RYSA Limited

The Sheridan Care Home

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection of this service on 21 and 22 October 2014. Breaches of legal requirements were found and we issued warning notices for repeated breaches in care and welfare of people who use service and in records. The provider was required to meet the regulations relating to care and welfare and to records by 31 January 2015. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches in the regulations relating to assessing and monitoring the quality of the service, managing medicines, consent to care and treatment, requirements relating to workers and supporting staff.

We undertook an unannounced focused inspection on 23 February and 6 March 2015 to check they had taken action to meet the regulations relating to care and welfare and to records and to confirm that they now met legal requirements. We also checked that they had followed their action plan in relation to the breaches in managing medicines, consent to care and treatment, and requirements relating to workers. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for The Sheridan Care Home on our website at www.cqc.org.uk.

Summary of findings

You can read a summary of our findings from both inspections below.

The Sheridan Care Home is registered to provide personal care and accommodation for up to 30 people. These are mainly older people who are living with dementia. Nursing care is not provided. The home is a converted period property with a modern, purpose-built extension. Accommodation is arranged over two floors and there is a passenger lift to assist people to get to the upper floor. The home has 26 single bedrooms and two twin-bedded rooms, which two people can choose to share.

Comprehensive inspection on 21 and 22 October 2014

This was an unannounced inspection.

There were 29 people living at the home at the time of our inspection. The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At our previous inspection on 2 and 11 September 2014, we asked the provider to take action to make improvements to care and welfare, staffing levels and record keeping. They sent us an action plan that stated they would meet the relevant legal requirements for staffing levels and record keeping by 8 October 2014, and for care and welfare by 20 October 2014.

After that inspection we received information about further concerns in relation to the home. As a result we undertook the comprehensive inspection. During the comprehensive inspection we looked to see if these improvements had been made. The action in relation to improved staffing levels had been completed, but the actions in respect of care and welfare and record keeping remained outstanding.

We identified five further breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and their visitors were broadly pleased about the service they received, but expressed reservations about people having meaningful activities to occupy them. Our observations and the records we looked at did not always match the positive views we heard.

People's care was not planned or delivered consistently. Care plans did not reflect people's interests and personal histories, and were not always reviewed or updated when their needs changed. Weight loss was not always promptly followed up. There were not enough meaningful activities for people.

Some records were inaccurate and incomplete, which meant that staff did not have all the information they needed in order to provide the care people needed.

Visitors told us they thought people were safe at the home. However, we found that people's safety was compromised in some areas, including out-of-date risk assessments, staff recruitment checks and handling medicines.

The home's systems to assess and improve the quality of its service were not effective. There was no system for obtaining and recording people's views about the home and using these to drive improvement. There had been no residents' or relatives' meetings, and people's views had not been gathered and recorded by any other means. Learning from accidents and incidents was not systematically shared with staff. Quality assurance checks had not been completed, other than for medicines.

The home is a specialist dementia care home, yet staff had not received training, beyond basic awareness training, in dementia, managing behaviours that challenge others, and the Mental Capacity Act 2005. They had not taken steps to make best interest decisions in line with the Mental Capacity Act 2005, when people lacked the mental capacity to give consent to aspects of their care.

Additionally, we identified areas where improvements could be made.

Whilst staffing levels were sufficient for staff to provide basic care, there was no system to assess staffing levels and adapt them according to people's changing needs. This meant the home's managers could not be sure that there would always be enough staff to meet people's needs.

Summary of findings

Snacks and drinks were not to hand for people to help themselves to between meals. It is good practice in dementia care to ensure that people have access to food and drink between meals, when they wish.

People's independence had not been promoted through involving them in the daily routines of running the home or through the provision of equipment that might help them eat meals independently.

Focused inspection on 23 February and 6 March 2015

After our inspection of 21 and 22 October 2014 we served warning notices on the provider and registered manager in relation to care and welfare of people who use the service and to records. These required the service to meet these regulations by 31 January 2015. We undertook this unannounced focused inspection to check that these breaches of the regulations had been addressed. We also checked whether the provider had followed their action plan in relation to the breaches in managing medicines, consent to care and treatment, and requirements relating to workers.

There were 26 people living at the home at the time of our inspection. The home had a registered manager.

We found a number of repeated breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us, and we observed, that people had little access to activities they enjoyed and found meaningful. Care was still not planned or delivered consistently. There had been a delay in assessing one person's needs when they moved into the home. Pain was not adequately assessed, leaving people at risk of insufficient pain relief. Some people lacked care plans that fully addressed their needs, including one person's diabetes and agitation that could be challenging for others, and another person's foot care. Staff did not support people effectively when they became distressed, reflecting their lack of understanding of dementia and people's personal histories.

Records, including care plans, remained inaccurate and incomplete. This placed people at risk of unsafe or inappropriate care.

Medicines were not recorded and administered safely. One person had not received all of the tablets prescribed for an infection, yet staff had signed to say they had given the tablets. There were insufficient instructions regarding how to apply skin creams and gels, and some people received creams only twice a day whereas their prescription stated the creams could be applied more often if necessary. Guidelines for staff administering 'as needed' medicines did not contain all the information needed, such as maximum doses, to ensure these were given safely.

People were not asked to give consent to their care plans and other aspects of their care. If people may not have been able to consent to particular aspects of care, the process for assessing their mental capacity and making a best interest decision did not follow the principles of the Mental Capacity Act 2005.

The home's systems to assess and improve the quality of its service were still not effective. Following the inspection in October 2014 the provider had returned an action plan that was due to be completed by 31 March 2015. We inspected before this date, however the failure to act on the warning notices for care and welfare and for records and to address other breaches of the regulations reflected continuing shortcomings in the assessment and monitoring of the quality of the service.

Relevant checks had been completed before staff started working at the home, hence systems were in place to protect people from individuals who were known to be unsuitable.

We will undertake another unannounced inspection to check on the outstanding legal breaches and to review the home's ratings.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

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

Comprehensive inspection on 21 and 22 October 2014

People were not kept safe at the home.

Risk assessments and care plans were not always updated when people's needs changed so people might not always receive the support they needed in order to remain safe.

Recruitment checks were not always sufficiently thorough to ensure staff were safe and sufficiently skilled to work with people.

Although there were sufficient staff to meet people's basic needs, there was no system for organising staffing levels according to people's changing needs.

Focused inspection on 23 February and 6 March 2015

People were still not kept safe at the home.

Risks were not always reassessed when people's needs changed, which meant care was not planned in a way that ensured their welfare and safety.

Monitoring of pressure-relieving air mattresses was insufficient to ensure equipment was set at the correct levels to meet people's needs.

People's medicines were not managed and recorded to ensure they received them safely.

Staff were recruited safely to ensure staff were safe and sufficiently skilled to work with people.

Is the service effective?

Inadequate

Comprehensive inspection on 21 and 22 October 2014

People's needs were not met effectively.

This is a specialist dementia care home, yet staff did not have the knowledge and skills they needed to care for people who live with dementia.

Staff and managers did not follow the requirements of the Mental Capacity Act 2005 to ensure that people consented to their care, or if they were unable to give consent, provided care that was in people's best interest.

Although people's weights were monitored, some people's weight loss was not adequately followed up with health professionals.

Focused inspection on 23 February and 6 March 2015

People's needs were still not met effectively.

Appropriate arrangements were not in place to obtain people's consent or, if they were unable to give consent to particular aspects of their care, make

Summary of findings

decisions on their behalf in line with the Mental Capacity Act 2005. This included decisions regarding future cardio-pulmonary resuscitation (CPR). People were not offered the opportunity to look at and discuss their care plans.

Prompt medical attention was not sought when a person complained of pain following a fall.

Prompt action was not taken in response to a person's weight loss.

Is the service caring?
(Text unchanged from comprehensive inspection)

Requires Improvement 

Is the service responsive?
Comprehensive inspection on 21 and 22 October 2014

Inadequate 

The service was not responsive to people and their needs.

People's care plans and the care they received did not take into account their individual interests and social histories.

People received little stimulation through encouragement to follow interests or take part in meaningful social activities.

Some people's assessments and care plans were out of date, and records were incomplete or contained errors. This meant staff had insufficient information about the care people needed.

Focused inspection on 23 February and 6 March 2015

The service was still not responsive to people and their needs.

Pain was not adequately assessed, leaving people at risk of insufficient pain relief.

Care was not always planned to address people's needs, jeopardising their welfare and safety.

Staff did not always respond when people needed assistance and did not support people effectively when they became agitated and upset.

Care records were inaccurate and incomplete, placing people at risk of unsafe or inappropriate care.

Is the service well-led?
Comprehensive inspection on 21 and 22 October 2014

Inadequate 

The service was not well led.

People and their relatives were given no opportunity to contribute to the running of the service and there was no system for managers to obtain, record and act on people's views.

Summary of findings

Managers and staff did not learn from accidents, incidents and complaints in order to improve the service.

Quality assurance systems had been allowed to lapse and there were no systematic checks on the quality of service provided.

Focused inspection on 23 February and 6 March 2015

The service was still not well led.

The warning notices issued following the inspection in October 2014 had not been acted upon and breaches of other regulations had not been addressed.

The Sheridan Care Home

Detailed findings

Background to this inspection

This inspection report includes the findings of two inspections of The Sheridan Care Home. We carried out both inspections under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspections checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The first was a comprehensive inspection of all aspects of the service and took place on 21 and 22 October 2014. This inspection identified breaches of the regulations.

The second was undertaken on 23 February and 6 March 2015 and focused on following up on action taken in relation to the breaches of four of the legal requirements we found on 21 and 22 October 2014.

You can find full information about our findings in the detailed key question sections of this report.

Comprehensive Inspection on 21 and 22 October 2014

This inspection took place on 21 and 22 October 2014. Our visit was unannounced and the inspection team consisted of two inspectors.

Before our inspection we reviewed the information we held about the home, including notifications of incidents that the provider had sent us since our last inspection in September 2014. We also spoke with the local authority safeguarding and commissioning teams. Because this inspection was undertaken in response to recent information of concern from the local authority safeguarding team, we did not request a Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we met and spoke with all but one of the people who lived in the home. They were living with dementia and were not all able to tell us about their experiences at the home, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with four visitors, a visiting healthcare professional, three care staff, a member of ancillary staff, two deputy managers and the registered manager. We observed care and support in communal areas and looked at the care records for seven people and medicines administration records for eight people. We also looked at records that related to how the home was managed, including four staff files, staff rotas for the period from 8 September 2014 up to the date of the inspection and the provider's quality assurance records.

Following the inspection, the registered manager sent us copies of policies and their training summary for all staff, as we had requested.

Focused inspection on 23 February and 6 March 2015

We undertook an unannounced focused inspection of The Sheridan Care Home on 23 February and 6 March 2015. This inspection was done to check the provider had taken action to meet legal requirements in response to the warning notices issued following our October 2014 inspection. On 6 March 2015, we also checked that improvements to meet other legal requirements planned by the provider had been made. The team inspected the service against four of the five questions we ask about services: is the service safe, is it effective, is it responsive and is it well led? This was because the service was not meeting some legal requirements.

Detailed findings

Before our inspection we reviewed the information we held about the home, including notifications of incidents that the provider had sent us since our inspection in October 2014. We also spoke with the local authority safeguarding and commissioning teams. Because this inspection was brought forward in response to information of concern from the local authority safeguarding team, we did not request a Provider Information Return (PIR).

The inspection was carried out by a team of three inspectors, two visiting on each day. During the inspection we met everyone living in the home, apart from a person who was in hospital, and spoke with two people about their care. Because most people were living with dementia, we used the SOFI to help us understand people's experiences. We also spoke with a visitor, three care staff, two deputy managers and the registered manager. We observed care and support in communal areas and looked at 12 people's care records, five people's current cream administration records and 18 people's current medicines administration records. We also looked at three staff files.

Inadequate

Is the service safe?

Our findings

Comprehensive inspection on 21 and 22 October 2014

People were not fully protected from risks to their safety.

At our last inspection in September 2014, we found one person's changing needs had not been reassessed or planned for. They were at risk of falls and staff did not have up-to-date information or a plan as how to minimise the risks. This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider sent us an action plan stating care plans would reflect reassessed needs by 20 October 2014.

At this inspection in October 2014, we found that risks were not managed so that people were safe. Risks were not always reassessed when people's needs changed, which meant people may not receive the care and support they require to meet their needs fully. One person's falls risk assessment had not been updated when they were prescribed a medicine that could make them drowsy and increase their risk of falling. Another person had fallen in October 2014 but their falls risk assessment and care plan had not been reviewed and updated following this. This meant that measures they needed to remain safe might not be in place. One of these people's relatives told us the person often behaved in a way that was challenging for staff to manage. However, there was no behaviour management plan so that staff would know how to manage the person's behaviours safely. A further person had an epilepsy care plan that did not specify how long staff should wait before calling emergency services when the person had a seizure. This meant there was a risk this person could experience a delay in receiving medical attention.

These shortfalls in assessing and managing risk were a repeated breach of Regulation 9(1) and 9(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Recruitment practices did not fully protect people from staff who might not be safe to work with them, or who were not sufficiently fluent in English to be able to communicate effectively. Prior to the inspection we had received concerns that some staff did not speak English fluently, and during the inspection two relatives expressed similar concerns. The staff we met were sufficiently fluent to be able to speak with us and we saw they were able to communicate with people at a basic level. Two staff recruitment records contained incomplete records. One staff member had not given a reason for why their previous employment in care ended. Another had no reference from their last employer, and this had not been pursued by the home's management. This meant they did not have complete information to assess whether these staff members were suitable to work with people living at the home. A further staff member's application in 2014 stated they had a 'pre-intermediate' understanding of English, yet they had started work at the home. This meant this member of staff would not be able to understand and have fluent conversations with people living with dementia, who had complex communication needs. This could lead to misunderstandings and the correct care and support not being provided to people.

These shortfalls in recruitment were a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicines were stored safely. Medicines that needed cold storage were stored in a dedicated refrigerator and temperatures were monitored to ensure they remained within safe limits. There were suitable arrangements for controlled drugs, although there were none held at the time of our inspection visit. Regular medicines audits checked that medicines in stock and disposed of could be accounted for.

Staff had been giving one person who had recently moved into the home, a medicine that was not recorded on their medicine administration record (MAR) sheet. This was a cholesterol-lowering medicine in the blister pack supplied by the person's pharmacy. This meant the person could be at risk from a medicine that had not been prescribed or staff not following the prescription instructions, and staff not recording the medicine they had administered. We asked a senior member of care staff about this. They acknowledged it was an error and told us they had queried this with the pharmacy and requested a revised MAR sheet.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our last inspection in September 2014, we were concerned that there were not always enough staff on duty to meet people's needs, particularly during the evenings. Some people were going to bed earlier than they would choose because there were not enough staff to assist them

later in the evening. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider sent us an action plan stating that they would make improvements to evening staffing levels by 8 October 2014. When we inspected the home again in October 2014, we found there had been some improvements.

One person described staff as "very busy". A visitor questioned whether staff had sufficient time to spend with people because they were so hard working but said they thought their relative was well cared for and safe. A care worker commented that they were very busy from day to day trying to get things done on time, and that this was more difficult if people were unsettled.

During the inspection there were sufficient care staff on duty to meet people's needs and we observed that care staff supported people in an unhurried way. For example, where people needed assistance to eat their meals, the staff who assisted them worked at their pace. The rota for the two weeks up to and including the inspection reflected five or six care staff on duty in the morning and four or five in the afternoon. Shift times had been adjusted following the last inspection so that an additional member of staff was on duty until 9pm. The registered manager told us they had introduced this change immediately following our last inspection, so that people don't have to go to bed or get up earlier than they would like.

The staff rotas showed only two staff on duty overnight, between 9pm and 8am. The registered manager said that although seven people needed assistance with personal care from two staff at once, none of these people woke at night, nor was there currently anyone who got up and walked around at night. However, there was no formal system for reviewing staffing levels according to people's individual needs. This is an area for improvement.

We recommend that the provider introduces a system for determining staffing levels according to people's individual needs.

Broken and inadequately cleaned kitchen fixtures and equipment compromised food hygiene. A refrigerator door handle was broken, and a freezer was dirty and frosted up. This meant the refrigerator and freezer might not operate at a safe temperature. The registered manager told us that there had been no outbreaks of food poisoning at the home and said they would purchase a new fridge. We advised the local authority environmental health department and they visited the home shortly after our inspection visit. They informed us that food hygiene was generally well managed and that some of the issues we identified had already been addressed. They identified some requirements consistent with routine wear and tear to improve the fabric of the building, such as replacing cracked tiles and cleaning the wall behind the oven. This is an area for improvement.

Other aspects of premises and equipment were managed to ensure people remained safe. Contractors had recently inspected and serviced the lift and had inspected and certified the hoists within the past six months. The gas system had been serviced within the past year. There were records of monthly checks that hot water temperatures were within safe limits to prevent scalding people and to prevent the growth of Legionella bacteria.

People who were able to said they felt safe. People's relatives also told us they felt their family member was safe. We observed that people were relaxed with staff, and that some actively sought their company. All but one member of staff had within the past two years received training in safeguarding adults. All the care staff we spoke with were aware of how to respond to and report concerns about abuse, including outside agencies they could contact. Information about safeguarding adults was displayed in people's bedrooms. The home's safeguarding policy contained some inaccurate contact information, including details of an organisation that no longer existed and the incorrect contact details for out-of-hours social services. This is an area for improvement.

Focused inspection on 23 February and 6 March 2015

People were still not fully protected from risks to their safety.

Risks were not always reassessed when people's needs changed, which meant people's care was not planned in a way that ensured their welfare and safety. One person had sores on their feet. Their Waterlow risk assessment for pressure ulcers had been updated in January 2015 to reflect these sores. However, their care plans had not been updated to show how staff should care for these pressure sores and reduce the risk of further sores developing. A further pressure sore risk assessment was undated and inaccurate, stating there were no areas where skin had

changed colour or had broken down. A recent body map was incomplete, as it made no reference to the person's sore toes. A staff member who provided this person's care was not aware of the sores on the person's feet.

People who required pressure-relieving air mattresses were not adequately protected against the risk of developing pressure ulcers. Where air mattresses were in use, there were no instructions in bedrooms so that staff knew how to set the mattresses correctly. Some air mattresses had dials with numbers that corresponded to the person's weight, but others had dials without numbers. Care staff recorded pressure-relieving air mattress checks throughout each day in people's bedrooms. They told us they did not adjust air mattress settings and just checked mattresses were switched on; the registered manager confirmed this.

These shortfalls in managing the risk of pressure sores were a repeated breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now Regulation 12(1) including Regulation 12(2)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The shortfalls in record keeping were a repeated breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now Regulation 17(1) including Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not managed so they received them safely.

Medicine recording was not always accurate and people did not always receive medicines they needed in line with their prescriptions. One person had been prescribed a short course of tablets for an infection. Their box of tablets contained a surplus of two tablets, which staff had signed for as given but had not administered. A member of staff who had most recently signed for the medicine was unable to explain the discrepancy. Another person was prescribed morphine for pain relief, to be taken before the district nurse visited to change their dressings. No morphine had been recorded as administered prior to four dressing changes in February 2015, leaving the person vulnerable to pain. A further person was prescribed ibuprofen gel for pain relief, with the instruction to 'Apply two or three times a day…'. However, the handwritten entry on the medicines administration record (MAR) indicated it should be administered twice a day and it had been signed for accordingly. Similarly, the person was prescribed cream to moisturise their skin, with the prescription instruction 'Apply 2 – 6 times per day to moisturise the skin', whereas a handwritten staff entry indicated it should be administered twice daily and it had been signed accordingly. Consequently, the person was at risk of insufficient pain relief or dry skin.

Some people who were not able to make decisions regarding taking medicines needed their medicines administered covertly, disguised in food or drink. However, arrangements were not in place to ensure that covert administration of medicines was safe. Whilst staff liaised with people's GPs regarding covert administration, they did not consult with pharmacists. There were no instructions from pharmacists regarding covert administration, including which form the medicine should take, which foods were compatible with the medicine and whether any foods should be avoided. The home's medicines policy made no reference to a requirement to involve a pharmacist in decisions regarding covert administration.

There were shortcomings in the recording of 'as necessary' (PRN) medicines. There was insufficient guidance for staff regarding people's doses of PRN medicines, leaving people at risk of receiving too much medication. Two people's protocols for their PRN medicines did not specify the minimum interval between doses or the maximum number of doses in 24 hours. Changes to the instructions for the administration of a further person's pain relief, which the registered manager told us was now prescribed routinely rather than on a PRN basis, had not been reflected on the person's current MAR, which showed the medicine as PRN. The previous MAR had reflected the change in prescription, but this had not been carried forward correctly.

Staff had insufficient instructions regarding how and when to apply people's prescribed skin creams and gels. People's MAR for their skin creams and gels contained instructions such as 'Apply when required' and 'Apply as directed by your doctor'. There were no indications, for example diagrams and further written instructions, for staff to know when the cream was required, the quantity to apply and to which areas of skin.

These shortfalls in medicines recording and administration were a repeated breach of Regulation 13 of the Health and

Inadequate

Is the service safe?

Social Care Act 2008 (Regulated Activities) Regulations 2010, now Regulation 12(1) including Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in October 2014, we found that recruitment practices did not fully protect people from staff who might not be safe to work with them, or who were not sufficiently fluent in English to be able to communicate effectively. This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider sent us an action plan stating that recruitment procedures had been reviewed so that the required information was in place prior to people starting work, by 31 January 2015.

We looked at three staff recruitment records for newer members of staff. Relevant checks had been completed before staff started working at the home, hence systems were in place to protect people from individuals who were known to be unsuitable. During the inspection, a visitor said they had experienced some language difficulties on the part of the staff. The staff we met were able to speak with us and to communicate with people at a basic level.

Inadequate

Is the service effective?

Our findings

Comprehensive inspection on 21 and 22 October 2014

Although staff received core training in topics such as food hygiene and safeguarding adults from abuse, this did not equip them to care for people who had specific needs associated with dementia. The home provides a specialist service for people living with dementia. However, our observations and discussions with care staff demonstrated they had a very basic understanding of dementia that made it difficult for them to meet people's social and emotional needs. For example, during our lunchtime observations people did not receive an explanation of what their meals were or a choice of food, as would be good practice in dementia care. Two care staff said they found it hard working with people who live with dementia, and one commented that it was particularly difficult when people were agitated and would not cooperate. The training records showed that only seven of the home's 16 care and management staff had undertaken dementia awareness training, and that no staff had undertaken training about behaviour that challenges others. There was no record that staff or managers had received training in the Mental Capacity Act 2005, including the Deprivation of Liberty Safeguards. The registered manager acknowledged that staff had not undertaken this training.

These shortcomings in staff training were a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because staff did have the skills and knowledge to meet the specialist needs of people living with dementia.

Consent to care was not always sought in line with legislation. In three care records the person's 'next of kin' had given or declined consent to photographs and influenza vaccination. Being 'next of kin' does not give a relative the legal authority to make decisions on someone's behalf.

Where there was no valid consent for people who lived with dementia, staff had not followed the requirements of the Mental Capacity Act 2005. The records we looked at were all for people who live with dementia. None contained, in the absence of valid consent, assessments of the person's ability to make decisions about particular aspects of their care, or of decisions that the care was in the person's best interest. This included mental capacity assessments and best interest decisions about care that could be restrictive, such as the use of bed rails or a person wearing cotton mittens at night to reduce scratching. One person's care plan for as-required medicines stated they had been assessed has having 'no capacity' but there was no record of the mental capacity assessment. The registered manager acknowledged that mental capacity assessments and best interest decisions were not in place.

'Do Not Attempt Resuscitation' (DNAR) forms were not completed properly. DNAR forms had been signed by people's GPs after discussion with staff or management. Often, the forms had been filled in by management staff and stated that managers had discussed with people's families whether they wished the person to be resuscitated. However, the only record of such discussion was the relative's yes or no answer. One person's DNAR form showed their previous address and would not have been valid at The Sheridan Care Home. Another person's was incomplete, with the section about the person's capacity to make decisions about resuscitation left blank. There was a risk that in the event of a medical emergency, a person might be resuscitated when they would not have wanted this or it was not in their best interest. There was also a risk that people might not be resuscitated when this would be in their best interest.

The lack of valid consent or mental capacity assessments and best interest decisions was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The home was meeting the requirements of the Mental Capacity Act 2005 in relation to the Deprivation of Liberty Safeguards (DoLS). The registered manager told us they had applied to the local authority to authorise the use of DoLS in respect of everyone in the home, but had not yet heard the outcome of their applications. Everyone living at the home experiences cognitive impairments and the registered manager confirmed that they would not be safe to leave the house alone.

Prior to the inspection we had received concerns about small portion sizes at meals and little variation in people's diet. We observed lunch on the second day of our visit on both floors of the home. Portion sizes were adequate and drinks and biscuits or cake were served between meals. However, there were no snacks, fruit and drinks available at other times in communal areas for people to help

themselves as they wished, as is good practice in dementia care. We saw that stores of food in the kitchen were replenished on the second day of our visit, although there was little fresh fruit other than bananas.

Research has shown that people living with dementia can see food more easily on coloured crockery and may subsequently eat more. None of the main meals in the first floor dining room were served on coloured plates. One person did not eat their main meal, repeatedly saying "Take it away" and "It's too much". Staff took the food away after encouraging them to eat. They gave the person some pudding in a red dish and the person then ate the food.

When the food arrived, staff did not explain to people what the meal was or offer them a choice of food. One person downstairs did not look keen on their main meal and a staff member asked if they would prefer a "butty". They smiled when they received their sandwich and said they enjoyed "butties". People were not offered a choice of drinks with their meal. However, staff did ask people whether they wanted salt and pepper.

One person required a halal diet. The registered manager said they purchased the person's food from a nearby specialist shop.

People's weights were monitored and food and fluid intake records maintained where necessary. Some people's weight loss was followed up. For example, staff had sought a dietitian referral for one person who had lost a lot of weight in a short period. However, another person had lost three kilogrammes in two months and their records showed no evidence that staff had addressed this with healthcare professionals, despite the person seeing their GP for other health issues. We saw supplies of cream used to fortify meals for people who needed this, although the cook demonstrated a limited understanding of special diets and could not tell us who needed fortified food.

The failure to address weight loss was a breach of Regulation 9(1)(b)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's day-to-day health needs were met. Records showed people saw GPs, chiropodists, district nurses, specialist nurses and community mental health staff. A relative whose family member had been unwell commented that the home contacted the GP when needed. A visiting healthcare professional said they had no concerns currently and that as far as they were aware, there were no pressure sores. The records we looked at did not show that people had seen a dentist. The registered manager told us people saw a dentist whenever this was required.

Focused inspection on 23 February and 6 March 2015

Appropriate arrangements were not in place to obtain people's consent to their care or, if they were unable to give consent to particular aspects of their care, make decisions on their behalf in line with the Mental Capacity Act 2005.

Two people told us they had not seen their records and had never been asked if they wanted to see them. One of these people was not living with dementia and was able to make decisions about their care. However, they had never discussed their care plans with staff in order to give their consent. Staff had recorded an assessment that the person had 'mental capacity', even though there were no grounds to doubt the person's capacity to make decisions. This conflicted with the principle set out in the Mental Capacity Act 2005, that a person must be assumed to have capacity unless it is established that they lack capacity.

We saw a person in bed with bedrails in situ. Their 'Safe use of bedrails assessment' was signed by staff as being 'in the best interest of the resident', yet there was no record of the person's consent. In the absence of consent, there was no mental capacity assessment and best interest decision in relation to the use of bedrails. Where people were unable to make their own decisions, consent had sometimes been sought from a relative as 'next of kin'; 'next of kin' status confers no legal authority to make decisions on someone's behalf.

A further person's file contained a 'do not attempt cardiopulmonary resuscitation document' completed by staff and endorsed by the person's GP. The document stated that the person's relative had expressed a wish for the person not to be resuscitated, as documented by staff, but the only record was a 'no' answer to the question 'Would you like the resident to be resuscitated?'. There was no consideration recorded of what the person might have wished had they been able to make this decision or of what was in their best interest.

People's mental capacity was assessed with no reference to particular decisions. This conflicts with the principle enshrined in the Mental Capacity Act 2005 that capacity assessments must be based on people's ability to make specific, rather than general, decisions. Additionally, the

Inadequate

Is the service effective?

capacity assessments assumed that people were unable to understand or communicate decisions because of their 'advanced dementia'. This conflicts with the Mental Capacity Act 2005, which states that a lack of capacity cannot be established merely by reference to a person's condition.

The home's consent documentation for photographs and vaccinations referred to people's 'next of kin'. It made no reference to that person's legal authority to give consent on their behalf, as their personal welfare attorney or deputy.

These shortfalls in arrangements for obtaining consent and making decisions in line with the requirements of the Mental Capacity Act 2005 were a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now Regulation 11(1) and Regulation 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prompt medical attention was not sought when a person complained of pain following a fall. The person had been found on the floor during the night, complaining of pain. Staff did not call 999 until the morning and the person was admitted to hospital with a fractured hip. There was no explanation for the delay. Their care records contained no body map on or after that date showing a broken hip and associated bruising.

Prompt action was not taken in response to a person's weight loss. They were identified at the end of January 2015 as having lost a significant amount of weight, but food and fluid monitoring had not started until over two weeks later.

These failures to seek prompt medical attention and to address a person's weight loss were a repeated breach of Regulation 9(1)(b)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now Regulation 9 and Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The shortfalls in record keeping were a repeated breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17(1) including Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did not inspect Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This related to the shortfalls in staff not having the skills and knowledge to meet the specialist needs of people living with dementia. This was because the provider had not reached their deadline for meeting their action plan from the October 2014 inspection for this regulation.

Requires Improvement

Is the service caring?

Our findings

(Text unchanged from comprehensive inspection)

Inadequate

Is the service responsive?

Our findings

Comprehensive inspection on 21 and 22 October 2014

At our last inspection in September 2014, we were concerned that staff were not following people's care plans. We found people in bed before their preferred time that was stated in their care plans. A person was not receiving the assistance their care plan said they needed, to reposition in order to reduce the risk of pressure ulcers. One person's risk assessment and care plan had not been reviewed and updated following a fall. This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. In addition, we found that records were incomplete. Fluid records for fluid intake and catheter output were not totalled; it was unclear how staff were monitoring this so they could take action if fluids consumed or urine output were lower than they should be. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider sent us an action plan stating that they would make improvements to records by 8 October 2014 and to care planning and delivery by 20 October 2014.

Overall, relatives were positive about the care their family member received. A regular visitor commented that the person was always clean and another relative said their family member was nicely shaved.

However, people were not supported to follow interests and take part in meaningful social activities. A relative questioned whether their family member received sufficient stimulation through meaningful activities and time spent with staff. Another relative said their family member liked music, but the person's music had gone off and staff had not addressed this. One person spent time in their room with no stimulation, such as music or television, and nothing to do.

People sat in lounges with the television playing but most were not involved in things that gave them interest or enjoyment. On the second morning, we observed staff supporting four people in the downstairs lounge. One person sought attention from staff; a member of the management team spent a while chatting with them about their past. Another person leafed through a magazine and then fell asleep. The other people looked at staff as they passed or gazed into space. Suddenly, for no clear reason, one of the managers sang "It's a Long Way to Tipperary" and tried to get people to join in.

Care staff were not aware of people's interests and personal histories and how they could use these to provide activities that were meaningful for them as individuals. Only the managerial staff were familiar with people's life histories and personal preferences. This information was gathered from families when people moved into the home, but was not reflected in care plans or used to plan activities.

Staff did not always acknowledge or act promptly to assist people with their needs. During our observation of lunch on the first floor, one person had a very itchy back and had told staff this throughout the morning. They found it hard to eat their meal because their back was so itchy and they constantly asked staff to scratch it. Throughout our observation staff repeatedly told the person they would take them to their room after lunch to wash their back and reapply cream. It was not clear why they did not take this person before lunch or whilst they were showing distress about how itchy they were.

On the first day of our inspection, we heard someone calling out from their room. We went to them and saw their call bell was out of reach. We passed the bell to them. They pressed it and staff came to assist them. This person said they had fallen previously a few days before. They were unable then to reach their buzzer and said they had to wait "quite a long time before they came". On the second day, another person who spent much of the time in their room called out, but staff did not respond to them. The registered manager told us that the person had been calling out more recently, but was unable to explain why this was or what was being done to assist the person.

People's care needs were assessed before they moved into the home and were used to develop care plans to meet those needs. However, assessments and care plans were not always reviewed and updated when people's needs changed, and monthly care plan reviews did not always identify where needs had changed. This meant that care staff did not have up-to-date information about how to provide care in order to meet people's needs. One person had recently been discharged from hospital but their care

plan, which was undated, had not been reviewed. Another person's mobility care plan was out of date as it stated they tended to walk around the home for much of the day, whereas the person was not currently walking around.

People's needs were not all addressed by care plans, which meant that staff did not have clear, written information about the care people needed. Whilst the home had applied to the local authority to authorise the deprivation of liberty for everyone who lived at the home, none of the care plans we saw contained any reference to people being deprived of their liberty.

Care plans and records did not all contain sufficiently detailed information so staff knew how to support people, or had received the care they needed. One person's skin integrity care plan did not specify how often they needed repositioning at night to help prevent pressure ulcers. The records for their daytime care did not show when they had been repositioned during the day, including when they were assisted to use the toilet. For example, at 4.30pm on the first afternoon of the inspection, the latest entry in their monitoring record had been recorded at 8am and stated that the person was sitting out. Another person was in bed at 12.05pm and 2.15pm. On both occasions, their records stated that they had last been repositioned at 7am. The registered manager acknowledged that all assistance from staff to reposition, including when people used the toilet, should be recorded. This would ensure staff knew when people were next due to receive assistance, in order to reduce the risk of pressure ulcers.

One person's care plan did not reflect accurately their religious and cultural needs. It specified that the person 'doesn't have non-kosher food'. The person was Muslim rather than Jewish, so required halal, not kosher, food. This placed this person at risk of not having their cultural and religious dietary requirements met.

Some records were erroneous or incomplete, so staff had insufficient information to guide them in caring for people and could not demonstrate they had met people's needs. Care staff had recorded that one person had spent time looking at their television. This person did not have a television. Another person's moving and handling assessment was not signed or dated, so it was not possible to see who had undertaken it or when. This person had dry and discoloured skin on their legs, and the registered manager told us they had had leg ulcers when they moved in to the home. There was no body map in their records documenting this.

The shortfalls in care planning and provision, including the organisation of meaningful activities, were a repeated breach of Regulation 9(1)(a)(b)(i)(ii) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The shortfalls in record keeping were a repeated breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The procedure for raising concerns and complaints was displayed around the home. Relatives were aware of how to raise complaints and told us they felt able to raise concerns with the home's management if they felt they needed to do so. Staff knew how to respond to complaints. The complaints file contained three records for October 2014, but these related to safeguarding investigations rather than complaints. The registered manager told us they had received positive feedback on the service, but these comments had not been recorded. This meant there was no system in place to learn from feedback and ensure further improvement of the service.

The shortfall in the system for learning from feedback was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Focused inspection on 23 February and 6 March 2015

Staff had not taken sufficient action to ensure people received care that was responsive to their needs.

A person who lived at the home and liked to read told us they only had magazines: "I like books but don't have access to them… It's just the way things are." A visitor commented that they did not see activities and felt the person they visited lacked stimulation. On the first morning of our inspection we saw people looking content as they listened to music in the lounge, but people were not otherwise occupied with things.

Pain was not adequately assessed, which meant people were at risk of receiving insufficient pain relief. Most people were living with dementia that could cause them difficulty saying they were in pain. Care files did not contain completed pain assessments, nor were these filed with people's current MAR. Some care records contained blank pro-forma pain scales. These pain scales were unsuitable

to use with people living with dementia, as they required people to understand the instructions and communicate their self-rating to staff. This did not reflect guidance issued by professional and expert bodies as to good practice in relation to pain management.

A person's MAR for ibuprofen gel specified the prescriber's instruction that this was to be applied to the person's left shoulder. Their medication care plan made no reference to their shoulder and instead referred to their painful knees. A staff member told us the gel was applied to the person's knees, that the MAR stated this and that staff followed the guidance on the MAR. The inconsistency between the care plan and the MAR meant the person was at risk of inadequate pain relief.

There had been a delay in assessing another person's care needs when they moved into the home. The person's needs were not assessed until two days after they moved in. This meant they were not protected against the risks of receiving inappropriate or unsafe care.

Care was not always planned to address people's identified needs, jeopardising their welfare and safety. One person's care plans did not contain information relating to the foot care they needed. They had been admitted to the home with a grade four pressure ulcer on their heel, for which they were still receiving treatment. We saw them wearing foam boots to help protect their heels and a district nurse had advised staff to ensure the person wore them. However, the person's care plans did not mention the foam boots or which day district nurses attended to change the dressing.

Another person, who was known to have diabetes, had been admitted to the home four months before the inspection. They had no care plan that addressed their diabetes, setting out how staff would recognise their health was deteriorating and act accordingly, and arrangements with health services for monitoring their diabetes. We raised this with the registered manager and a care plan was put in place when we returned for our second visit. Senior and managerial staff acknowledged that care plans were not up to date and needed further work.

One person had a history of becoming distressed. Despite this, their care plans did not guide staff in supporting them, in the least restrictive way possible, when they behaved in a way that others might find challenging. The person became agitated during the first day of our visit, shouting at two others who also became distressed. All three people were living with dementia. Staff were unsure of how to intervene and did not respond effectively. Throughout the day these people raised their voices at each other and at other people. A different person told us that they sometimes found the home very noisy, which they disliked, because of people shouting.

A further person, who was living with dementia, had a care plan that explained how staff could reassure and calm them if they became anxious or upset. However, staff did not follow this plan when the person became distressed. Staff tried to reassure them but did not know enough about dementia or the person's life history and preferences to be able to respond effectively or engage them in activities that were meaningful to them.

Staff did not always respond to other care needs. One person's vision and sight care plan stated they needed to wear glasses at all time. The person was not wearing their glasses during the first day of our inspection. Over lunch on the first day of the inspection we observed food sliding off another person's plate; the person lost most of their meal on the table. They needed a plate guard in order to avoid this, but staff had not attached one to their plate. On both days of the inspection we observed this person calling out and staff not responding.

People did not have access to activities they found meaningful. Information provided by a person's family explained that the person liked to walk out in the garden. The person's care plans made no reference to this and their care records contained no record of time outdoors, despite fine weather in the days preceding the inspection.

These shortfalls in assessment, care planning and provision were a repeated breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now Regulation 9 and Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's records of care contained errors and were incomplete or undated, so did not protect people against the risks of unsafe or inappropriate care. One person required assistance to change position; we saw the person sleeping in bed moments after staff had completed a repositioning chart wrongly stating the person was in the lounge. Their body maps were incomplete, recording bruising but giving no indication of the size or colour of

Inadequate

Is the service responsive?

bruises, or with areas marked but no explanation of what this represented. One body map on the person's file was unnamed and undated. Other people's falls risk assessments and PRN medication protocols were undated.

One person had a history of trying to leave the premises, and was assessed as being at risk if they did so. They had previously been returned to the premises by police. On the first day of our inspection there was no photograph of the person on their file to assist the police to find them, although the registered manager put one in place when we drew this to their attention.

These shortfalls in record keeping were a repeated breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17(1) including Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Comprehensive inspection on 21 and 22 October 2014

The home did not promote a person-centred or empowering culture. People were not involved in developing the home as there was no acknowledgement that people living with dementia could make a valuable contribution.

Relatives told us they could speak to the registered manager or deputy if they wished. The registered manager said they often received complimentary feedback from visitors. However, there was no system for obtaining and recording people's views about the home and using these to develop and improve the service provided. There had been no residents' or relatives' meetings, and people's views had not been gathered and recorded by any other means. The most recent quality assurance forms from people and relatives had been returned in 2013. There had been no 2014 quality assurance survey.

There was a whistleblowing policy in place that encouraged staff first to raise concerns with the management team, in line with the Public Interest Disclosure Act 1998. However, the registered manager said that rather than going to the management team, staff went directly to social services, the Commission or the police. They commented that staff tended to do so after they had left employment. This indicated that some staff did not feel able to raise concerns with the home's managers. The staff we spoke with said they could speak with members of the management team if they had concerns about safety or malpractice.

Staff had regular support and development meetings with one of the management staff, where they discussed and received feedback on their work. There were also staff meetings. Minutes of meetings for July and September 2014 showed staff had discussed their apprehension about writing daily notes and supervision and appraisal. However, there was no evidence that staff influenced the development of the service.

Whilst most accidents, incidents and complaints were recorded, there was no evidence that learning from these was shared with staff, although staff meeting minutes showed that staff had been reminded to speak English on duty and report incidents to senior staff. The registered manager told us they gathered the staff after an incident and explained what had happened, but did not record this.

The registered manager told us they obtained information about good practice in dementia care from The Alzheimer's Society. It was not clear how this information was shared with staff.

The systems to assess the quality of service it provides were not effective. They had not identified the shortfalls we found during this inspection. When we asked to see records of quality assurance checks, the management team provided us with records of monthly medication audits, but were unable to provide details of any other checks. One of the management staff told us they checked people's care plans on an ongoing basis but there was no system for checking that care documentation was complete and up to date. We found records that were incomplete and out of date. The most recent "yearly monitoring 'quality of service'" report was from January 2013 and had no dated action plan. The home was not following its own quality assurance policy, which stated there were quarterly audits of catering, housekeeping, caring and administration, and that records of these were kept for review. The registered manager acknowledged there were deficiencies in the home's quality assurance processes and records. They explained that they had appointed a new member of the management team, who had just started work at the home, to help address this.

These matters were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The home met the Commission's registration requirements, including submitting notifications of incidents, such as deaths, as required by the Regulations. There was a registered manager in post, who was a director of the company that owns the home. They were supported by two deputy managers, one of whom had just started in post.

Focused inspection on 23 February and 6 March 2015

Following the inspection in October 2014 the provider returned an action plan. This stated they were introducing a suggestions box, undertaking a survey of relatives, friends

Inadequate

Is the service well-led?

and outside agencies, carrying out their own audits and arranging meetings for residents and relatives to discuss the service. The plan stated these actions would be completed by 31 March 2015.

These improvements were not complete at the time of the inspection, which took place before the provider's deadline. The failure to act on the warning notices given relating to the care and welfare of people and record keeping, and to address other breaches of the regulations reflected shortcomings in the assessment and monitoring of the quality of the service.

These matters were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people were not fully protected against the risks of inappropriate or unsafe care and treatment by means of the effective operation of quality assurance and risk management systems.

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 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: People's care and treatment was not appropriate and did not meet their needs or reflect their preferences.

The enforcement action we took:
We have imposed a condition on the provider's registration. This means further people cannot move into the home without our agreement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not provided in a safe way.

The enforcement action we took:
We have imposed a condition on the provider's registration. This means further people cannot move into the home without our agreement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems or processes were not operated effectively to ensure compliance with the regulations. Accurate, complete and contemporaneous records were not kept in respect of each service user's care and treatment.

The enforcement action we took:
We have imposed a condition on the provider's registration. This means further people cannot move into the home without our agreement.