Kesh-Care Limited

The Old Hall Residential Care Home

Inspection report

Northorpe Road
Halton Holegate
Spilsby
Lincolnshire
PE23 5NZ

Tel: 01790753503
Website: www.theoldhallspilsby.co.uk

Date of inspection visit:
20 August 2018
23 August 2018

Date of publication:
09 November 2018

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?	**Inadequate**

Summary of findings

Overall summary

The Old Hall Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide accommodation for up to 25 people, including older people and people living with dementia. On the day of our inspection there were 20 people using the service.

A registered manager was not in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. A new manager had started working at the service in XXXX and was intending to register with us.
This is the fourth inspection carried out by the CQC at the service since August 2015. The standards of care during this time have fallen and at our last inspection we imposed a condition on the provider's registration preventing them from admitting people to the service. At that inspection the provider had not complied with a warning notice we had issued and we found they were in breach of four regulations of the Health and Social Care Act (Regulated Activities) Regulations 2014, (HSCA) and one regulation of the CQC Registrations Regulations 2009. The service was rated as Inadequate and placed in special measures.

At this inspection we found although the provider had made some improvement to the management of medicines, responding to people's need for greater mental and physical stimulation and addressed some infection control issues we had raised at our last inspection. They had not complied with other ongoing issues such as the quality monitoring of the service and staff training and supervision. We also found further serious issues of concern and as a result we have been unable to lift the restriction we placed on the provider at our last inspection. The provider was in continued breach of three of the HSCA regulations identified at the previous inspection and in breach of a further HSCA regulation.

The risks to people's safety were not always assessed and appropriate measures were not in place to reduce the risks to people's safety. This had resulted in increased falls and unplanned weight losses for some people who lived at the service. Staffing levels did not always meet the needs of people at busy times. People were protected from potential abuse as safeguarding issues were dealt with appropriately by staff who understood their roles and responsibility toward the people in their care. Medicines were managed safely and people were protected from the risks of cross infection.

Staff were not supported with appropriate training for their roles and they were not receiving supervision in line with the provider's own policy. People's needs were assessed using nationally recognised tools but the assessments were not always used to guide staff to provide effective care. People's nutritional needs were not always well managed. People had not always been referred to appropriate health professionals to manage their health needs.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service did not support this practice. The environment people lived in was well maintained. However, although there had been improvement to the outside of the building people were still not able to access the outside areas if they chose to as they were not safely enclosed.

Details of people's specific preferences, choices and views were not always recorded in their care plans. People were supported by a staff group who were caring, and treated them with dignity and respect. Their privacy was maintained.

People's care plans lacked sufficient detail to guide staff to provide personalised care. Information in essential areas such as end of life care was sometimes generic and some areas of the care plans were incomplete. There was a lack of accessible information to support people at the service who had communication issues. Complaints and concerns were dealt with effectively.

Although there was a new manager in post who had been making some gradual improvements. There was a continuing failure by the provider to effectively monitor the quality of the service and this had affected a wide range of issues relating to the care people received at the service.

The home continues to be rated inadequate and remains in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The Service was not safe.

People were not protected against the risks to their safety. There was a lack of adequate environmental risk assessments in place.

There was not always enough staff to support people at busy times.

Staff were aware of their roles in protecting people from potential abuse and people's medicines were managed safely.

People were protected against the risk of infection.

There were some processes in place to feedback to staff on safeguarding issues to aid learning from significant events.

Is the service effective?

Inadequate

The service was not effective.

Staff were still not receiving appropriate training and supervision in line with the provider's policy requirements.

People were not always provided with care in line with the Mental Capacity Act 2005.

People's dietary and health needs were not always managed effectively and the assessment tools used to support needs were not always used to provide people with effective care.

There had been some improvements to the environment at the service. However, people were still not able to safely access the outside of the service.

Is the service caring?

Requires Improvement

The service was not always caring.

There was a lack of information in peoples care plans about their specific preferences and people were not always involved with the planning of their care.

People were supported by staff who were kind and caring, and treated people and their relatives with respect.

People's privacy and dignity was maintained by the staff who supported them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The information in people's care plans lacked sufficient detail to provide staff with the information they needed to offer person centred support for the people in their care.

End of life care information was not always completed correctly.

There was a lack of accessible information for people at the service.

People's complaints were dealt with in line with the company's policy and people were satisfied their complaints and concerns were addressed.

Is the service well-led?

Inadequate

The service was not well led.

There was a continued lack of oversight of the service by the provider which had resulted in a lack of effective quality monitoring processes. This had affected a wide range of issues relating to the care people received at the service.

The new manager had a positive effect on the service. However, their workload had resulted in a lack of improvements required to raise the quality of the service provided for people.

The Old Hall Residential Care Home

Detailed findings

Background to this inspection

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

We visited the service on the 20 and 23 August 2018. On the first day of our inspection the team consisted of two inspectors and one assistant inspector. On the second day one inspector returned to complete the inspection.

Prior to our inspection we reviewed information that we held about the home such as notifications; these are significant events which happen in the home that the provider is required to tell us about. We also reviewed information sent to us by the local authority and the local safeguarding teams. We reviewed previous reports we had produced about the service.

On this occasion we did not ask the provider to complete a provider information return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. However, we gave them an opportunity to provide us with further information during the visit. During our inspection we spoke with two people who used the service, four visiting relatives and one health professional. We spoke with five members of care staff, the cook, the housekeeper and the activities co Ordinator. We also spoke with the manager, the supporting consultant and the provider.

We looked at a range of documents and written records which included eight care records, medicine administration records, servicing records and any audits that had been undertaken.

Inadequate

Is the service safe?

Our findings

At our previous three inspections we identified ongoing concerns with the management of medicines at the service. At the last two inspections we also found ongoing concerns with the management of infection prevention and control. This led to a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA). While we saw the manager had made improvements to these areas of concern, we found further serious concerns in relation to the management of falls and nutrition which meant the provider remained in breach of this regulation.

There was a failure to assess the risks of people's safety in relation to falls. There had been 88 falls recorded in the previous seven months. Some people at the service had suffered multiple falls and there had been a lack of adequate measures put in place to reduce these falls. For example, one person who was living with dementia had suffered a fall that had resulted in a serious injury for which they required surgery. Following their return to the service after surgery the person had fallen a further 20 times before they had been referred to the falls team. On one day the person had fallen four times. Their care plan contained limited information on the measures in place to reduce the risk of falls for them. Their mobility risk assessment only noted the person needed the support of two staff members to transfer with the use of a hoist. Their specific care plan was a repeat of this information. The person's falls risk assessment tool scored them at high risk of falls but gave no further information on how this risk should be managed.

The person had a 3-inch thickness mat by the side of their bed, and a sensor mat in place for when they were in bed. This information was not noted in their care plan and there was no record of when these measures were put in place. However, we also saw when the person sat in their chair in their room or in the communal areas the sensor mat was not placed in front of them, so if they attempted to get up, staff would not be alerted. During our visit we saw the person sometimes became disorientated and agitated, asking where they were, and required input from staff to help calm them. The communal areas were not always supervised by staff which meant if the person tried to get up when disorientated, there was not always a staff member around to support them.

Another person had fallen 18 times during a period of two and half months. There was a lack of information in the person's care plan to show what measures had been taken to reduce the risks of this person's continued falls. Their records showed they had been referred to the falls team on 13 June 2018 however this referral had been withdrawn as the person's physical health had deteriorated and they were less mobile. At the time of our visit the person was being nursed in bed for most of their time, we saw there was a sensor mat in place by the person's bed on the days of our visit. However, we also saw records that showed the person had fallen a further three times in July and on one occasion the record noted the sensor mat was not positioned correctly.

A further person had four unwitnessed falls in the space of two days. One fall resulted in a head injury, sustained when the person was thought to have knocked their head on the bedside cabinet as they fell. There was no record of any observations of the person following this injury. Furthermore , there were no information to guide staff as to what observations they should undertake should someone sustain a head

injury following a fall. The Person fell a further two times and after one of these falls sustained a further head injury. The accident record showed the person was walking without their walking frame, and needed to be admitted to hospital because of this injury. The person's mobility care plan and risk assessment completed on the 6 August 2018 made no mention of their history of falls. It only noted they walked using a walking frame and staff were to ensure they used it, it did not record the person often forgot to use the frame. This information was in a risk assessment in a different part of the care record. This meant the information in the mobility care plan was incomplete and did not give staff enough information in relation to the risk to the person. There was no information in the care record to show how often staff should monitor the person and there were no other measures in place to alert staff of the person's movements around the service.

These examples show people continued to be at risk of falls as the provider had failed to adequately address the risks and consider appropriate measures to prevent avoidable harm for people in their care.

There was a lack of risk assessments in place to highlight any risks to people's safety from the environment they lived in. During our inspection we noted the stairs to the second floor of the service were accessible to the people who lived on the first floor. There was a courtesy rope across the stairs but there were no other measures in place to alert staff if people living on the first floor attempted to access the stairs. This posed a risk to the people who lived on the first floor. We asked if this risk had been assessed for the people who lived on the first floor and were told it had not. This meant the provider continued to fail to consider the impact of environmental risk on the people who lived at the service.

The risk to people's nutritional wellbeing was also not being monitored and adequately assessed. For example, one person had an unplanned weight loss of 9.7kg between January 2018 and August 2018. The person's weight record showed they had been weighed in January 2018 and weighed 68.30kg, they were then weighed six and a half weeks later, in February 2018, and had lost 2.8kg in weight. The person was recovering from surgery during this time, however despite the weight loss they were not weighed again until June 2018 when they had lost a further 2.4kg. The following month in July 2018 the person was recorded as having lost a further 4.4 kg and the last record on the 6 August 2018 showed a further small weight loss of 0.1kg. There was no evidence that staff had acted upon this significant weight loss. The person's care plan completed in June 2018 when the monthly weight record showed a weight loss of 5.2kg made no mention of the weight loss. The care record stated the person was to be weighed monthly and the weight to be recorded in their 'notes' and actioned if any concerns were noted. This was not undertaken and the person had lost a further 4.5kg up to our visit.

We also noted a number of other people had unplanned losses over the previous months. One Person had lost 7.7 kg in the period between February 2018 and August 2018, a further person had lost 10.5kg in the period between November 2017 and August 2018. Another person had lost 6.8kg in the period betweenDecember 2017 and August 2018, and a further person had lost 9.9kg between the period of September 2017 and August 2018. There was a lack of information on how to support these people with their nutritional needs in their care plans and there was a failure to act on the information being recorded about their weight losses. This led to the continued detrimental unplanned weight losses for these people and meant the provider continue to fail to provide safe care and treatment.

This meant the provider continued to be in breach of Regulation 12 of the HSCA for failing to provide safe care and treatment.

At our previous inspection we saw the provider had increased staffing levels to improve the support people at the service received. At this inspection the feedback from people and relatives was mostly positive, with some relatives saying they had seen an improvement in the staffing levels. However, one relative told us they

felt there was not always enough staff at weekends and they felt they were not always sure of who was in charge at weekends.

Staff we spoke with told us while they were aware the number of staff on duty had improved, the needs of people had also increased. One member of staff told us there were people who were in the end stages of their life with increased needs, but staffing levels had not increased to reflect this. One member of staff said, "Ideally we need 4 staff and a senior this would allow us to chat with people and take them out in the garden for a walk." We were told a number of staff had left when the previous registered manager had left, this had meant the remaining staff needed to undertake extra shifts to cover and agency staff needed to be used. The manager had also needed to support staff by undertaking shifts as a care worker to maintain safe staff levels. During our inspection we saw staff worked hard to meet the needs of the people in their care but that there was not always enough staff to support people in the communal areas at busy times. This meant people's needs could not always be met by the number of staff on duty at particular times during the day. We discussed staffing levels with the manager, they told us they were working to recruit staff as they were aware they did not have the full complement of staff employed to meet the established need. They had just appointed a deputy manager and was working to employ senior care workers and care workers. They felt this would improve the consistency of care for people and allow them to effectively monitor the staffing levels going forward.

The registered manager used safe recruitment processes to ensure people were supported by fit and proper staff. We saw staff records contained evidence of appropriate references with any gaps in employment explained. The registered manager used the Disclosure and Barring Service (DBS) checks for potential staff members. The DBS helps employers make safer employment decisions, as any criminal convictions will be highlighted through this check.

At the last inspection we had also found there were some infection prevention and control issues. There was a lack of hand washing equipment around the service, such as a lack of hand towels and hand sanitizer. This increased the risk of poor hand hygiene among staff. During this inspection we found the new manager had addressed this issue by ensuring the housekeeping staff had responsibility for ensuring these items were readily available for staff. The housekeeper told us they completed a weekly housekeeping record, which demonstrated the daily and weekly duties they were required to undertake. Whilst we saw these documents had been completed and on the day of our visit the hand towels and hand sanitizers were in place throughout the service, we were unable to find any regular audits to show this was being monitored. This showed there was a lack of ongoing over sight of how infection prevention and control issues were being managed by the registered manager or provider. .

When we last visited the service we found there was an ongoing breach in regulation 12 in relation to the management of medicines. At this inspection we found the new manager had worked to address the concerns and medicines was being managed in the safe way. The specific areas of concern relating to the management of controlled drugs (medicines which are subject to special storage requirements) the correct recording of administration of topical creams and the storage of medicines, had been addressed. Staff told us there was "more paperwork" but this had led to less errors as staff were monitoring the administration and storage of medicines more closely.

People we spoke with told us they felt safe at the service. Staff we spoke with had a good understanding of their role in addressing any potential safeguarding issues. One member of staff told us they had confidence the manager would deal with any safeguarding issues for the people in their care. We saw the manager had dealt with a safeguarding issue raised to them. They had undertaken an investigation into the concern and had acted on the guidance from the local safeguarding team. The manager told us they fed back guidance

on any safeguarding incidents to staff at meetings, to ensure staff were aware of the lessons to be learnt.

Inadequate

Is the service effective?

Our findings

When we previously visited the service, we found they were in breach of regulation 18 of the HSCA 2008 RA Regulations 2014. In that they were failing to provide adequate training and supervision for staff. At this inspection staff we spoke with told us they were undertaking on line training to ensure they were up to date with their training needs. However, we viewed the training matrix and this showed that some members of staff were undertaking large numbers of training modules in one day. For example, one member of staff had undertaken 26 modules in one day, and another member of staff had completed 23 modules, with a further staff member completing 18 modules in one day. The modules included such modules as safeguarding, medication awareness, COSHH and fire safety. The modules varied in the time it took to complete them but the manager told us they varied between 30 to 45 minutes to complete. One staff member who we spoke with told us they were only able to comfortably complete four or five modules a day for them to retain the information. This showed the provider was failing to provide an effective learning environment to ensure staff had the necessary skills to undertake their role to safely support people in their care.

At our last inspection we identified the provider was not providing supervision for staff in line with their policy which showed staff should receive supervision six times a year. At this inspection we found the provider was still not providing staff with supervision in line with their policy. Their records showed that majority of staff had only received one supervision during 2018 and only five members of staff had received two. This lack of supervision meant there was continued to lack effective support to guide staff in their roles to support the people in their care.

This was a continued breach of Regulation of the HSCA. failure to ensure staff received adequate training and supervision in line with the provider's own policy requirements.

The Mental Capacity Act (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

During our inspection we found the service was not always working in line with the principles of the MCA. For example, we looked at the care records of a person who was living with dementia. There was a mental capacity assessment tool in the person's care record that had been partially completed with the question 'Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain.' This had been ticked with the answer no. There was no further information in the document. The person's communication care plan stated the person could communicate normally and noted staff were to have meaningful conversations with the person. However, when we tried to speak with the person they were unable to communicate with us. They gave inappropriate answers during our conversations. We tried to speak with the person more than once during our visit and the responses we received were the same each time. Staff we spoke with told us this was the person's normal response to conversation.This meant the information in relation to the person's communication needs and mental capacity was incorrect and did not

provide staff with the guidance required to adequately support the person.

The person's care plan also contained a document entitled "General Power of Attorney", this document had been completed and signed by the previous registered manager stating the person's relative had power of attorney, the document had been signed by the person. Power of attorney (POA) means a person gives another person the authority to act on their behalf. There are several different types of power of attorney and the document was not specific as to the type of POA the decision related. There was also no evidence that a mental capacity assessment had been undertaken to establish if the person had the capacity to understand the decision they needed to make about this important aspect of their care. There was no evidence of any legal advice being sought to establish what decisions the relative would make on behalf of the person. As a result we could not be sure this decision was in the person's best interest and the least restrictive option.

During our visit we also saw a letter that had been written by a relative about their relation's refusal to take medicines. The person was living with dementia but throughout their life had always been resistant to taking medicines and the relative wanted the person's wishes to be considered. There was no information regarding the person's wishes in relation to medicines in their care plan. This only stated the person was not taking any prescribed medicines at the time of writing the care plan. There was a lack of information of how any specific decisions around medications would be managed. There was no mental capacity assessment or best interest meetings undertaken in relation to this decision to show if the person was still able to make their own decisions, or if they needed support to do this.

These examples show the service had failed to follow the principles of the MCA to undertake appropriate assessments of people's mental capacity and act in the least restrictive way in their best interests. This is a breach of Regulation 11 of the HSCA.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw there were some DoLS authorisations for people in place. However, we were told by the manager there had been some applications made by a member of staff who had since left the service, and the local authority DoLS team had asked for these to be resubmitted. The manager told us they were unsure of who the previous member of staff had made the applications for, as there were no records. They told us they would contact the DoLS team to address this issue to ensure that where required people had these safeguarding's in place.

People's needs were not always assessed using nationally recognised assessment tools. The use of assessment tools was inconsistent, some care plans did not contain these tools and staff were not always aware of the tools or how to use them. Although we saw some assessment templates were available, staff had not followed the guidelines that would support good care practices. For example, at the front of the monthly weight records folder we saw a Malnutrition Universal Scoring Tool (MUST), this tool if used correctly gives staff guidance on how to manage variances in people's weights effectively. We saw this had not been used to guide staff to take appropriate actions in relation to the management of people's weight, and as a result changes to people's weights had not been managed safely. We also saw a falls risk assessment tool in place for one person that used a range of criteria to assess the level of risk for the person. However, although the risk score for the person was high, there was no information in the assessment tool to guide staff on how to manage the risk for the person safely. This shows the provider was not using

assessment tools to manage people's care effectively.

People at the service told us they were happy with the meals provided to them. One person said, "The food is very good, I like salad so the cook will prepare this for me, they come around each day to see what I want." On the day of our visit we saw people were supported at mealtimes and offered drinks throughout the day. When people chose to eat in their rooms, staff checked on them and supported them with their meal choices.

However, people's nutritional needs were not always met and several people had suffered unplanned weight losses. We also found that people who had underlying medical conditions that could be affected by their diet did not always have these issues highlighted and addressed. One person required adjustments to their diet and their health condition was recorded in their care plan in their medical history. However, the health condition and how their diet could affect this was not mentioned in their physical health care plan or their nutritional and hydration care plan and the person was living with advanced dementia, so was unable to communicate their needs to staff.

Another person who was living with advanced dementia had a food allergy and although staff were aware of the allergy, they were not aware of how the person would be affected should they ingest the food they were allergic to. There was no information in the person's care plan other than the person was allergic to the food. This lack of information put these people at risk of receiving an inappropriate diet that could cause them serious harm.

People were not always referred to the appropriate health professionals when they had underlying health issues. One member of staff told us one person had been receiving a soft diet but had never been referred to the Speech and Language Therapy (SALT) team for assessment of the need for this diet. The staff member told us the person had "always" received a soft diet. This meant the person's needs had not been adequately assessed by health professionals who are trained to ensure people received the most appropriate diet to meet their needs.

During our inspection we saw there had been further improvements to the physical environment at the service and the provider had an ongoing improvement plan. There had been some improvements to the outside of the building. However this had still not resulted in people being able to safely access the outside of the building, as there were no enclosed areas for people to safely sit.

Requires Improvement

Is the service caring?

Our findings

People's choices and views were not always considered. While we saw there was documentation which asked questions such as what people's special routines were, some of the records we viewed were not completed. Relatives we spoke with felt their relation's views on their care was not always listened to. In the care plans we viewed we did not see any evidence that people or their relatives had been involved in the production of their care plans. One relative who visited on a regular basis told us they had not seen their relation's care plan but the new manager had invited them to take part in a review of their relation's care. However, they had not yet been given a date for the review.

One relative told us their relation had been distressed that they had received personal care from a staff member of a different gender. Although they told us the new manager had addressed this, prior to the incident the person's views on how they wanted their care delivered had not been established, so their choices had not been considered when providing care. We spoke with the new manager who told us there had been some work carried out on the care planning but they stated that they felt that there was some way to go to ensure people's views and choices were reflected in their care plans.

Staff we spoke with told us they had good knowledge of people's views and choices and some staff could give examples of these. Such as, where people liked to sit or what activities different people enjoyed. However, there were new staff and agency care workers who would have benefited from more detailed information on people's choices in their care plans. This would have improved staff's knowledge of people's views and preferences related to their care.

There was a lack of information displayed on advocacy services for people at the service. Advocates are trained professionals who support, enable and empower people to speak up about issues that affect them. It is considered good practice for services to display available advocacy services for people in their care. During our visit no one was using the services of an advocate.

People we spoke with told us the staff who provided care for them were caring and supportive. One person said, "Quite honestly, I'm very well looked after, the staff are very caring." They went on to say, "I have no worries at all, I am very happy here." Relatives we spoke with also praised the staff at the service. Two relatives said, "Can't praise the staff enough." They went on to say there had been some recent changes in staffing when the new manager had started. They said some staff had left, but felt this had, "Weeded out the staff who weren't pulling their weight." The relatives also told us they built up good relationships with staff, they told us the senior care staff were excellent and they communicated well with them. They also told us their relation had also built up some good relationships with particular care staff.

Another relative we spoke with said, "When I arrive each day, staff will tell me how [relation] has been, if they are ever poorly they (staff) will ring me at home." They went on to say, "The staff are friendly, approachable and cooperative, [relation] has an appointment at the hospital tomorrow, the manager has said that I could choose a staff member that we know well to accompany us, she will support my [relation] but also me."

Staff we spoke with told us there had been some changes recently, and this had resulted in better team working. They told us they felt supported by the new manager who they felt listened to them. During our visit we saw staff worked well together and we saw several positive interactions. Such as staff's attitude and behaviour towards people and their relatives, and in positive team working. This was evident throughout the visit, for example the way mealtimes were managed or how staff were organised to provide care. The atmosphere was calm and pleasant for the people who lived at the service. We spoke with the manager who told us they had focused on team working and improving staff morale. This showed people were supported by a staff group who were caring and supportive, and the manager was working to sustain this good area of practice.

People we spoke with told us staff treated them with dignity and respect. Relatives we spoke with also told us they had witnessed staffs' positive behaviours towards their relations. One relative said, "I know [name] is well looked after, they are always clean and dressed well." Staff we spoke with were aware of their responsibilities in relation to maintaining people's privacy and treating them with dignity. They gave examples of how they achieved this, such as knocking on doors before entering, keeping people covered during personal care, and ensuring people were wearing appropriate clothing of their own choice. During our visit we saw people were treated with respect and their dignity supported. This showed the service considered people's right to be treated with respect and dignity when providing care, and worked to maintain the standards of care.

Requires Improvement

Is the service responsive?

Our findings

The information in people's care plans was not always detailed enough to ensure they would receive individualised person-centred care. For example, we looked at care plans detailing people's health needs. The information often lacked a rationale as to why the person required support for particular areas of care. For example, several people's care plans showed the staff should monitor them for pain. However, the records did not give any indication as to what type of pain a person may suffer from and how the person would present. One person had a urinary catheter but there was no information for staff on how they should support the person with the daily care of the catheter.

Information on people's nutritional preferences were not always documented. One person's care plan noted they were at risk of not eating meals regularly as they did not like the food. However, there was no evidence to show what their preferences were, or that meals had been planned around their preferences.

Some care plans contained generic information, for example we viewed some care plans that recorded that the individual liked to brush their own hair and clean their own teeth. We discussed this aspect of care for one person with a member of staff, as their care plan noted the person could undertake these aspects of their personal care with encouragement from staff. The member of staff told us the information was not correct and the person needed full support with every aspect of their personal care. Staff told us the care plans had been developed by a senior member of staff who had only worked at the service for a short period. The member of staff did not always discuss people's care with the person, relatives or the staff who knew the person's needs. We discussed this with the manager who told us they had been working to review the care plans as they had become aware the information recorded was not always detailed enough or correct.

Staff we spoke with told us they felt the care plans needed some improvement, although they felt there was a core of staff who knew people well. However, we saw there were new members of staff and agency staff working at the service and the lack of detailed information about people's individuals needs meant there was a risk they would not receive individualised personal care.

When we last visited the service, the provider was in breach of Regulation 9 of the HSCA. This was an ongoing breach of this regulation as people at the service were not provided with enough mental and physical stimulation to prevent isolation.

At this inspection we saw there had been some improvements made in this area of care. The relatives we spoke with told us they saw there was some improvement, but felt there was further improvements required. One relative told us there were no trips out for people but they could see that people were using the communal lounge more, and there were some activities taking place in the lounge since the new manager had arrived. However they said their relative did not come out of their room as they had got so used to staying in there. The relative was hoping staff would be able to encourage the person to join in with some of the activities that had started to take place at the service. Another relative also told us the new manager had improved things since they had been in post. The relative told us they had been encouraged to

bring their pets in and people had enjoyed this. The relative had also been asked to come in and chat about one of their interests that people at the service may find interesting.

The manager had employed an activities co-ordinator who had been in post for five weeks. We spoke with the staff member who told us they were gathering ideas to see what things people were interested in. They had been given funds to buy some craft materials. The member of staff told us they did go to people's rooms to try to encourage them to join in the activities, but if they didn't want to, the member of staff said, "I allocate some time for chatting to people in their rooms." On the day of our visit we saw people were offered different activities such as knitting or other crafts, and the activities person was engaging with people to attempt to stimulate their interests. This meant that although further improvements were required the provider was no longer in breach of this regulation.

People were not always provided with accessible information to support their care at the service. There was a lack of easy read signage around the home to support people find their way around the service. People's bedrooms did not have signage to support people who may be confused when trying to find their own rooms.

We spoke with the manager about how they ensured they met their duties under the Accessible Information Standard. The Accessible Information Standard ensures that all people, regardless of impairment or disability, have equal access to information about their care and support. The manager was aware the signage and information displayed required some improvement but they had not yet had the time to address this issue. However, they were aware they needed to make improvements in this area.

There was a lack of detailed information about people's individual preferences in their end of life care plans. The information was generic and there was no record to show wishes had been discussed with people or their relatives. We also found some documentation in relation to Do Not Attempt Resuscitation (DNAR) forms were incomplete. This meant there was a risk people may not receive the care they or their relatives had discussed with their doctors at the end of their life, and put them at risk of receiving inappropriate care. We discussed this with the manager and a health professional we spoke with at the service and were assured this would be addressed.

People told us they had seen an improvement in the way complaints and concerns were addressed at the service. Relatives we spoke with told us the manager engaged with them and responded to concerns. Staff we spoke with were aware of their responsibilities in dealing with complaints and concerns raised to them. We saw the manager was following the company processes when dealing with complaints.

Inadequate

Is the service well-led?

Our findings

At our previous three inspections we found the provider was failing to monitor the quality of the service provided for people and as a result people were not receiving safe, effective care and treatment and was in continued breach of regulation 17 of the HSCA. At this inspection, despite the provider retaining the services of an external consultant to support them, we found there had not been the required improvement in the overall governance of the service, and people were still not receiving the quality of care and treatment they were entitled to.

There was a lack of monitoring and analysis of falls at the service resulting in 88 recorded falls at the service between January 2018 and July 2018. However there had been no analysis of these falls to establish trends and address individual concerns around the people who had fallen. This lack of analysis meant there was a lack of adequate control measures put in place to reduce falls. This resulted in people continuing to sustain falls that may have been avoided with adequate control measures in place.

There was a lack of analysis of people's weights and this lack of oversight had resulted in inadequate monitoring and people suffering significant unplanned weight losses that were not being acted upon. This affected people's health and wellbeing.

There was a continued lack of robust environmental auditing at the service. The new manager had been undertaking daily checks to monitor aspects of care such as staff completing daily records. While they also made checks on people's rooms to check on cleanliness and maintenance. There were no records to show what they had done when they had found omissions and errors.

Since our last inspection the manager had made improvements to medicines management and processes to help prevent infection at the service. However there was still a lack of oversight to ensure the improvements in these areas were sustained. For example, we saw staff administering medicines undertook daily and weekly checks of medicines, medicine records and storage. But there were no monthly audits undertaken by the manager to monitor any trends and show how any errors would be addressed. There was a lack of auditing of people's care plans and this had resulted in the concerns we found in people's care records in relation to the incomplete records, poor quality of information and conflicting and incorrect information. This meant there was a lack of systematic auditing to show where the failures were and how they had been addressed to improve practice.

The provider consistently failed to have effective oversight of the service and as a result, this lack of awareness and lack of oversight meant people in their care were not receiving the standard of care expected of a care home.

These issues have resulted in an ongoing breach of Regulation 17 of the HSCA. Good governance.

At our last inspection we found the provider was in continued breach of regulation 18 of the Care Quality Commission (Registration) Regulation 2009 as they had failed to notify us of significant events at the service.

At this inspection we found the provider had fulfilled their legal obligation and had been informing us of all significant events at the service. This meant the provider was no longer in breach of this regulation.

Since our last inspection there had been a change in manager. The registered manager had left the service and the new manager was in the process of applying to register with the Care Quality Commission to become registered manager for the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We will continue to monitor their application.We will continue to monitor their application.

People at the service did tell us they had seen some improvement in the management of the service since the appointment of the new manager. One person said, "The manager is first class and very well accepted by all." Relatives told us their concerns were responded to quickly. For example, one relative told us they had been asking for support for their relation with an aspect of their care for over two years, and the new manager had followed up and addressed the issue as a matter of priority. The relatives were happy with the responses from the manager.

Staff we spoke with felt the new manager was supportive and worked with them to try to improve standards of care. One member of staff said, "The manager is great." They went on to say the manager had told them, "My door is always open for anything you need." Another member of staff said, "You can go to the manager with suggestions and she will listen."

We saw the manager had worked on particular issues since their appointment, but they had also needed to support staff by working alongside them because of a lack of staff when they first arrived. This influenced the time they had to make the changes to improve the quality of the service for people. They told us there had been a lot of changes for staff. Such as the introduction of allocation of roles each day and improvement of recording care. This had meant the manager had spent a significant amount of time working with staff to change and improve the culture among staff. Our conversations with staff confirmed there had been a change in staff attitude and they understood their roles and what the manager wanted to achieve. One member of staff told us the manager addressed issues of concern and was consistent and clear with staff on their roles. During our inspection we saw the results of this work in that staff worked well together as a team and recording of daily care was undertaken. This showed the manager was working to ensure there was an open and inclusive culture among staff to achieve good outcomes for people.

Relatives and staff we spoke with told us the new manager had begun to undertake meetings to ensure people, their relatives and staff were aware of the changes and improvements they were going to undertake to improve the service. However our inspection showed there were significant ongoing concerns which had been identified at previous inspections. The slow responses from the provider to our concerns meant that people were still not receiving safe care and treatment at the service.