our last inspection. Staff demonstrated good practices when lifting and moving people.

Staff were aware of their responsibilities to safeguard people from abuse and were able to tell us what they would do in such an event. And in the case of an emergency people's care would not be compromised because the provider had contingency plans and suitable arrangements if people needed to be evacuated.

Staff felt supported by the registered manager. They had the opportunity to meet with their individual line managers on a regular basis and contribute towards the running of the home through staff meetings. Appropriate checks were carried out to help ensure only suitable staff worked in the home.

During the inspection we found breaches 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.

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

# Summary of findings

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.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**
The service was not safe.

People were living in an environment that was not clean or well maintained and staff did not follow infection control procedures.

People's medicines were not always managed safely as staff did not always follow current best practice.

Staffing levels were appropriate to meet the needs of people.

Risks of harm to people had been identified.

The provider employed staff to work in the home who had undertaken appropriate checks.

A contingency plan was in place to ensure continuity of care.

**Inadequate**

**Is the service effective?**
The service was not effective.

Consent to care had not always been sought appropriately for people who lacked capacity.

Staff had not sought legal authority in relation to restrictions on people.

People were not involved in decisions about their meals and some records in relation to people's food were not accurate.

Staff had not received regular training.

Staff supported people to receive care from external healthcare professionals to help them remain healthy.

Staff were given the opportunity to meet with their line manager regularly.

**Inadequate**

**Is the service caring?**
The service was not always caring.

Staff did not always show respect to people or allow them their privacy.

People were not always supported by kind, caring staff who engaged with them spontaneously.

Relatives and visitors were able to visit the home at any time and were made to feel welcome. People could make decisions for themselves when they were able to.

**Requires improvement**

**Is the service responsive?**
The service was not always responsive

**Requires improvement**

# Summary of findings

People were able to take part in activities but we found staff were not providing individualised activities for people.

Staff could not provide evidence they always responded to people's changing needs.

Information about how to make a complaint was available for people and their relatives.

**Is the service well-led?**

**Requires improvement**

The service was not consistently well-led.

Care records were not always complete or up to date.

Staff and the provider carried out quality assurance checks to ensure the home was meeting the needs of people. However these checks had not identified areas that required improvement.

The home had a registered manager, and staff said they felt supported by them.

People and their relatives were involved in the running of the home and staff met regularly as a staff team.

# Coombe Dingle Nursing Home

**Detailed findings**

## Background to this inspection

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

This was an unannounced inspection that took place on the 22 September 2015. The inspection was carried out by three inspectors.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. This inspection was carried out to follow up on some breaches of regulation we had identified at our last inspection. Due to the length of time between inspections we decided to carry out a fully comprehensive inspection.

As part of our inspection we spoke with four people, eight care staff (which included to nurses and the head of carers), two relatives, the registered manager, the provider and two external healthcare professionals. We observed staff carrying out their duties, such as assisting people to move around the home and helping people with food and drink.

We reviewed a variety of documents which included eight people's care plans, three staff files, medicines records and policies and procedures in relation to the running of the home.

We last inspected this home on 16 January 2015 where we identified breaches of Regulation 11, 13 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond to Regulation 13, 12 and 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service safe?

## Our findings

People were living in an environment that was not well maintained or clean. At our inspection in January 2015 we found the provider had not ensured people lived in a suitable environment. The provider told us following that inspection they would make the necessary improvements, however at this inspection we found the environment was still not well maintained or suitable for people. We saw people lived in rooms which were unpersonalised, sparse and unwelcoming. A further person's room had a large area of peeling paint on the wall. We saw walls, doors and cupboards were dirty and stained.

We found that hot water in three people's rooms and two bathrooms was lukewarm which meant people could not wash in hot water. In the sink of one toilet there was also lukewarm water. People's mattresses were lumpy. There was a large piece of flooring missing from the threshold of one room which could cause a trip hazard and the bottoms of the cabinets in the kitchen were rusted which meant staff could not ensure this area was clean when they were preparing food for people. There was a strong malodour in one area of the home. In the lounge we noted two people sitting in high-backed wheelchairs and saw the foot plates of these chairs were stained and dirty. The base around one hoist was covered in stains and dirt and one person's bed rail covers were old and cracked. A relative told us, "Apart from the décor, I can't complain."

Staff did not follow infection control procedures. For example, staff told us soiled washing was washed separately and on a hot wash. However, they explained that in order to wash their hands after handling soiled laundry they would have to leave the laundry room as there was no sink in there. We watched as a member of staff did this with their gloves still on meaning they touched doors with contaminated gloves.

We found no bin in the sluice room for staff to put soiled items in and although there was a small sink in there, staff explained they did not use it but instead would go to another room (through two doors) to remove their gloves and wash their hands. The doors they went through were in the communal areas of the home meaning there was a risk people could touch these doors after staff had touched them with contaminated gloves. Although we saw housekeeping staff working in the home during our inspection we found toilet chairs and floors stained from faeces after these areas had been cleaned by staff.

The provider failing to ensure the environment and equipment was clean and suitable for people was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicine administration processes were not always carried out safely. At our inspection in January 2015 we identified a breach in medicines management. Following that inspection the provider told us they would ensure up to date training was provided for staff, staff competencies would be assessed by the registered manager and staff would be reminded of the medicines protocols. However we found medicines processes were still not being followed. For example, we saw in gaps in people's Medicines Administration Record (MAR). We looked to see if staff had noted the reason for these gaps, but there was no evidence to show they had. Gaps in the MAR charts may indicate that people did not receive their medicines as prescribed.

In one person's MAR we saw some of their medicines for the following day had been signed for which indicated this person may have been given a double dose of medicines. We spoke with the nurse in charge about this who advised us they had made a recording error as they had not noticed the other nurse (who was shadowing them) had already signed the MAR. Although the nurse had previously told us what actions they would take in the event of a medication error (they would advise the GP and keep the person under observations to keep them safe) we did not see the nurse take this action. We asked if the medicines needed to be checked to ensure a double dose had not been administered, but we were told by the two nurses this was not necessary as they were confident the person had only received today's medicines. We found at one point the medicines trolley had been left unlocked in the lounge area whilst both nurses were administering medicines in another room which meant people could access medicines not meant for them. The top of the medicines trolley was cover in a sticky residue which showed staff did not keep the medicines trolley clean.

Medicines were not stored correctly and were found to be out of date. We found an out of date medicine stored in the fridge. We noted this particular medicine had also not been

# Is the service safe?

stored correctly as it should be stored at room temperature. However, had it been stored in the clinical room it may not have been stored appropriately as staff told us they recorded the temperature of the fridge they did not record the temperature of the clinical room. We found the clinical room was very warm.

The lack of proper medicines management processes was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

MAR records for people contained all the necessary information to ensure people received the medicines they required. For example, we saw each MAR had a person's photograph on it, together with their prescribed medication and any allergies they had. We read people were prescribed PRN (as required) medicines and we saw the nurse give some to one person and record this. We observed staff dispensing and administering medicines to people and saw these were dispensed from blister packs into pots before giving them out.

There were a sufficient number of staff to meet people's needs. The head of carers told us there should be six care staff and two nurses on duty in the morning, five care staff and two nurses on duty in the afternoon and three care staff and one nurse at night. There was also laundry, housekeeping and kitchen staff and an activities person. We saw throughout our inspection staffing levels were in line with what we had been told.

We saw staff respond to people in a timely way and did not observe anyone needing to wait to be assisted. There was always someone around for people and we observed staff attending to the needs of people. We did note at times there was a lack of staff on the top floor of the home where two people spent all of their time in bed. However one of these people confirmed if they required assistance they would ring their bell and staff would come straight away. We spoke with the provider about this at the end of our inspection.

We recommend that the provider reviews staff deployment procedures and practices.

People were protected from the risks of abuse and harm. Staff received safeguarding training and there was information about safeguarding displayed throughout the home for both staff and people. This included the local authorities safeguarding procedure and local contact telephone numbers. Most staff were able to tell us about abuse and knew how to report it in and outside the home. Staff said they could also use the whistleblowing procedure if they felt they were unable to approach their manager.

Risk assessments were in place to help keep people safe. Care plans included risk assessments in relation to people's use of bedrails, falls, self-injurious behaviour and skin integrity, for example. We read these were individualised.

At our previous inspection we saw staff using inappropriate moving and handling procedures when assisting people to get up from their chair. We saw during this inspection that staff followed the proper procedures. We were told by the registered manager that manual handling training had been held for all staff in the last few months. This was confirmed by staff we spoke with. This showed us the provider had taken action and was now meeting the regulation in relation to moving people in a safe way.

People's care and support would not be interrupted or compromised in the event of an emergency. Guidelines were in place for staff in the event of an unforeseen emergency and there was a contingency plan in place in the event the home had to close for a period of time.

The provider carried out appropriate checks to help ensure they employed suitable people to work at the home. Staff files included a recent photograph, written references and a Disclosure and Barring System (DBS) check. DBS checks identify if prospective staff had a criminal record or were barred from working with people who use care and support services. This was confirmed by staff we spoke with.

Inadequate

# Is the service effective?

## Our findings

Where people did not have capacity their freedom was restricted without legal processes being followed by staff. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. At our inspection in January 2015 we found one DoLS application had been made and we were told by the registered manager they were in the process of completing this piece of work for other people who lived in the home who lacked capacity. We found at this inspection the provider had installed key-coded pads on the doors leading out of communal areas and bedroom corridors but they had not made the required applications to the local authority DoLS team with regard to this restriction to people's liberty.

We saw staff putting people's walking aids together in one area meaning people would not be able to get up from their chairs independently. Other people had bed rails on their beds. We were told by the provider and registered manager that all DoLS applications had been submitted and the information was held electronically within care records. We sampled 13 of the electronic records of people who lacked capacity in relation to DoLS and found that only one application had been submitted in relation to the restrictions in the home.

The lack of following legal requirements in relation to restriction was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people may not be able to make or understand certain decisions for themselves staff did not have a good understanding of and had not always followed the requirements of the Mental Capacity Act (MCA) 2005. At our inspection in January 2015 we saw people being wheeled around in armchairs. We witnessed this happening again at this inspection. We had been told by the provider following the last inspection that, 'this was agreed with families to minimise the frequency of hoisting these people and in their best interest'. However, we did not find records of best interest decisions in people's care plans to support this.

Where a person required their medicine in food or drink (covert administration of medicines) there was no evidence that a best interest meeting had been held or that the decision for example by a GP, had been reviewed.

Decisions on behalf of people had not been made following proper procedures. One person's medical appointment was cancelled because their relative refused consent. There was no evidence in this person's care records to indicate their family member had the legal right to do this. We saw everyone's room had a sign on the door which read, 'can you please lock my door when I'm not in it'. Staff told us no-one living in the home had capacity but there was no information in people's records to show how the decision had been reached to display these signs.

The lack of following legal requirements in relation to consent was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received support from staff who were not provided with regular training or training to meet people's specific needs. Staff told us they had an induction when they started working in the home and this was followed by a period of shadowing a more experienced member of staff. One member of staff said they had received training such as manual handling, food hygiene and person-centred care and they had training planned in tissue viability, speech and language therapy and MCA and DoLS. However, we found most staff were behind on their training. For example, of the 32 staff only 12 were recorded as having received food hygiene training, four staff had received dignity and respect training, 19 staff had fire training and 10 staff had MCA and DoLS training.

Despite the majority of people in the home living with dementia only nine of the 32 staff had received dementia training. We asked staff to explain to us the different types of dementia, but some were unable to do so. One senior member of staff did not understand the differences in dementia and another member of staff was unable to give a confident explanation to show their understanding. These staff confirmed they had not had training in supporting people living with dementia. This may mean that people receive inappropriate care or support.

Inadequate

# Is the service effective?

The lack of supporting staff to receive appropriate training in order to ensure they could competently carry out their role was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were able to tell us what they would do in an emergency, such as if someone stopped breathing or were choking on food. They were able to explain the different types of diabetes and how these could be managed. However we did not find people were necessarily supported by staff who had a good knowledge of them. When we asked staff about individuals they were able to describe people to us and the reason they were living in the home. However, a member of staff told us one person was at risk of falls, but they were unable to tell us anything else about this person and told us they had not read their care plan. The staff member said they got all the information from the nurse as to people's needs, care and support.

**We recommend the provider ensures that staff are aware of each person's needs and with the content of people's care plans.**

Although there was a choice of main meal at lunch time we did not observe staff offer this to people. We told that people who were on a pureed diet were not given a choice of meal. We observed staff putting meals in front of people. We did not hear staff tell people what the food was and we did not see staff offer the two meals plated up to people to allow them to choose what they wished to eat by seeing the food visually.

We saw staff offer people a choice of drinks throughout the day, however between breakfast and lunch (a period of over three hours) we did not see people being offered a snack. The chef told us the menu was pre-decided and there was no process for involving people in developing the menu. We noted there was no fresh fruit available and were told by the chef, "We don't always have fruit every day."

People's dietary requirements were not always made available to kitchen staff or clear in care records meaning people may be served inappropriate food. We were told that one person was served pureed food at meal times, however when we looked at their care records we found no mention of a need to have this. We spoke with their relative who said they didn't know why they were on pureed food and said, "Maybe everyone has pureed." We spoke with staff about this and they gave us conflicting views on this person's dietary requirements. We asked two staff members what the pureed meal served on the day was and neither were able to tell us.

The chef did not hold a list of people's individual requirements and was only provided with a list from staff of those people who were on a soft diet and those who were on a normal diet. We asked the chef about people who may be diabetic or have any other dietary requirement and they told us they were reliant on staff knowing this information when they requested food at the serving hatch. However, the chef did tell us that sweeteners were used in all foods that otherwise would have contained sugar so people with diabetes could eat them.

The chef felt restricted in the meals they were able to provide people. For example, they said they would like a fryer to be able to cook fish and chips and a blender in order to puree food in a better way. We noted they had requested the fryer earlier in the year.

We found people may not always receive responsive care. We read one person was suffering from a pressure sore but their care plan body map had not been completed. And a further person who suffered from a skin injury had no care plan or pre-assessment in their records to indicate what care and treatment this person required.

People's individual needs were not being met which was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who required support to eat were done so in an unhurried way. We saw staff sitting at the same level and facing people they were assisting with their meal. We observed how staff ensured the person was ready for their next serving before offering it to them. One person was reluctant to eat and we observed staff trying different tactics to encourage them. A relative told us the food was always served nicely and was always hot.

Relatives were happy with the care staff provided. A relative told us that staff encouraged their family member to get out of bed each day and they felt they could see they had, "Straightened up" since they had been in the home. Another relative said they felt their family member had immediately brightened up when they moved in.

Staff had the opportunity to meet with their line manager to discuss work, any concerns and their aspirations. We

Inadequate

# Is the service effective?

were told the head of carers supervised the care staff and the registered manager carried out clinical supervisions with the nursing staff. Staff told us they felt supported as the care staff were divided into teams and each team had an assigned nurse. We saw evidence of staff receiving supervisions and one to one meetings as well as appraisals.

People were supported to access external health care professionals. The local GP practice was very involved in the home and visited every week. We spoke with one of the GPs who told us referrals to the practice were made appropriately by staff and staff were very good at working with people living with dementia. They said there was always someone (a nurse) who knew what was going on in the home in relation to people's health. There was evidence in care records that people had involvement from other health care professionals such as an optician, physiotherapist or speech and language therapist. A healthcare professional said staff listened to their guidance and in one particular case one person had improved considerably due to staff giving good care.

Requires improvement

# Is the service caring?

## Our findings

One person told us, "No complaints" when we asked how well they were being looked after by staff. They said, "Staff come when I call and if I want a cup of tea they'll make one for me." A relative told us, "It's the cat's whiskers. I am so impressed with it."

Despite these comments however, we found staff did not always treat people as though they mattered or with respect and dignity. At our inspection in January 2015 we observed occasions when staff were not respectful to people. Following that inspection the provider said they would re-emphasise with staff the importance of showing people respect and remind them to follow good practice guidelines. However, from our observations at this inspection we found staff still lacked a respectful attitude and approach when caring for people. We saw one person sitting in the lounge in wet clothes. We saw staff talk to this person several times and offer them their afternoon tea. Despite this staff failed to notice this person's wet clothes and we had to point this out to staff after a period of over an hour.

We saw people being wheeled around in armchairs and at one point a member of staff pulled someone backwards in the chair as opposed to pushing them. We saw the staff member place them at the dining table with their back to everyone. We observed this person trying to turn around to see whether or not they were going to get lunch. They were calling out, "When are we going to get any food?" Another person was placed underneath a television when staff brought them into the lounge, meaning they would be unable to watch it. We heard one person shouting out and heard a staff member ask them what was wrong. However, we watched the member of staff walk away without waiting for the person to respond. At tea time one staff member asked a person if they would like a clothes protector on, but another member of staff told them, "Just say yes, for her." Laundry staff told us people's protective underwear was shared out amongst everyone and people did not have their own individual items which did not promote people's dignity.

People were not cared for by staff who were proactive in engaging with them or making spontaneous conversation. Although staff sat in the lounge area at times and we saw them respond to people's requests, we did not hear staff instigate much conversation with people. We observed some staff just walking around or leaning up against the wall watching the television. During the afternoon when staff had more time to attend to people we did not see staff take the opportunity to spend time with people.

People did not receive the individualised care they required. One person was unable to communicate and we read in their care records they were to be checked every two hours for taking to the toilet. We observed this person sat for the majority of the day without staff checking them. Their care notes also noted, 'you must use pictorial language and speak slowly and clearly and ask yes/no questions' but we did not see this happen when staff spoke with them.

People's privacy was not always upheld and staff carried out practices which meant they did not respect people's privacy or personal space. We noted some of the bedroom doors were locked which meant people were unable to return to their rooms for privacy if they wished it. One room had a door either side of the room and we noted staff used this as a walkway between two corridors. We asked staff why they did this and were told it was easier to do this, rather than going through the hallway doors which had keypads fitted. We also noted that only one door had signs on to indicate it was someone's room. The other door was bare which meant people would not necessarily know it was someone's room.

The lack of respect and dignity shown to people was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see some good examples of care however. We saw staff reassure people when they displayed anxious behaviour and we observed staff spend time with these people, comforting and chatting whilst trying to establish what was upsetting them. We saw people respond in a positive way to this interaction, for example smiling at staff.

Other staff interacted with people and showed patience, compassion and gave people time. When people were being transferred between different seats, we heard staff give reassurance and guidance throughout the procedure. People were encouraged to make some decisions for themselves. For example, we saw one person had asked for a sandwich mid-morning which they enjoyed with a cup of tea.

Requires improvement

# Is the service caring?

We saw one person being brought into the lounge in their wheelchair. The member of staff ensured they were warm and covered their legs with a blanket. We heard some staff use lots of endearments throughout the day. A member of staff discreetly asked one person if they could take them to the toilet and another member of staff stooped down to speak to someone. We saw the person gently cradle the staff member's face.

Visitors were able to visit when they wanted. We saw visitors arrived in the home and heard them greeted by staff. We heard staff chat comfortably with visitors showing they knew them.

Requires improvement

# Is the service responsive?

## Our findings

One person said they liked to do their word search puzzles and watch the news to keep up with what was going on the world.

Activities were varied, although we found people who spent a lot of time in their room, or who preferred not to join in on the group activities did not have much one to one interaction from staff. The large lounge area was divided into two separate spaces. During the morning we observed a pet dog session. We saw people in the larger lounge area pet the dog after which it was taken to some people who were in their rooms. During the afternoon an entertainer came into the home and we heard and observed people enjoying the event and singing along. However, we noted the activities person sat watching this event, when people sitting in the smaller part of the lounge were on their own and people in their rooms could not participate. We did not see them or other staff take the opportunity to spend one to one time with people during this period. One person had recorded in their care records, 'take time to sit and chat on a one to one' but we did not see this happen. One person told us staff came to assist them when they needed it, but they didn't come to have just "A chat."

At the start of the inspection we found six out of seven people asleep in the lounge area and one person asleep sitting at a dining room table. Throughout the day people in the smaller area of the lounge were seen either just sitting or asleep. One person in particular had been asleep most of the day and we did not notice staff encourage them to wake up or engage with them, apart from during the lunch period. Some staff told us they felt there was enough going on each day and they sat and talked to people when they could, but we did not see this happening much during our inspection. However, other staff said more activities were needed and they said people were bored.

People could not always access the activities room. There was a separate activities room which contained textiles and sensory items. We asked if people were able to access this room if the activities person was not around and were told, "Yes", but this was not possible because the room was locked when they were not working. A board containing details of the activities taking place each day was in this room meaning that although people were told each day what was happening, they did not have anything visual to remind or prompt them. Folders containing information and photographs of people were also held in this room, meaning they were not always immediately accessible to staff. Staff told us they had not read these folders which meant they had not taken the time to get to know people's backgrounds.

Staff did not always understand the need to consider people living with dementia. The lounge area and downstairs corridors had been redecorated since our last inspection and appeared much brighter and a more pleasant environment for people. The provider told us they were trying to make the environment more suitable for people living with dementia and there was more work to do. However, we saw a person placed under the television by staff. At the time there was a cowboy film on the television meaning this person would have been able to hear loud banging noises, but would not have been able to identify where they were coming from. We also noticed the clock in the lounge did not have any numbers on the dial which would not be easy for people to read and we also noticed it was set at the wrong time which may cause confusion for people.

People did not receive responsive care. For example, we noted one person had a two-hourly repositioning chart but there was no record they had been turned between 10:50 on one day and 12:28 on the next. Staff told us this had happened but could not evidence it. Another person had not had their weight recorded since they moved into the home which meant staff would not be able to identify if this person was losing weight. This person had six records of refusing food in seven days but despite this staff were not monitoring this person's weight to see if they were at risk of malnutrition. A further person had a sore on their back and it was noted in their care plan, 'do not put on their back' yet the turning chart information completed by staff indicated staff had not followed this guidance which may put this person at further risk of sores. One person with diabetes, had no care plan or guidelines regarding this diagnosis or possible symptoms they may display which meant they may not receive appropriate treatment.

The lack delivery of care as well as a lack of person-centred care was a breach Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were provided with information on how to raise a concern or make a complaint. A relative told us they would have no hesitation in speaking to the (registered) manager

Requires improvement

# Is the service responsive?

if they felt unhappy about anything. We noted one complaint was on-going and we talked to the registered manager about this. They explained to us the detail of the complaint and how this was being addressed as the complainant had not been satisfied in how their complaint had been responded to.

Requires improvement

# Is the service well-led?

## Our findings

Records held were not always complete which meant new or agency staff who did not know people might not be providing appropriate care or working to the most up to date information. At our last inspection we made a recommendation to the provider in relation to the care records and the importance of keeping up to date information. We were informed by the provider following that inspection that records would be reviewed and updated as necessary. However we still found inaccurate and missing information. For example, one person required their blood sugar levels to be taken daily, however there were no records to confirm this had happened on 10 occasions in the last nine weeks. In relation to the care people may require. We noted in three people's care records it was recorded, 'today we had x join us for pet therapy. Enjoyed by all'. Of these three people one person was seen to be asleep all morning, another told us they had not seen the dog and the last person was frightened of dogs.

The registered manager did not always have a good understanding of their responsibilities, for example sending in notifications to the CQC when certain accidents or incidents took place. We found during our inspection a serious incident had not been reported to CQC which meant they were not complying with their registration requirements. We talked with the provider and registered manager about this who said they had involved the police and local authority in relation this incident. We spoke with the local authority who confirmed they had been informed of it.

Quality assurance processes were not effective. The provider showed us they carried out regular audits of the home as well as holding management meetings to discuss all matters relating to the home and to monitor improvements. However although these were done, the provider and registered manager had not picked up or actioned areas we identified at both this and our previous inspection. For example, the unclean environment, the lack of suitable premises and the poor medicines management procedures.

Health and safety checks were carried out in the home by staff. For example, we saw annual testing in place for legionella, gas safety and the intercall system. We spoke with the maintenance person who told us they carried out regular portable appliance testing (PAT). They explained this was done as and when people moved into the home. However, they were not able to show us any evidence of how they recorded this or monitoring when the next PAT test was due.

The lack of robust record keeping and quality assurance was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One relative told us, "The (registered) manager is terrific. She really takes care and looks after people." A professional said the registered manager was very supportive and related well to relatives and staff. And staff told us the team working in the home was better now. One member of staff said things weren't so good at the beginning of the year, but there were new staff and it was working well. They said the registered manager knew people well and people knew her. Staff said they felt very supported by the registered manager and one had been encouraged to complete some additional qualifications. One member of staff said they loved their job and another said, "The staff are very good, hard working, we all work as a team."

Relatives, people and staff were involved in the running of the home. We saw the provider had sent out a survey questionnaire in the last 12 months and the responses had been collated. The response rate was low, but we noted that most people were happy with the care provided by staff in the home. Staff met regularly and had the opportunity to discuss any aspects of the home as a whole team. Staff told us they felt comfortable speaking up at these meetings.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment<br>**The registered provider had not provided people with clean, suitable premises and equipment.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**The registered provider had not ensured staff followed proper and safe medicines management procedures.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br>**The registered provider had not followed legal requirements in relation to restrictions to people.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br>**The registered provider had not followed legal requirements in relation to consent.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>**The registered provider had not ensured all staff were provided with appropriate training.** |

This section is primarily information for the provider

# Action we have told the provider to take

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect<br>**The registered provider had not ensured staff treated people with respect and dignity.** |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br>**The registered provider had not ensured effective planning of care or people were not provided with person-centred care to meet their needs or preferences.**<br>**The registered provider had not ensured people's nutritional needs were being met.** |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**The registered provider had not ensured that up to date, contemporaneous and accurate records for people were maintained.** |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>Regulation 12(2)(g)<br><br>The registered provider had not ensured staff followed proper and safe medicines management procedures. This was a continued breach from our inspection in January 2015. |

**The enforcement action we took:**
We issued a warning notice to the registered provider on the 18 November 2015 in relation to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have set a timescale of 30 January 2016 by which time the registered provider must have addressed this breach.