Care Quality Commission

Regal Care Trading Ltd

Linden Manor

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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

Linden Manor provides a service for up to 28 older people, who may have a range of care needs including dementia, sensory impairments and physical disabilities. There were 19 people living in the home on the day of this inspection.

We carried out an unannounced comprehensive inspection of this service on 5 March 2015 and found legal requirements had been breached.

We also reported that the home had been operating under an administration company since May 2012, along with 16 other services, due to the financial difficulties of the previous provider. In April 2015, we were informed that a new owner had acquired the home, but had kept the same provider name (legal entity). A representative for the new owner wrote to us to say what they would do to meet legal requirements; to ensure people using the service were protected against the risks associated with unsafe or unsuitable premises, because of the design and layout.

We undertook this inspection to check that they had followed their plan and to confirm they now met legal requirements.

Summary of findings

Since the last inspection in March, the Care Quality Commission (CQC) has received information about a number of concerns relating to the service. These included concerns about staffing levels and dementia care provision. We looked at these concerns during this inspection too.

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

This inspection took place on 7 October 2015 and was unannounced. We found a number of concerns and areas where improvements were required:

Processes in place to manage identifiable risks within the service were not sufficiently robust.

There were insufficient numbers of staff to keep people safe and meet their needs.

The provider carried out recruitment checks on new staff to make sure they were suitable to work at the service, but these did not fully meet legal requirements.

Parts of the premises and equipment used by people living in the home were not adequately clean or used properly.

There were inconsistencies in the way the service worked to the Mental Capacity Act 2005 key principles, which meant that people's consent was not always sought in line with legislation and guidance.

People had enough to eat and drink, but assistance to eat was not provided adequately where this was required.

The staff were kind and caring, but there were missed opportunities for meaningful engagement with people.

People were not fully involved in making and planning their own care.

People's dignity was not consistently upheld.

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

People's social needs were not provided for and they did not have adequate opportunities to participate in meaningful activities.

People were given opportunities to express their views on the service and raise concerns, but this feedback was not always acted on.

There were ineffective management and leadership arrangements in place.

The systems in place to monitor the quality of the service provided and drive continuous improvement, were also inadequate.

Staff had been trained to recognise signs of potential abuse and keep people safe.

Systems were in place to ensure people's daily medicines were managed in a safe way, and that they got their medication when they needed it.

Staff had received training to carry out their roles and meet people's assessed needs.

People's healthcare needs were met. The service had developed positive working relationships with external healthcare professionals; to ensure effective arrangements were in place to meet people's healthcare needs.

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

Summary of findings

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.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service is not safe

Staff understood how to protect people from avoidable harm and abuse.

However, processes in place to manage risks were not sufficiently robust.

There were insufficient numbers of staff to keep people safe and meet their needs.

Recruitment checks did not fully meet legal requirements.

Parts of the premises and equipment were not adequately clean.

Systems were in place to ensure people's daily medicines were managed in a safe way and that they got their medication when they needed it.

Is the service effective?

Requires improvement

The service was not always effective.

Staff received training to carry out their roles and responsibilities.

There were inconsistencies in the way the service worked to the Mental Capacity Act 2005 key principles.

People had enough to eat and drink, but assistance to eat was not adequately provided.

People were supported to maintain good health and have access to relevant healthcare services.

Is the service caring?

Requires improvement

The service was not always caring

The staff were kind and caring, but there were missed opportunities for meaningful engagement with people.

People were not fully involved in planning their own care.

People's dignity was not consistently upheld.

Is the service responsive?

Requires improvement

The service was not always responsive

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

People's social needs were not provided for.

People were given opportunities to express their views on the service, but their feedback was not always acted on.

Summary of findings

Is the service well-led?

Inadequate

The service is not well led.

There were ineffective management and leadership arrangements in place.

The systems in place to monitor the quality of the service provided and drive continuous improvement were also inadequate.

Linden Manor

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.

The inspection was unannounced and was carried out on 7 October 2015 by two inspectors, a specialist advisor in dementia care, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The inspection was carried out to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 5 March 2015 had been made.

Since the last inspection in March 2015, the Care Quality Commission (CQC) has received information about a number of concerns relating to this service. These included concerns about staffing levels and the care provided to people living with dementia. We looked into these concerns during this inspection as well.

We checked the information we held about the service and the provider, such as notifications. A notification is information about important events which the provider is required to send us by law. In addition, we asked for feedback from the local authority who has a quality monitoring and commissioning role with the service.

During the inspection we used different methods to help us understand the experiences of people using the service, because some people had complex needs which meant they were not able to talk to us about their experiences.

We used a dementia mapping tool. We used this to observe the care provided to people and to help us understand the experience of people who could not talk with us.

We spoke with thirteen people living in the home and also observed the care being provided to thirteen people - some of whom we had spoken with, but not all. We also spoke with the registered manager, the area manager, the head of care, six care members of staff, the chef, the housekeeper and three relatives.

We then looked at care records for three people, as well as other records relating to the running of the service such as: staff records, medication records, audits and meeting minutes; to corroborate our findings, and to check whether or not the required improvements had been made.

Inadequate

Is the service safe?

Our findings

Staffing levels were not sufficient to meet people's needs.

Prior to this inspection, we received information raising concerns about staffing levels in the home relating to staffing levels at night being reduced to two; this was a concern as many people living at the service required two members of staff to help them get up. This meant that if one person needed the toilet during the night, for example, there would be no staff available to provide other people with care or support. The registered manager confirmed that night time staffing levels had been reduced to two, stating that this was due to the current occupancy level of the service. They also confirmed that over half of the people living in the home required two members of staff to support them with their mobility.

People told us there were insufficient numbers of staff to keep them safe. One person told us: "If I want to go to the toilet I have to wait, it's sometimes too late." Another person said: "I know they are busy so I try not to ring the bell." A third person added: "They have been doing the garden up for us, it would be good to get out there but we don't go out, I think it would take too many staff to move us."

Relatives echoed these concerns. One relative told us: "I think the staffing is sometimes a problem at weekends, they always seem rushed then." Another relative said: "I would like [person] to have more baths but I don't think they can fit it in." A third relative told us, "You can sit here for ages and not see a member of staff. They are all very caring, lovely people, but they are so pressed, with so much to do."

Staff told us that sometimes they were unable to provide people with the care they needed, when they needed it. One staff member said, "If we are busy with someone and then another resident needs attention, we have to work out who needs us most. There are times when we need more staff." Another staff member explained to us that there were times when people would be left sitting in the communal areas of the service, without any staff interaction. This was because the staff that were on shift had to provide support to people who were unable to independently mobilise. Observations throughout our inspection confirmed that people were often left sitting in communal areas, without staff support or interaction. We also saw people having to wait for extended periods of time, before staff were available to help them to use the toilet. On one occasion, we saw that by the time staff were able to attend to someone, their clothing was wet.

We spoke to the registered manager about staffing levels in the service. They told us that these were set by the provider and we saw an email which confirmed this. The registered manager was not able to demonstrate that staffing requirements had been calculated taking into account the number of people living at the service, their assessed needs or the complex layout of the building. Staff rotas confirmed that on the day of the inspection, there were four members of care staff during the day and two at night, providing care and support for 19 people. The registered manager was supernumerary on that day but we noted that at weekends, the planned staffing levels decreased to four during the day, because the registered manager was not planned to work.

This showed that staffing levels had not been regularly assessed and were not sufficient to meet people's individual needs and keep them safe.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had not planned to look at arrangements for the prevention of control and infection prior to the inspection. However, we found a number of areas on the day that raised concerns about the cleanliness of the home, and the use of equipment that was intended to keep people safe.

We found that a number of people required the use of a hoist to go to the toilet. The registered manager confirmed this to be over half of the 19 people living in the home. To minimise the risk of cross contamination, sufficient individual toileting slings would need to be available. The registered manager confirmed there were only eight toileting slings available - two of each different size. She confirmed that this was not enough to ensure people had clean slings available when they required them, and in order to prevent the risk of infection. We raised this with the area manager who confirmed the following day that new slings had been ordered, in numbers sufficient to meet the needs of the people currently living in the home. She also informed that the provider had authorised for new slings to be ordered as required in the future.

Inadequate

Is the service safe?

Offensive odours were detected in parts of the home. One person living in the home commented on this too. They told us: "It sometimes smells a bit in here." Other areas that raised concerns about cleanliness included damaged tiles in the downstairs shower room behind the toilet; meaning this area could not be cleaned properly. We found cobwebs on light fixtures and dirt / dust on top of furniture and around fixtures / fittings. Table cloths that were used at lunch time were stained; they had been in place since breakfast.

The registered manager told us there were normally two domestic staff on every day across the week. However, she told us that one member of staff had been on long term sick leave. This meant there was only one domestic member of staff on duty. Staff rotas we looked at confirmed this. There was no evidence that arrangements had been made to cover this absence.

We noted from records that poor standards of cleanliness had been highlighted by the area manager in her August 2015 audit of the home. Our findings showed that action had not been taken since to address the concerns about cleanliness in the home. This meant that the arrangements for keeping the service clean and protecting people from potential acquired infections were not adequate.

We observed some potential hazards for people living in the home, staff and visitors. For example, fire fighting equipment was not in a usable condition, and safe procedures were not always followed. We saw a fire door propped open with a chair, and a fire extinguisher had its pin missing, with no tamper proof seals observed. An audit undertaken by the area manager in August 2015 identified that a fire extinguisher had been found empty on that occasion, and no one could remember how it had happened. Our findings meant there was a possibility of this happening again.

This meant that parts of the premises and equipment were not always clean or properly used.

This was a breach of Regulation 15 (1) (a) (d) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people were not effectively assessed and managed by the service. For example, we found an open bottle of disinfectant in a communal area of the home. We were concerned that someone might mistake the contents of this bottle for another type of fluid, if they were confused.

We also found risk assessments that were inconsistent with the providers own policies. We looked at three people's falls risk assessments. Each had a rating of 'high risk' or 'very high risk'. The risk assessments stated that a risk rating at these levels required a specific falls care plan. In all three cases we found that a falls care plan had not been put in place. We asked the registered manager about this and they confirmed that these plans were not in place. This meant that the registered manager and provider had not taken steps to do all that was reasonably practicable to mitigate the risks to people which they had identified.

We also found inconsistencies in the risk scale used within the organisation's own tools for measuring falls. We found that that one person had two separate falls risk assessments in their files, using slightly different scales for assessing the level of risk. The outcome for one was moderate risk whilst the other was high risk. It was therefore unclear to us which contained the correct level of risk. Both assessments had been reviewed by the registered manager on the same day on a regular basis. This indicated that reviews of people's assessed level of risk were ineffective.

This was a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People confirmed that they felt safe living at the service. One person told us: "It's alright here, I do feel safe." Another person added: "I feel safe and secure here, they treat me ok and I don't feel frightened or threatened." Relatives were in agreement with this. For example, one relative told us: "I feel that [person]'s very safe here, they care for [the person] well."

Staff told us they had been trained to recognise signs of potential abuse and knew how to keep people safe. They demonstrated a good understanding of safeguarding procedures. One staff member told us: "I think the residents are safe, we all care about them and would speak to the manager if I had a concern." Another staff member said: "I am an experienced carer and take safeguarding very seriously. I would have no hesitation about speaking out if I wasn't happy about anything." We saw that information was on display which contained clear information about safeguarding, and who to contact in the event of suspected abuse. Records confirmed staff had received training in safeguarding, and that the service followed locally agreed safeguarding protocols.

Inadequate

Is the service safe?

We observed that people who were being cared for in bed were turned regularly; to minimise the risk of developing a pressure ulcer. We also observed staff on a number of occasions supporting people to mobilise and move about the home. One person told us: "I have to be moved using the hoist; it's safer for me as I have fallen in the past." Staff demonstrated safe techniques and were kind and gentle. They provided people with clear explanations, so they understood what was happening to them.

Clear information was available regarding fire safety and the arrangements to follow. We spoke with one person living in the home who told us: "I do feel a bit anxious as I am in a wheelchair, if there's a fire I don't know how I would get out." We found that each person had a PEEP (personal emergency evacuation plan) in place. These outlined people's specific support needs and the equipment required, should the need arise, to evacuate them from the building in an emergency. We noted for the person we had spoken to that their PEEP had not been signed by them, indicating that they were not aware of its existence. This might have provided the person with some assurance that plans were in place to protect them in the event of the outbreak of a fire. The registered manager also showed us that a business continuity plan had been developed. This showed that there were arrangements in place to respond to emergencies or untoward events.

The registered manager showed us the processes in place to ensure that safe recruitment practices were being followed; to ensure new staff were suitable to work with people living in the home. We saw that new staff did not take up employment until the appropriate checks such as, proof of identity, references and a satisfactory Disclosure and Barring Service [DBS] certificate had been obtained. We looked at a sample of staff records and found that the majority of legally required checks had been carried out.

However, providers are legally required to obtain a full employment history for people working in registered care setting, and we noted that the organisation's application form only requested information for the previous five years of employment. This meant that this information was not available for all staff. We brought this to the attention of the area manager who told us changes had been approved by the provider, to ensure they obtained this information in future.

Systems were in place to ensure people's medicines were managed so they received them safely. People told us they got their medication regularly and when they needed it. One person told us: "I get painkillers when I need them." Another person said: "I have all my pills regularly, no problems." A relative added: "If they change [the person's] tablets, they let me know."

Staff demonstrated a good understanding about medication processes such as administration, management and storage. We observed people receiving their medication and noted that people were given time and staff explained what they were being given. Medication administration records (MAR) provided information about medication stock levels and administration, including missed / refused doses or use of PRN (when required) medications. We did note however, that staff did not always provide an explanation for one of the codes they used on the MAR. This meant we could not be clear about whether some medications had been given as prescribed or not. We also noted that one person had a thickener prescribed which was added to drinks; to minimise the risk of them choking. Although we saw the thickener being used during the inspection, the MAR was not used to record this. This meant there was a risk of the person not receiving the thickener as prescribed, because staff did not have a record of its use to refer to.

Requires improvement

Is the service effective?

Our findings

At our last inspection in March 2015, we issued a 'requirement notice' because parts of the building were not dementia friendly. This was because we had observed one person becoming very distressed because the hallway flooring gave them the impression that they were in a train station, and if they went through to that area they would be in danger of being hit by a train. We also saw that the colour of carpet on the second floor landing and staircase were the same; making it difficult for some people living with dementia to discern the change in floor level. This was a breach of regulation 15 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which relates to regulation 12 (1) (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new provider initially agreed to address our findings, but we were contacted again in June 2015 by the registered manager. She told us that the person in question had been unwell at the time of the March 2015 inspection. She also told us that a similar incident had not happened since, and that people and relatives wanted the floor to remain as it was. During this inspection we observed the person in question walking around the home and there was no indication that they or anyone else were affected by the flooring. We saw minutes of a meeting, where the manager had discussed the flooring with five people living in the home. No one had raised any concerns and they wished for the flooring to remain. We therefore found that the flooring was no longer causing a problem for people using the service.

Staff told us that they received training on dementia, including a 'virtual dementia' experiential training course, which some had attended. They were able to tell us about different types of dementia people may have, and different ways of communicating effectively with people living dementia. Staff also explained how they would deal with some specific aspects of dementia, such as challenging behaviour. However, some of their explanations raised concerns about how people were cared for, as well as the effectiveness of their training. For example, if somebody became aggressive, staff told us they would walk away and return when the person was calm. Only one member of staff was able to demonstrate an understanding of potential causes for this behaviour. None of them took into account the safety of other people in the same area.

During lunch, we noted that staff provided minimal support to people who needed assistance with eating and drinking. For example, we saw that a number of people spilt food down their clothes, and there was a lack of appropriate adapted cutlery and crockery to support good eating. In one of the communal areas, we observed four people sat with plates of food in front of them for twenty minutes. We brought this to the attention of the registered manager on three occasions before she asked a member of staff to provide verbal encouragement to support these people to eat. By this time, it was likely that the food would have been cold. A relative told us they visited every day to assist their relative with eating; to ensure they ate.

One person was given their lunch just after 12:00, despite only having their breakfast at 10:45. This indicated that meal times were not appropriately spaced and flexible to meet people's individual needs.

Staff had some understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS); to ensure people who cannot make decisions for themselves are protected. However, they were clear that all of the people living in the home did not have the capacity to make day to day decisions, because the majority of people were living with dementia. The MCA code of practice however, clearly states that capacity must be presumed and assessments of someone's capacity should be time and decision specific. Therefore, unless someone is in the later stages of dementia it would be very unlikely that they could not make some day to day decisions; provided enough time was given to communicate with them in a way that met their needs.

Although we did observe some verbal consent being obtained before care staff undertook aspects of care, people confirmed that staff did not always seek their consent or involve them in decisions about their care. One person told us: "Staff do ask me what I want doing and I just go along with it, I never say yes or no, it just happens." We observed an occasion when a member of staff came up to move someone who was sat in a wheelchair but did not tell them what they were about to do first. We then saw a recent dignity audit undertaken by the registered manager, which also highlighted that staff did not always explain to people what was happening, why and gain their consent before starting a task. The registered manager told us they intended to include this on the agenda for the next staff meeting, but there was no planned date for this meeting.

Requires improvement

Is the service effective?

We saw that staff meetings were being held, but on an infrequent basis. The last meeting was recorded as 12 May 2015. We did not find minutes for this meeting, only for the meeting before this in April 2015. Staff told us that there had been another meeting in August, but we found no evidence of this. This showed that there were limited opportunities for the staff team to meet regularly as a group; to discuss good practice and potential areas for the development of the service.

People told us they received effective care from staff with the right skills and knowledge. One person told us: "Staff are good here; they know what they're doing." Another person said: "I need the hoist, staff strap me in and I feel very secure, they have a lot of training on this." A third person added: "Staff are pretty good they know what they're doing and they know us all as individuals."

A relative echoed these comments and told us: "The staff seem to know [person] very well and what [their] needs are. Some of them are very experienced and are well trained…I watch them using the hoist; they know exactly what they are doing."

Staff reported that the training they received was good and there was always someone to ask if they needed help. One staff member told us: "I had a good induction; I've never worked in a care home before." Another person said: "The training is kept up to date, the manager oversees that." A third member of staff added: "I understand what each resident needs and what signs to look for if they are becoming unwell."

A training matrix had been developed which provided clear information to enable the registered manager to review staff training and see when updates / refresher training were due. This confirmed that staff had received training that was relevant to their roles such as induction, safeguarding, nutrition, moving and handling, dementia awareness, communicating effectively, pressure care, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Under DoLS arrangements, providers are required to submit applications to a "Supervisory Body" where it is identified that someone's freedom may need to be restricted, if they require more care and protection than others. We saw that a number of DoLS applications had been approved, where people's liberty was potentially being deprived, in order to keep them safe.

People told us they had enough to eat and drink. One person told us: "The food is very good, it's usually warm." Another person said: "Can't beat the food here, I really like it. We also get plenty of cups of tea." A third person added: "The food is okay, I don't have a choice as I have to have it all mushy." Relatives confirmed that people received enough to eat and drink too. One relative told us: "[The person] seems to eat well in here and they offer plenty of choice."

We spoke with the home's chef who was clear about people's nutritional needs and preferences. They spoke knowledgeably about people living in the home, and told us about how they provided for the needs of people with dementia. They also talked about a 'dysphagia diet' which was being introduced following a suggestion by a relative; to ensure that a range of appropriate food was available for people experiencing problems with swallowing.

Throughout the inspection people had fluids within easy reach, and food and drinks were provided at regular intervals. For example, mid-morning, tea and coffee were served with a selection of sweets, chocolates and biscuits for people to choose from.

At lunch time, we observed the chef going around to each person in turn and asking what they would like to eat. They then served each person individually and encouraged people to eat. The portions were generous and the food was well presented and smelt appetising. The majority of people enjoyed the food and ate well. One person who didn't attempt to eat the hot meal was given an alternative choice, which they then ate. This was done in a supportive way with no fuss.

Records we looked at showed that people's nutritional needs had been assessed, with any specific requirements such as soft options or assistance with eating outlined. There was also evidence of involvement from the local nutrition and dietetic service. After lunch we observed that a member of staff went round to check how much each person had eaten.

People talked to us about how their day to day health care needs were met. They told us that they always saw a doctor when they needed to. One person said: "They call the doctor if I need him; they are good at getting them quickly." Another person said: "The doctor came quickly when I wasn't well, and I only have to ask if I need him again."

Requires improvement

Is the service effective?

Relatives were able to confirm this. One relative said: "[The person] hasn't been well and they were quick to call the doctor and get things sorted out." We were also told that if people were not able to get into town for routine appointments, a chiropodist and an optician would come to the home.

Staff told us they felt well supported by external healthcare professionals, who they called upon when they required more specialist support. One member of staff told us: "I ask the district nurse about diabetes." During the inspection, a community nurse came to visit someone living in the home. Records showed that visits to and from external health care professionals were recorded by staff, with the outcome of those visits.

Requires improvement

Is the service caring?

Our findings

People told us that they were treated with kindness and compassion. One person told us: "There is a friendly atmosphere here and staff want to help you." Another person said: "They hang their coats up and get on with the job, they are brilliant." A third person added: "They are all doing their best, its hard work for them."

Relatives echoed these comments. One relative told us: "The staff are very kind and caring. They really care for [person]." Another said: "Staff are lovely and friendly, very caring." We also read some recent feedback from another relative who had written to thank the staff for the care they had showed their relative, and 'the friendliness and respect you all gave to us when we visited'.

Staff told us they believed that all staff were caring and able to meet the needs of people living with dementia at Linden Manor. One member of staff said: "It's a lovely crowd, staff are very caring." We observed a number of positive interactions between staff and people using the service throughout the inspection. For example, a member of staff found time after lunch to chat with someone living in the home. This was a warm exchange and the person appeared engaged and relaxed throughout. However, this approach was not consistent and there were a number of occasions, such as lunch time, when there were very few verbal exchanges between staff and people. This meant there were missed opportunities for meaningful engagement with people.

People confirmed they did not feel involved in making decisions about their care. One person told us: "[I] have never heard of care plans." Another person said: "I think they write things about me but I don't see it." A third person added: "I have a shower each week but I have asked if I could have a bath."

Relatives confirmed this was their experience too. One relative said: "I haven't seen care plans, if [the person] says they want something different, I talk to the staff and it usually gets actioned." Another relative said: "I do think [person's] care is focussed on what they need but sometimes they don't understand what's being said, they keep saying they would like a bath, then end up with a shower." The registered manager showed us a bathing rota which she had developed. This showed that people had two to three slots allocated to them during the week. The rota stated that this was only a guideline, but the approach was not person centred and did not include people's preferences for a bath or shower.

Care records demonstrated inconsistencies in the way the service involved people in making decisions about their care and support. Some people had provided written consent to their care, but there was no evidence of how frequently this had been revisited, or whether they had been involved in a review of their care needs. Other care files lacked evidence of any involvement from the person or their relatives, where appropriate.

Some people told us that they were treated with dignity and respect. One person told us: "They treat me with respect." Another person said: "I feel that it's private when I have a shower." Other people had less positive things to say however. For example, one person told us: "I just sit here all day; they don't come to me much." Another person said: "I would like to have a bath more often." A relative added: "I would like [person] to have a bath more, [they] sometimes look grubby." Another relative talked to us about the food provided and said: "Sometimes it's still all over [the person's] shirt when we visit."

We did observe occasions when people were treated with respect. For example, care staff always knocked on people's doors before entering. We also saw a member of staff discreetly adjust someone's clothing to protect their dignity. However, We found that people's dignity was not consistently respected and promoted. For example, people were not supported adequately during meal times to protect their clothes, and we saw a number of people who were left with food on their clothes. We also observed that people living with dementia had not received full personal care. For example, we saw people who were unshaven or with unclean teeth, and many people had long, dirty finger nails.

Before people had finished their lunch, a member of staff began clearing away using a 'slop bucket' system to clear the plates. This was unpleasant to see, and we noted this process was carried out in close proximity of people. This demonstrated a lack of respect for those people who were still eating their meal.

In addition, people's confidential and personal information was not always stored securely. For example, we found a file with records regarding the personal care that each

Requires improvement

Is the service caring?

person had received in a communal area, which people and their visitors could access. We also found an electronic device, which staff used to carry out people's daily recordings, left unattended, switched on and not password protected. This meant that people's personal information was not kept securely.

Requires improvement

Is the service responsive?

Our findings

People provided a mixed response when we asked them about whether the care they received was person centred. One person told us: "They do know me well and try hard to do what I need." Another person said: "The staff have a great attitude, they care about me as a person and we often talk about what I need." However, some people were not so positive. One person said: "I just sit here all day really, I don't mind what time anything happens - it's just the same each day." Another person added: "I sit in the same place every day, the days are very long."

Staff confirmed that daily routines did not always support a personal centred approach. One member of staff told us: "We routinely take people to the toilet before or after meals." Another member of staff said: "We try and make it individual, but sometimes staffing is low so you have to do your best." We observed occasions when people attempted to communicate with staff but the staff did not respond. Staff appeared more concerned with people's physical needs rather than their psychological needs. For example, we observed a task focussed approach to how people were taken to the toilet after lunch; they were taken in turns as and when two staff became available.

Some people felt they had some choice and control over what they did each day. One person said: "If I don't want to do anything they don't push me." Another person added: "I get up early because that is what I want to do." Other people were less positive, and told us they were not always able to have as much control over their lives as they would like. For example, one person told us: "There is give and take with bedtime, just depends how busy it is." Another person said: "Sometimes I just want to stay in my room, we talk about that and I sometimes go down for tea." We observed care interactions throughout the day. People appeared to have choice for example, in terms of times for breakfast and getting up.

We talked to staff about people's care records, and how these reflected peoples' individual needs and preferences. One member of staff said: "I do refer to the care plans or ask the seniors if I need to know more about a resident's condition." Another said: "I know what they need and I try hard to provide all they need." Records showed that people had numerous care plans in place which covered a comprehensive list of needs. However these were not always clear. For example one care plan for 'maintaining a safe environment' included information about the person's medication support, personal care, falls risk and DoLS (Deprivation of Liberty Safeguards). This made it difficult to get to the point of that particular plan. There was no clear summary of the person's overall needs; making it difficult for a new member of staff or an agency member of staff to gain an oversight of someone's needs, without having to read a considerable amount of information first.

We saw that each person had a 'My Life Story' document in their file. We found very little information in the documents we looked at including blank spaces for people's likes and dislikes. Notes had been attached to confirm staff had not been able to obtain any more information than was recorded. However, some people had lived in the home for a number of years and there was no evidence that staff had tried to revisit this document with the person, or their family; to ensure people's care plans centred on them as individuals and reflected their personal interests and preferences.

We saw that people's care plans were regularly reviewed; to ensure the care and support provided was still appropriate. We were not assured about the quality of the reviews we read however, because some of the entries lacked relevance and appropriate detail. For example, a care plan about self-medication for one person referred to them being unwell, and needing an urgent referral to a doctor. When the care plan evaluation sheet had next been completed, it did not provide an update on this situation, but instead recorded that the person continued to be compliant with their medication. Other records contained regular entries such as: '[person's] wishes remain the same'. There were inconsistencies too in terms of evidence of involvement from people and / or their relatives.

People talked to us about their hobbies and social interests and how they spent their days. One person told us: "We only have entertainment now and again if there's money for it." Another person said: "I just watch TV; there isn't a remote so we can't change the channel." A relative added: "It used to be very good, singers and painting before that staff member left." Another relative told us more one to one activities were needed to provide appropriate mental stimulation for people.

Staff seemed keen to get people involved in activities, but it was clear from their comments that this did not always happen. One staff member told us: "There is a good variety of activities and carers will do it if there's time when all the

Requires improvement

Is the service responsive?

work is done." Another staff member said: "They should go out more; there is too much sitting around." The registered manager explained that an experienced activities coordinator had recently left and that a care member of staff had taken on this role. The member of staff was off sick on the day of the inspection and arrangements had not been made to replace them. There did not appear to be any activity provision in place when the activity coordinator was not present. Staff rotas showed that this included weekends.

We observed missed opportunities during the day for people to participate in daily living activities; to support them in maintaining their independence for as long as possible. For example, at lunch time condiments were not provided. A member of staff went around with salt and added this to people's meals as requested. The same happened with drinks; with jugs being removed from tables once staff had poured the drinks on behalf of people.

At lunch time, we also heard loud music playing in the conservatory which had been popular in the 1990s. We asked the registered manager who was listening to this and were given the name of someone living in the home. We went to check and the person was not in the vicinity. Instead two other people were sat in the conservatory, one of whom told us the music was "rubbish" and that they preferred country music. The television was also on in this room. We passed this onto the registered manager, but it took over 20 minutes before the music was changed. It was a concern that staff had not taken into account the impact of noise level / conflicting sounds for people living with dementia, which can be disorientating and distressing, especially at busy times of the day such as meal times. After the music had been changed, we heard someone singing along to the music, and it was clear that they were engaged with it.

Aside from external visitors such as relatives and a Chaplain, we did not observe any meaningful activities taking place during the inspection, which lasted just over eight hours. We read some information that had been written for prospective users of the service which stated: 'The home offers a wide range of activities designed to encourage the client to keep mobile, and most importantly take an interest in life'. Throughout the day we saw people sitting in chairs drifting in and out of sleep. They only moved when going to the toilet, or getting up for meals. Records we looked at confirmed that activities had been identified as an issue by the area manager in her August 2015 audit of the home. Findings from this inspection have shown that improvements were still required in this area.

People told us they would feel happy making a complaint if they needed to. They told us they felt staff were approachable, and they would feel comfortable talking to them if they were unhappy about something. One person said: "I don't know the formal route but I would speak to the senior." Another person said: "I have asked for things to be changed and it was sorted quickly." This was confirmed by a relative who said: "We have complained and they usually listen and act."

A formal complaints policy had been developed, outlining what people should do if they had any concerns about the service provided. The registered manager showed us a complaints log which she used to record any complaints and compliments received, and the actions taken to address these. We noted that complaints entered into the log had not always been completed or signed off. In one case, a copy of the original complaint had not been filed. This meant there was no clear audit trail or evidence to show that the complaint had been resolved to the satisfaction of the complainant.

In addition, we read some feedback from people using the service following a residents meeting the month before the inspection. A number of issues had been raised by people and recorded in the minutes. For example, one person said they would like to get up earlier in the morning and go to bed a bit later. Another person raised concerns about not always getting assistance when they needed the toilet. These issues had not been transferred to the complaints logs for action, nor was there any evidence to say what action had been taken in response.

Other meeting minutes, for a meeting held in May 2015, recorded that a relative had requested an exercise programme to be implemented for someone living in the home. The registered manager confirmed during the inspection that this had not yet happened. This showed that people's feedback, concerns and complaints were not adequately listened to and acted on.

Inadequate

Is the service well-led?

Our findings

The service did not deliver high quality care.

When we spoke with the registered manager it became clear that she was not fully aware about all her legal responsibilities. This is because she had not yet familiarised herself with the Health and Social Care Act (Regulated Activities) Regulations 2014, which came into force on 1 April 2015. An example of this was in terms of staff recruitment, and the required checks that need to take place before someone is employed to work in a registered care setting.

The registered manager and area manager talked to us about the audits they carried out; to check the quality of the service provided. We looked at some of the most recent audits, which had been carried out in August and September 2015. We noted that the audits had been designed to comply with previous CQC guidance and legal requirements, which had changed over six months prior to the inspection. This meant the provider could not demonstrate how they assessed the quality of service provision in terms of the five key questions we ask: is the service safe, effective, caring, responsive and well-led?

We were not assured about the effectiveness of the internal audits that had been carried out. This is because a number of areas identified as requiring action during the inspection had also been identified within the service's own audits. It was clear from our findings that changes had not yet been implemented; to improve the service provided to people living in the home. For example, the arrangements for keeping the service clean and protecting people from potential acquired infections were not adequate, people were not always treated with dignity and respect, people were not supported to follow their interests and take part in social activities of their choosing, and people were being placed at possible risk; because equipment designed to keep them safe, such as fire extinguishers, had not been maintained properly. There was nothing to demonstrate the actions taken by the service to address these concerns, and improvements were still required in all of these areas.

We also found that staffing levels had not been assessed; to ensure they took into account people's individual needs and the layout of the home. We found that the care people received was not person centred as a result, and that the current staffing arrangements were not sufficient to meet people's individual needs and keep them safe.

In addition, there had been a failure to carry out robust reviews of key documentation, such as people's risk assessments. Reviews had taken place, however they had failed to identify concerning issues, such as the lack of falls care plans, or the fact that one person had two conflicting risk assessments for the same area. This meant that reviews of people's assessed level of risk were not effective, and they were being placed at risk because steps had not been taken to mitigate identified risks.

This showed that the provider and registered manager had not implemented effective systems or processes to assess, monitor and improve the quality and safety of care which people received.

This was a breach of Regulation 17(1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Systems were in place to ensure legally notifiable incidents were reported to us, the Care Quality Commission (CQC). Our records showed that the registered manager reported these incidents as required. Prior to the inspection however, we received information of concern about the call bells not working in the home. We spoke with the registered manager and provider about this, because we had not been informed by them. It was clear from meeting minutes we read, that informing CQC about the call bells had been considered. The provider told us they had sought advice from CQC on this, and been advised that this was not a notifiable incident. There was no record of this on our system to support this. Although the regulations are not specific on this particular matter, we discussed that the lack of information and updates about the call bell situation raised questions about their honesty and transparency; in terms of what else we may not have been informed about. We checked other records such as safeguarding referrals, accidents /incidents and complaints. We did not find evidence of any concerns, accidents or incidents that should have been reported, but were not. Since the inspection, the registered manager has also ensured that we have been kept informed of potentially notifiable events, such as a fault on the home's

Inadequate

Is the service well-led?

fire alarm system. She reported that this and the call bell system had been fixed. We checked the call bell system during the inspection and found that it was in working order.

There was a registered manager in post, who was supported by a head of care and senior care staff. At the time of this inspection there was no deputy manager. We asked people about the management of the home and we received a mixed response. For example, one person told us: “It’s a lady, she seems ok and I have spoken to her.” Another person said: “I speak to the senior carer I don’t know the manager.” The majority of staff we spoke with felt that the manager was approachable. One person told us: "I see her around a lot; she encourages us to talk to her.” Another person said: “She’s very supportive, especially with further training.” A third person added: “She tries to do what’s best for the home.” Staff were clear about their roles and responsibilities. They knew what was expected of them; to ensure people received support in the way they needed it.

People told us there were opportunities for them to be involved in developing the service. For example, we were told about relative and resident meetings that took place, and satisfaction surveys. We also observed after lunch that people were given opportunities to provide feedback about the meal, soon after eating. Many people were aware of plans being developed to improve the home. They were not aware of the timescale for this to happen however. The building is a former manor house with lots of history and original features. The layout is complex in parts and could be difficult for people living with dementia to orientate around. For example, we saw a toilet that had a number on the door rather than appropriate signage to help people to know where the toilet was. The registered manager told us she had requested more dementia friendly signage, but there was no timescale for this to be provided by. She also showed us a development plan that she had put in place to address a number of issues she had identified as requiring improvement with the building. After the inspection, we spoke with the new provider who explained they had been working through their new portfolio of services, prioritising those with known issues. They assured us of their commitment to providing a fit for purpose building that would meet the needs of the people living there.

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
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment How the regulation was not being met: People using the service were not adequately protected against the risk of falling. This is because the provider had not taken steps to do all that was reasonably practicable to mitigate the risks to people, which they had identified.

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	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15 (1) (a) (d) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Premises and equipment How the regulation was not being met: People using the service were being placed at risk of harm. This is because parts of the premises were not clean, and equipment that was intended to keep people safe was not properly used.

The enforcement action we took:
We propose to impose a condition of registration to suspend new admissions to the location until such as time as the location is no longer in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17(1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance How the regulation was not being met: Systems to assess, monitor and improve the quality and safety of care which people received were not effective.

The enforcement action we took:
We propose to impose a condition of registration to suspend new admissions to the location until such as time as the location is no longer in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing How the regulation was not being met:

This section is primarily information for the provider

Enforcement actions

Staffing levels were not sufficient to meet people's needs.

The enforcement action we took:
We propose to impose a condition of registration to suspend new admissions to the location until such as time as the location is no longer in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.