Mr. Liakatali Hasham

St Catherine's Manor

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

St Catherine's Manor is registered to provide accommodation with care for up to 34 people. At the time of our visit, there were 22 people living at the home. The majority of the people who live at the home are living with dementia; some have complex needs. The home also provides end of life care. The accommodation is provided over two floors that are accessible by stairs and a lift.

The inspection took place on 23 February 2017 and was unannounced.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A manager had been appointed and had begun the process of registration with the Care Quality Commission (CQC). They supported us during the inspection.

At our last inspection in November 2015 we found breaches of the legal requirements. The provider wrote to us to inform us of the action they planned to take to address the concerns. This comprehensive inspection was conducted to check that the action had been taken by the provider and that they were now meeting their legal requirements. We found that the provider had failed to make the changes required and there were continued concerns relating to providing people with safe care and treatment, insufficient skilled staff deployed, identifying and reporting safeguarding concerns, protecting people's legal rights, providing person centred care in line with people's needs and a lack of effective leadership and good governance.

Sufficiently skilled staff were not provided throughout the service. There was a high level of agency staff used which impacted on the care people received. Some people and their relatives felt there were insufficient staff to respond to people's needs in a timely manner and call bell audits showed that staff did not respond promptly.

Safeguarding incidents had not been reported to the local authority to enable them to investigate and ensure people received safe care. The service had not always informed the CQC of significant events to enable us to monitor the service. Risks to people's safety were not consistently identified and acted upon to keep people safe from harm. Where incidents and accidents had occurred appropriate action was not always taken to prevent them being repeated. Improvements had been made to the way in which medicines were managed although there were on-going concerns regarding how people were supported in this area.

People did not receive consistent care in line with their needs. People's care plans contained conflicting information and were not always followed by staff. This meant that people were at risk of their needs not being met in a responsive manner.

Staff had not completed all training required to support them in their role. Where training had been

completed this was not always effective in ensuring that staff understood their responsibilities. People's rights legal rights were not always protected as staff were not working in accordance with the Mental Capacity Act 2005.

There was a lack of consistent leadership and management oversight of the service. Systems in place to monitor the quality of the service provided were not effective in ensuring people received a safe, effective and responsive service. Staff were not clear on the values expected of them and were not involved in the development of the service.

Safe recruitment practices were followed to ensure that people were supported by staff who were safe to work in the service. Staff received regular supervision to monitor their performance and any concerns identified were addressed.

People's nutritional needs were met and there was a choice of foods available to people. Where people required support to eat this was done in a respectful manner. People had access to a range of healthcare professionals. People and their relatives told us that staff responded to healthcare concerns promptly and informed them of any changes. Staff respected people's dignity and spoke to people in a caring manner. Welfare checks were completed on a regular basis to monitor people's comfort. The provider had a contingency plan in place to ensure people would continue to receive care in the event of an emergency.

There was a range of activities for people to take part in and people were supported to maintain their hobbies and interests. However, people who needed to spend the majority of time in their rooms were not provided with activities or company. The provider had a complaints policy in place and relatives told us they were confident that any concerns would be addressed. Relatives told us they were made to feel welcome and there were no restrictions on the times they could visit. People and their relatives were given the opportunity to give feedback on the service provided.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's safety were not adequately assessed and monitored to ensure they were protected from harm.

Accidents and incidents were not effectively recorded and monitored to minimise on-going risks.

Sufficient, skilled staff were not deployed to keep people safe and people's needs were not responded to in a timely manner.

Staff had not recognised and reported safeguarding concerns.

People's medicines were stored and managed safely.

Safe recruitment processes were in place.

Is the service effective?

Requires Improvement

The service was not always effective.

People's legal rights were not protected as the requirements of the Mental Capacity Act were not being met.

Staff did not always receive effective training to support them in their role.

Staff received regular supervision to monitor their performance.

People's nutrition and hydration needs were met.

People had access to the healthcare they required.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff interaction was caring although this was related to tasks rather than staff spending meaningful time with people.

People were not always supported to maintain their

independence.

People's dignity and privacy was respected.

Visitors were welcomed to the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were not always detailed and lacked consistency.

People did not always receive care in line with their care plan and needs.

People had access to activities which took into account their hobbies and interests.

Complaints were recorded and action was taken to address concerns.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager in post.

Sufficient action had not been taken to address and maintain improvement in relation to the previous identified breaches of regulations.

Audits were not in place to monitor and assess the quality of the service and shortfalls in people's care had not been identified or addressed.

Staff were not involved in the development of the service.

People and their relatives were given the opportunity to give feedback on the service.

St Catherine's Manor

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This inspection took place on 23 February 2017 and was unannounced. The inspection was carried out by three inspectors.

Prior to the inspection we looked at notifications which we held about the organisation. Notifications are events which have happened in the service that the registered provider is required to tell us about, and information that had been sent to us by other agencies. The provider had completed a Provider Information Return (PIR). The PIR is a form that asks 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 observed care in the home and spoke with the manager, the provider's Head of Nursing and Compliance Manager, the Group Operations Director and three members of care staff. We spoke with three people who used the service and four relatives. 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 looked at seven people's care plans and records relating to people's care including daily notes, food and fluid recording and behaviour monitoring charts. We reviewed a range of documents which related to how the home was managed including accident and incident forms, policies and procedures, training records and health and safety monitoring.

Inadequate

Is the service safe?

Our findings

People and their relatives told us they felt the service was safe. One person told us, "Yes I feel safe at the home, no-one has shouted at me or I haven't received any rough treatment. If they had hurt me, I would have said something." One relative told us, "I am happy with the safety of the home, which includes the front door. No-one can just walk in." Another relative said, "My mum's room is very safe. She has problems with her knees but she is safe."

Although people and relatives said they felt safe they expressed concerns regarding the number of staff available to support them. One person told us, "Staff are very good but there isn't enough of them. Staff are gentle but they are rushed off their feet." One relative said, "Staffing levels are a problem."

At our last inspection in November 2015 we found concerns regarding the safety of people's care. These included risks not being adequately assessed, insufficient staff being deployed to effectively meet people's needs and unsafe medicines practices. At this inspection we found continued concerns relating to the management of risk and the deployment of staff. We also identified concerns relating to the reporting of safeguarding concerns. We found improvements had been made to the way in which people's medicines were managed although further improvements in this area were still required.

At this inspection we found sufficient numbers of skilled staff were not deployed to meet people's needs in a timely manner. During the inspection we observed that staff did not have time to spend with people as they were busy completing routine care tasks. This meant that a number of people spent lengthy amounts of time without any interaction from staff. Two people who were at high risk of falling were left in the communal areas without staff supervision for periods of up to ten minutes during the day. One of the people concerned had experienced an unwitnessed fall the previous day. We observed that two people who received their care in bed did not receive their morning personal care until after midday. We asked staff about staffing levels at the service. One staff member told us, "There is so much paperwork. We can't get the care done because of it." Weekends are the most difficult. We don't have any admin help so we have to answer the phones and there are a lot more relatives to deal with. The numbers of nurses and carers are the same though." Another staff member told us, "Staff are pushed, most people needs hoisting, which needs two members of staff to assistance. Responding to call bells is a problem."

People's requests for support were not always met in a timely manner. People told us that they sometimes had to wait for their call bell to be answered. One person said, "I have the call bell in easy reach. Most of the time the staff are really good and responded well. But there are times when I have to wait and they tend to be when the agency staff are on." Another person told us that they had experienced discomfort whilst waiting for staff to support them to use the toilet. We reviewed the feedback forms submitted by people and visitors. Seven of the eight feedback forms completed in the past four months stated that staff availability needed to improve. One relative had commented, "They (staff) are caring but sometimes too busy due to lack of staff." The manager completed a call bell audit on a monthly basis. They told us they did this by pressing the call bells of three people and recording how long it took for the staff to respond. Records showed that the in January 2017 it had taken staff an average of 15 minutes to respond and in February

2017, an average of over 30 minutes. The manager told us they felt this was due to staff not being able to hear the alarms when they were in people's rooms and as a result a new call bell system had been ordered. There was no management plan in place to monitor this risk whilst waiting for the new system to be installed. We informed the provider that plans needed be implemented as a matter of urgency. Following the inspection the provider informed us that nursing staff had been instructed to monitor the call bell system and record response times. All staff, including auxiliary staff had been told that they should alert care staff when call bells were heard.

People did not always receive support from regular staff with the skills and experience to know people's needs. The manager told us that the recruitment of staff had been difficult which had resulted in a high use of agency staff. We viewed rotas for the past seven weeks and found that more than 50 percent of care hours had been covered by agency staff. The manager said that wherever possible they would try to use the same agency staff to provide consistency. Rotas showed that there were a number of regular agency staff working at the service although due to the number of hours covered this was not always possible. This meant that people were not always receiving consistent care from staff who knew their needs and preferences. One relative told us, "When staff move mum they know what they are doing. Although mum gets upset when agency staff move her as she does not know them and they don't know her. The regular staff are good."

We discussed our concerns regarding staff deployment with the manager and the Group Operations Director. They told us that a dependency tool was completed and reviewed on a regular basis. A dependency tool should be used to assess people's needs and how many staff are required to meet those needs. We saw evidence that staffing levels were discussed during provider meetings. However, these discussions did not include the results of call bell audits, the impact of high agency usage or feedback received from people, their relatives or staff. The manager told us there were normally six care staff on duty but due to sickness this had been reduced to five staff on the day of the inspection. They said they had taken the decision not to arrange an additional carer to cover the shift. The Group Operations Director told us they had worked hard on recruitment and were awaiting recruitment checks for a number of new staff. They said this meant that the service would have a full complement of care staff within the next three months.

Failing to ensure sufficient staff were deployed to meet people's needs in a timely manner was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's safety continued not to be satisfactorily identified or addressed. We found that a number of people did not have risk assessments in place for the use of bedrails. One person's care file stated that due to the high risk of falls bedrails should be used and we observed that they were in place. However the care plan also said that the person may put their legs over the bedrails when anxious. There was no risk assessment in place with regards to the bedrails which meant this risk had not been addressed. The bedrails log completed for January 2017 recorded only seven of the sixteen people using bedrails had a risk assessment in place.

Staff were not provided with guidance regarding supporting people with their anxiety or behaviours and staff did not demonstrate skills in supporting people in these areas. We saw records of three occasions where people had become distressed when being hoisted which had resulted in injuries including skin tears and bruising. There was no detailed guidance available for staff on how to support the people concerned to minimise their anxiety or protect them from harm. Staff had continued to use the hoist with the people concerned during times of high anxiety which increased the risk of harm. Despite these risks being known, risk assessments regarding the use of the hoist did not address these concerns. One person's care file stated that on occasions they were, 'both verbally and physically aggressive'. The person's care plan did not describe possible triggers to behaviours or give guidance to staff on how to de-escalate situations to keep

the person, other people and staff safe.

Reviews of accidents and incidents were not effective in keeping people safe. Staff had recorded that on two occasions a person had sustained skin tears following incidents whilst using the hoist. Following the second incident the manager had recommended that the person's risk assessment should be reviewed to include guidance to staff on how to support the person as there was, 'No information for staff on what to do should (name) become physically violent.' The person's risk assessment had not been updated and no checks had been completed to ensure this recommendation had been actioned. We observed that on the day of the incident a staff member had received injuries following a further incident. Another person had slipped from their chair on three occasions in recent months. The control measure in place was that a foot stool should be placed under their feet to prevent them from slipping. On the day of the inspection we noted the person had moved the foot stool out of their reach. We later saw that staff had removed the stool. During the late afternoon we saw that the person was beginning to move down in their chair. As no staff were present in the lounge we asked the manager to ensure that the person received the support they required. The manager reviewed the third incident of the person slipping out of their chair during the inspection. They had recommended that a non-slip slide sheet be placed in the person's chair. This was not actioned during the inspection. Other concerns raised within the incident report were not addressed in the manager's review of the incident.

People medicines were not consistently managed safely. The provider completed regular audits to identify medicines concerns. The audit completed in February 2017 showed errors in the recording and dispensing of medicines which the provider's daily Medicine Administration Record (MAR) check had failed to spot. A further audit was completed on the day of our inspection which showed that the above concerns had been addressed although further concerns were identified. On two occasions agency staff had dispensed medicines without signing the MAR chart or signed when medicines had not been given. A review of incident forms showed that an agency staff had administered one person's medicines which had already been administered and signed for earlier in the day. We spoke to the manager and Head of Nursing and Compliance Manager about this. They told us that where staff made a medicines error their competency when administering medicines was reassessed. The manager told us that this had been completed but not recorded. They added that agency staff had been informed that should a second error occur they would not be able to return to work at the service. We asked if the agencies used had been contacted to discuss these and other errors, with a view to discovering the cause of these recurring problems. The manager told us this had not been done. They added this process to the audit tool to ensure relevant agencies were contacted in the future.

One staff member did not demonstrate that appropriate care would be provided to meet people's needs in relation to medicines management. During the inspection a GP visited one person and prescribed medicines which they said should be started as soon as possible. The staff member said that they were unable to collect the medicines as there was no pharmacy available and there was not enough staff available. The manager informed the nurse of where the prescription could be collected and arranged for this to happen.

The lack of effective risk management systems and safe medicines management to protect people was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Concerns regarding the safe management of medicines identified at our previous inspection in November 2015 had been addressed. Medicines were stored safely. The medicines trolley was locked whenever it was unattended and the temperatures of medicines storage where recorded daily. Where people were prescribed PRN medicines, guidance was available for staff to ensure this was administered safely. Guidance

was available for medicines which required careful monitoring and we saw records were accurately maintained.

People were not protected from the risk of abuse as the manager and staff had failed to identify and act upon safeguarding concerns. There had been a number of incidents which had resulted in injuries whilst people were receiving care. None of these incidents had been reported to the safeguarding authority. We also read that one person had complained about the standard of care they had received from agency staff. The alleged concerns related to the staff present neglecting the persons needs which had led to them experiencing distress and discomfort. The manager had contacted the agencies concerned and had requested the same staff did not return. The incident had not been reported to the local safeguarding authority to ensure that the events could be fully investigated and appropriate action taken. The complaints log contained concerns from relatives relating to the standard of care their relative received. The manager had dealt with the complaint by speaking to staff about the standard of care expected. They had not reported this as a safeguarding concern which meant the local authority were unable to investigate these specific issues or monitor how many potential safeguarding incidents may have occurred.

The failure to ensure systems and processes were in place to protect people from potential abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the provider informed us they had informed the local safeguarding authority of all the above concerns and were working alongside them to conduct investigations were appropriate. They also assured us they would be working with staff to ensure they were clear of their responsibility to address safeguarding concerns in a timely manner.

Safe recruitment practices were followed before new staff were employed as checks were made to ensure staff were suitable for their role. The four staff files we looked at contained evidence that the provider had obtained a Disclosure and Barring Service (DBS) certificate for staff before they started work. DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. Staff files also contained proof of identity and references to demonstrate that prospective staff were suitable for employment. Staff we spoke to confirmed that they weren't allowed to commence work until their DBS and references had been received.

There was a contingency plan in place to ensure that people would continue to receive care in the event of an emergency. The plan covered disruption to utilities and services such as lift breakdown, loss of heating and floods. There was an evacuation plan which included details of where people should be taken in the event the building could not be used.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (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. 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 are called the Deprivation of Liberty Safeguards (DoLS).

At our last inspection in November 2015 we found that people's rights were not fully protected and best practice was not being followed in accordance with the MCA. At this inspection we found continued concerns.

People's legal rights were not protected as staff were not working in accordance with the MCA. Records in relation to people's capacity to make decisions contained contradictory information and did not record what specific decision the assessment related to. One person's care records stated they had the capacity to make decisions. However, a family member had signed the person's consent to care form and signed in agreement to bedrails being used. There was no evidence available that the person had been involved in these decisions and no evidence that the person's relative had the legal authority to sign on their family members behalf. Another person's care records stated the person did not have capacity to make decisions and, 'Asks to leave in a persistent and purposeful way'. There was no best interest decision recorded in relation to the person not being able to leave the service and no DoLS application had been submitted to the local authority.

One person was receiving their medicines covertly, (without their knowledge or permission). The person's care records contained conflicting information regarding their capacity to make decisions. The last capacity assessment completed in June 2016 stated the person had the capacity to make decisions. There was no capacity assessment in place regarding the specific decision to take prescribed medicines. This meant that administering medicines covertly to the person was an infringement on their rights and was not consistent with the law. Records for other people receiving their medicines covertly were completed in line with the MCA but these principles had not been applied in every case.

Staff did not have the understanding of the principles of the MCA. We asked one staff member who had received training in the MCA about people's right to make decisions. They told us, "The residents are like children. If someone (with mental capacity) wanted to do something we would talk to their family." This demonstrated the staff member did not understand that people must be given all practicable help to understand specific decisions before anyone treats them as not being able to make their own decisions or that people have the right to make unwise decisions.

We discussed the application of the MCA with the provider. They told us they would take action to review people's assessments. We will check the effectiveness of the action taken at our next inspection.

People's human rights were not protected because the requirements of the MCA were not always followed. This is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had not always completed training to support them in their role and training had not always been effective in ensuring people received safe and effective care. A training matrix was in place which recorded the training staff had undertaken. However, this tool was not effective in enabling the manager to evaluate the training staff had completed. The Head of Nursing and Compliance Manager told us that staff completed safeguarding and moving and handling training prior to starting work at the service. They said the remaining mandatory training needed to be completed during their three month probationary period. The training matrix recorded mandatory training as 'not applicable' for those staff members in their probationary period. This meant the manager could not easily track the training staff needed to complete. The training matrix showed a number of gaps in the training permanent staff had completed in line with the providers policy. These included fire evacuation, nutrition and hydration, health and safety and MCA. The matrix showed that most staff had completed safeguarding training. Staff we spoke to were able to describe the different categories of abuse and reporting procedures. However, they were unable to demonstrate their learning in practice as safeguarding concerns had not been reported to the local safeguarding authority. We spoke to staff who had completed MCA training. They were unable to tell us the requirements of this legislation and were unable to describe their responsibilities in ensuring people's rights were protected.

Failing to ensure that staff receive regular and effective training to carry out their role was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had recently started to implement a series of training days for clinical staff across the organisation to increase their awareness of risks associated with poor practice. The 'Harm Free' training covers areas such as falls prevention and management, reducing the risk of skin breakdown and having evidence based interventions to reduce risk.

At our last inspection in November 2015 we found that staff did not always receive supervision in order to monitor their performance. We made a recommendation relating to this. At this inspection we found that staff were now receiving regular supervisions to support them in their role. One staff member told us, "I have one to one meetings with the manager every three months, I feel that (manager) listens to me." The manager maintained a supervision tracking form which showed that all staff were now receiving regular supervision. Where concerns regarding staff performance were raised these had been addressed within individual meetings with senior staff within the organisation.

People told us they liked the food and were able to make choices about what they had to eat. One person told us, "They always give me a choice." Another person said, "(Chef) is very good and goes that extra mile with my meals as I cannot chew very well." One relative told us, "Mum likes salmon; if there is something she doesn't like they will cook her scrambled eggs." The kitchen staff monitored the food which was returned to the kitchen. Where people had not eaten their meal the chef ensured they were asked if they would prefer something different. Staff told us, "I go around and asked each person what they would like from the menu that day, if they don't like what is on offer they can have whatever we have in the kitchen." Records showed that people were involved in menu planning. Residents meetings included discussions on the menu and where requests were made these had been included as regular items on the menu.

People's nutritional needs were met. There was a list of people's dietary needs in the kitchen which included details of any allergies, medical conditions such as diabetes, fortified foods (high in calories) and people who required their food to be softened or pureed. The kitchen staff were knowledgeable about people's

dietary needs and the guidance provided was followed. Where people required their food to be pureed this was well presented and was done on an individual basis to ensure people still had a choice. Where people required a fortified diet this was presented on a red tray to ensure care staff were aware. People's weight was monitored regularly and where significant changes were noted action was taken to address the concerns.

Where people required support to eat this was done in a respectful manner. We observed staff interacted well with people when supporting them to eat and explained what they were doing. People were supported to eat at their own pace and staff offered encouragement. One person became anxious whilst being supported with their meal. The staff member offered gentle encouragement but the person told the staff member to take the food away. The staff member did as the person asked. They later returned and placed a sandwich on the persons table which they then started to eat.

People had access to healthcare professionals to support them in managing their health needs. People and their relatives told us they received the healthcare support they required. One person told us, "The doctor comes on a regular basis to visit the home." Another person said, "I do have a dentist who visits." One relative told us, "The doctor visits the home on Wednesdays. The girls are very good if they have any concerns they will make sure mum is seen by the doctor and they will always inform me." Care records showed that the service involved a range of external health and social care professionals in people's care, such as Community Psychiatric Nurses and Speech and Language Therapists. One visiting healthcare professional told us they were satisfied that staff followed advice and guidance given and were knowledgeable about the people they were caring for. Records showed that clinical staff supported people appropriately with healthcare needs such the monitoring of skin integrity and pressure areas.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us that staff treated them with kindness. One person told us, "The carers are marvellous. The regular carers are so efficient and they are friendly. They are lovely." A relative told us, "Some of them are friendly, others are wonderful and they go that extra mile." Another relative said, "Staff are human, really human."

Despite these comments we found that people were not always put at the centre of the service. Although we observed staff interacted with people in a caring manner this was mainly whilst they were providing support rather than spending meaningful time engaging with people. The lack of skill shown in supporting people with their anxiety and behaviours demonstrated a lack of understanding of the needs of people living with dementia.

People were not always supported to maintain their independence. We asked one staff member how they supported people in this area but they were unable to give us any examples. One person's care records stated they were able to eat independently and due to their mental health did not like people watching them. We observed that staff did not give the person the opportunity to eat on their own and sat directly in front of the person whilst supporting them with their meal.

We recommend the provider ensures that people's needs are placed at the centre of the service and that people are supported to maintain their independence.

We observed examples of staff interacting positively with people when supporting them. We heard staff chatting with one person whilst they were being supported with their personal care. They talked about each other's families and different foods they enjoyed. When talking to people staff knelt down or sat next to the person to make eye contact. One person was confused about their drink. Staff took time to reassure them and explain the drink on their table belonged to them. One person had fallen asleep at lunchtime and we observed staff gently wake the person by stroking their hand.

People's dignity and privacy were respected. Relatives told us that staff respected their family member's dignity when providing personal care. One relative told us, "They are very good. They make sure all personal care is done in private. Even when I arrive, I will wait in the room along the corridor as they won't let me in when they are doing personal care." Another relative said, "They always make sure that when they are shaving or providing personal care they do it in private." We observed that people's doors were closed whilst staff were providing personal care and staff used dignity screens when supporting people with the hoist in communal areas. Staff were seen to knock on people's doors and wait for a response before entering.

Visitors were made to feel welcome in the service and relatives told us they were able to visit at any time. One relative told us, "I visit mum a lot and there is no restrictions on when we visit. They told us treat it as her home." Another relative said, "I can visit anytime. They even invited me for Christmas so I had Christmas day here, which was lovely." People told us that they were supported to keep in touch with their families. One person told us, "The phone in my room helps me to keep in contact with my family."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in November 2015 we found that appropriate care and treatment was not always provided to meet people's needs. At this inspection we found continued concerns as people's care plans contained contradictory information and staff did not always work to the guidance provided.

Care plans contained conflicting information which meant people were at risk of receiving care which may put them at risk. This was of particular concern due to the high numbers of agency staff working at the service as they may not be aware of people's changing needs. One person's care file stated they should be cared for in bed as they were at risk of falls when sitting in a chair. We spoke to the person's relative who confirmed that due to their changing needs the person now spent their time in bed. The persons care plan later stated that they were able to sit in an upright chair when not in bed and that they should be encouraged to sit in the day room when they felt able. Another person's care plan stated they were able to eat their food independently but required supervision. The person's needs had changed and they now required support to eat but their care plan had not been updated. We observed the regular staff who knew people were responding to those people's needs appropriately.

People's care plans were not always followed by staff. One person's care plan stated they were able to understand information better if it was written down and recommended that staff used the person's notebook to communicate what was happening. We observed the person was sat in the communal lounge area for the majority of the day. They did not have a notebook with them and staff were not seen to communicate in writing with the person.

People's care records were not always completed in a person centred manner. Records lacked details regarding people's personal and social histories and staff were not always able to tell us about people's interests, families or previous working lives. People's daily care records were task orientated and repetitive. They did not always reflect on the person's mood, conversations or what they had enjoyed. This meant that staff were not able to gain a holistic picture of people in order for them to ensure people's care was personalised and provided in line with their preferences.

The failure to ensure that appropriate care plans were in place to meet people's individual needs and preferences was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had a range of activities they could be involved in. An activity worker had recently been appointed and it was clear this had had a positive impact. One relative told us, "Mum likes the activities, especially the sing-along. They make sure that mum is included in the activities." There was an activity programme in place which included crafts, pet therapy, cake decorating and exercises. We observed the activity worker supported people to be involved to the extent they wished, offering one to one support where required. We did note that several people had expressed a wish to go out on trips. The activity worker said this was something they were now looking into and hoped to start local visits in the near future.

People who were able, were supported to maintain their hobbies and interests. One person told us, "I am able to do the things that I enjoy doing such as knitting, drawing and painting." They went on to say the activity worker had also encouraged them to take up crochet, "I would never have thought about doing it, but we talked about it. (Activity worker) even brought me a large needle and book of instructions, and look what I have managed to do." One relative told us, "Staff paint mum's nails as she like to be pampered and look good, the hairdressers comes to the home and mum loves it." We observed another person was supported to watch musical films which their relative said they had always enjoyed. The activity worker told us that they spent time with people in their rooms. They said, "I go around and chat with people in the mornings. It gives me chance to get to know people. I read to one person every day." However, staff did not engage in activities or spend time with people who needed to spend the majority of their time in their rooms. We observed people spent long periods of time without interaction which put them at risk of isolation. The activity worker told us they were aware further work was required in supporting people in this area and they were spending time getting to know people's preferences and speaking to families.

Relatives told us they would feel able to raise a complaint and were confident their concerns would be addressed. One relative told us, "I have never had to make a complaint. I have confidence that if I had any concerns they would deal with it quickly." Another relative said, "I am confident if I raised a complaint they would deal with it."

Action was taken as a result of complaints being made although as reported concerns had not been passed to the local safeguarding authority regarding a complaint from one family member. The complaints policy was displayed in the communal hall and gave information to people and their relatives on how to make a complaint and how this would be addressed. The manager maintained a complaints log which evidenced that complaints had been addressed in line with the provider's policy. One relative had raised a concern that their family members call bell was placed out of their reach. The manager had introduced a series of welfare checks throughout the day to ensure call bells were available to people. Several people had complained about their relative's laundry going missing. The manager had investigated these concerns and had ordered a labelling machine to ensure staff were clear who clothes belonged to.

Inadequate

Is the service well-led?

Our findings

At our inspection in November 2015 we found concerns regarding the governance of the service as action had not been taken to resolve concerns which the provider had identified. At this inspection we found continued concerns relating to the leadership of the service. The lack of clear management processes meant people continued to experience care that was not safe, effective and responsive to their needs.

Quality assurance systems were not effective in ensuring continuous improvement. Records showed that regular provider visits were completed by the quality assurance team and these had increased over recent months. However, the visits had not led to the required improvements in meeting legal requirements.

We found that recommended actions following audits had not been completed. The manager had conducted call bell audits to monitor the length of time staff took to respond. The provider audit evidenced that this exercise had been completed but did not address the concern of how long it had taken staff to respond. The provider had not addressed concerns expressed by people and their relatives that they did not always receive care in a timely manner. There was evidence that during a provider visit staff had been shown how to complete a capacity assessment and care plan for people whose medicines were being administered covertly. The record of the visit stated that this information should be shared with nursing staff as soon as possible to ensure it could be applied to other people. We found that the required safeguards for one person receiving their medicines covertly had not been adhered to. Provider audits did not review accident and incident forms and the lack of reporting of safeguarding incidents had not been identified. The manager and provider reviewed an average of five people's care records each month. Where gaps were identified these were recorded but the records were not reviewed again the following month to ensure that action had been taken.

We asked the manager about the visions and values of the service. The manager told us they felt there was a lack of team work and poor morale amongst the staff team which was leading to staff not working together to provide good care. We asked what steps they were taking to improve this. They told us they had tried to organise a social event but staff had declined to attend. They said they planned to introduce 'Employee of the Month' as an incentive to staff. This response did not demonstrate an understanding of how to effectively lead a team and ensure that all staff were aware of the aims of the service. The action plan which was developed following provider audits acknowledged that team work needed to be improved but did not give guidance to the manager on how this could be achieved. One staff member told us they felt there was a lack of consistency in the management approach which had led to a lack of direction for staff. They told us, "There have been a lot of managers here. We rely on ourselves. We have to as one manager says one thing, then another one comes in and does another."

Staff were not actively encouraged to be involved in how the service was run. Staff meetings were held on a monthly basis. Minutes recorded that a variety of issues were discussed relating to improvements which were required. Examples of this included how daily notes were written, keeping areas of the service tidy and staff wearing the correct uniforms. However, minutes did not demonstrate that staff were involved in finding solutions to problems or sharing ideas of how improvements could be achieved.

The lack of effective quality assurance systems and the failure to maintain accurate and organised records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not notified CQC of all significant events that had happened in the service. Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC) of important events. There had been a number of incidents related to safeguarding concerns. Our records showed that the CQC had not been informed of these incidents to ensure that we were able to monitor the service provided effectively.

Failing to submit statutory notifications is a breach of Regulation 18 of the of the Care Quality Commission (Registration) Regulations 2009.

The provider had taken some steps to improve the quality of the service as a result of quality monitoring and feedback. As a result of concerns regarding the care people received the provider had implemented welfare check forms which recorded that people had been checked regularly, that equipment such as pressure relieving mattresses were at the correct setting and that people had a drink within reach. Areas of the home had been renovated and the appearance of communal areas and people's rooms was now comfortable and welcoming. Following the inspection the Group Operations Director told us they had been due to meet with the management team on the day of the inspection to discuss the improvements required at the service. The meeting had been postponed due to our inspection. Following our feedback during the inspection the provider took the decision to increase the management support provided to the service.

People and relatives were given the opportunity to give feedback on the service. Regular residents and relatives meetings were held. Meeting minutes showed that discussions were held on areas including entertainment, menus, staffing levels and laundry services. Action had been taken to add people's requests to the menu on a regular basis and laundry concerns were being addressed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to submit statutory notifications in line with requirements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that appropriate care plans were in place to meet people's individual needs and preferences

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that the requirements of the Mental Capacity Act 2005 were followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure systems and processes were in place to protect people from potential abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

The provider had failed to ensure sufficient staff were deployed to meet people's needs in a timely manner and that staff received effective training to support them in their role.