Norfolk Care Limited

The Close

Inspection report

The Close Residential Home
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11 August 2017

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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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 9 and 11 August 2017 and was unannounced. The Close Residential Home is a care home that provides accommodation and personal care for up to 30 people. At the time of the inspection there were 27 people living in the home, 16 of whom were living with dementia.

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

At our last inspection of the home in September 2016, we found three breaches of regulations. These were in respect of risks to people's safety not having always been assessed or managed well and consent not being obtained from people in line with relevant legislation. Also the provider did not have robust and effective systems in place to monitor and drive improvement within the home. Following that inspection we rated the home overall as Requires Improvement.

At this inspection we found that the required improvements had not been made. The provider continued to be in breach of these three regulations. These were in respect of Regulations 11, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found six new breaches in respect of Regulation 9, 10, 15, 18, 19 and 20A. We have now rated the home overall as Inadequate.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Risks to people's safety had not always been assessed or managed well. This included risks to individuals and risks from unsafe premises. Due to our high level of concern in relation to gas and fire safety, we reported these to the Norfolk Fire and Rescue Service and the Local Authority Health and Safety teams respectfully. They took action against the provider regarding shortfalls in these areas.

There were not always enough staff to keep people safe or to meet their individual needs and preferences. Although some people were engaged in various activities for part of the day, at other times the staff did not have time to provide people with adequate stimulation to enhance their wellbeing.

Checks to ensure that staff were of good character before they started working in the home had not all been completed as is required by law. People did not always receive their medicines when they needed them.

Staff had received training in a number of different subjects but some demonstrated they were not competent to provide people with effective care. Consent had not always been obtained from people in line with the relevant legislation and less restrictive measures not always considered before restraining people.

People did not always have choice or control over their care. Some areas of the home were not freely accessible to people including their rooms or the secure outside garden space. People were not always given a choice of what they could eat or drink.

People received support with their healthcare needs and some staff were kind and caring. However, this was variable in practice with some people's dignity and privacy being compromised by practices used within the home. Some of these were task-based and institutional in nature.

The leadership within the home was poor. Effective communication was not always in place in respect of people's needs and practices that were taking place in the home.

The provider had failed to ensure that the governance systems they had in place were effective at assessing and monitoring the quality of care people received. They had also failed to identify issues that placed people at risk of avoidable harm. This was in part due to the fact that both the provider and registered manager lacked knowledge in relation to regulation and risk assessment.

The staff were happy working in the home. They felt supported and that they worked well as a team.

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 had not been managed well placing them at risk of harm.

There were not always enough staff to meet people's needs.

Not all of the required checks had taken place before staff began working in the service to ensure they were of good character.

People's medicines were not managed safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Some areas of the service were not safely accessible to people.

Staff had received training but they were not all competent to provide people with effective care.

Consent had not been obtained in line with the relevant legislation.

There was a lack of choice of food but in the main, people received enough to eat and drink to meet their needs.

People were in the main, supported with their healthcare needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some staff were kind and caring but this was not consistently applied.

Some people's dignity was compromised.

Is the service responsive?

Inadequate

The service was not responsive.

People did not always receive adequate levels of stimulation.

People did not always have choice and control with some institutional practices being in place.

Some people were reluctant to raise concerns about the care they received.

The provider had a complaints procedure in place but this required updating to give people adequate information on how their complaints would be dealt with.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of robust and effective systems in place to assess and monitor the quality of care people received. Furthermore, their systems did not adequately mitigate risks to people's safety.

The leadership in the service was poor. Communication was not always effective and the provider and registered manager lacked knowledge in some important areas of regulation.

The Close

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 9 and 11 August 2017. Both days were unannounced.

On 9 August 2017, the team consisted of two inspectors. On this day we visited in the afternoon/early evening in response to concerns we had received about staffing levels within the home. On 11 August 2017, the team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. This visit was carried out during the day.

Prior to the inspection we reviewed the inspection history of the home. We also looked at any notifications the provider had sent us. The provider has to notify us of certain incidents such as serious injuries or allegations of abuse. We gained information about the home from the local authority and clinical commissioning group.

During the inspection we spoke with five people living in the home and three visitors. We also spoke with a healthcare professional, four care staff, the chef, the deputy manager and the registered manager.

Some people living in the home could not verbally tell us about their experience of the care they received. Therefore 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 carried out general observation throughout the inspection. This included observation of people's experience during their lunch and evening meal and how staff interacted with people.

The records we looked at included six people's care records, five medicine records and three staff recruitment files. Records in relation to staff training, the management of the premises and how the quality of care was assessed and monitored were also reviewed.

Inadequate

Is the service safe?

Our findings

We inspected the home in September 2016 and rated it as Requires Improvement in safe. However, at this inspection we have rated safe as Inadequate.

At our previous inspection in September 2016, we found the provider had not ensured that risks to people's safety had always been assessed or were being adequately managed. This had resulted in a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. At this inspection, we found that no improvements had been made and that the provider continued to be in breach of this regulation. Furthermore, where assessments of risk had been made, these were not always robust as they did not contain all information for staff on what they needed to do to reduce risks to people's safety.

Four people whose care we looked at had bedrails fitted to their beds. The registered manager told us these were in place to prevent these people from falling out of bed. However, they had not assessed whether it was safe to have these bedrails in place.

Records showed that there had been an incident in March 2017 where staff had found one of these people on the floor in their room. In a subsequent investigation, the registered manager had concluded that the person must have fallen through the gap that existed between the bed rails and the footboard at the end of the bed. They did not complete an assessment following this incident to ensure the bed rails were safe to use or were fitted correctly. We measured this gap and found that it was smaller than recommended within current health and safety guidance. This therefore posed a potential risk of entrapment and injury to the person.

A speech and language therapist (SALT) had assessed one person as being at risk of choking when drinking. They had advised the registered manager that the person required their drinks to be thickened with a thickening agent to reduce this risk. On the first day of our inspection visit, this person was given a large beaker of drink. When we looked at this drink it was not very thick in consistency. A staff member told us they had added half a teaspoon of thickener.

The person's risk assessment did not specify how much thickener the person required. When we raised this with the deputy manager, they told us that one to two scoops should be added. The registered manager did not know how much should be added. On the second day of our inspection visit, the deputy manager advised they had contacted the SALT and had ascertained the correct amount of thickener was 1.5 scoops per 200ml of liquid. Therefore, the correct amount of thickener had not been added to the person's drink which placed them at risk of choking.

The registered manager had assessed another person as being at risk of choking. They had therefore made a decision to puree the person's meals so they were easier to swallow. However, the person's risk assessment in relation to this stated the person could eat sandwiches with the crusts off. This is a contradiction. We spoke with the deputy manager about this. They told us the person's relative had requested they had sandwiches and that the GP was aware of this. This information was not recorded within the person's care

record. We asked the deputy manager to speak with the person's GP and obtain a SALT assessment if necessary to ensure it was safe for the person to be eating sandwiches. The deputy manager agreed to do this. Giving this person sandwiches may have placed this person at risk of choking.

Risks in relation to people not eating enough to meet their needs had not always been managed well. The registered manager had assessed one person as being at risk of losing weight. Records showed that since March 2017 they had lost seven per cent of their bodyweight. To mitigate the risk of them losing further weight, the registered manager had recorded within the person's care record that they needed prompting and encouragement to eat their meals.

During our observation of the evening meal on the first day of our inspection, a staff member sat with this person. When the person did not eat their meal they were not given any prompting or encouragement. This meant they left over half their meal. They ate all of their dessert but were not offered an extra portion. No other actions such as fortifying the person's foods with extra calories or offering them high calorie snacks had been introduced to help the person maintain or gain weight. This demonstrated that actions were not being taken to reduce the risk of this person losing weight.

The registered manager had assessed some of the people whose care we looked at as being at risk of developing a pressure sore. In some cases, they had identified the need for specialist equipment to be in place to reduce this risk. However, this equipment was not always being used or applied correctly to help mitigate the risk effectively. One person who required a pressure cushion was observed not to be sitting on this when staff assisted them to sit into an armchair.

Another person who the registered manager had recorded as needing their position regularly changed, did not receive this. They were observed sitting in the same position for long periods of time during both days of the inspection. Another person's specialist mattress on their bed was set at an incorrect setting for their weight. Therefore, it may not have been effective at mitigating the risk of them developing a pressure sore. Furthermore, the information for staff on how to reduce risk in relation to pressure sores effectively had not always been written in people's risk assessments. For example, one person was observed sitting on a pressure cushion but the need for this had not been recorded in their risk assessment.

The registered manager had assessed that some people living in the home were at high risk of falls. We saw that one person had experienced several falls this year. The registered manager confirmed that one of the actions required to mitigate this risk was for a sensor mat to be in place when the person was in their room. This was stated in their risk assessment. On the first day of our inspection visit, the staff were alerted to the person moving in their bedroom when the call bell sounded. However, one staff member switched off the call at a display panel and went back to a person they were already attending. They did this rather than visit the person in their room to ensure they were safe. The registered manager told us the staff member should have checked the person immediately.

On the second day of our inspection visit, we saw that this mat was not always plugged in when the person was in the room. One staff member said it did not need to be plugged in when the person was sitting in the chair but the registered manager told us it should be. We saw the deputy manager enter this person's room but they did not notice the mat was not plugged in. The sensor mat had also not been placed near the person when they were sitting in their chair. Therefore, if they had got up from the chair, the staff would not have been alerted. Some of the incident forms that had been completed in relation to this person's falls stated they had had to shout for assistance. This indicated the sensor mat may not have been utilised as was required. The registered manager had not referred this person for advice from a specialist falls team even though they had experienced six falls between April and August 2017. They confirmed the last time the

falls team visited the person was in March 2017.

One person had been involved in a fall when staff were assisting the person to transfer from their commode to a wheelchair. They fell onto the edge of their armchair and then onto the floor. We noted that when this person had fallen, they had stated they were in pain in their hip. However, it had been recorded that staff had lifted this person back into their wheelchair. This was potentially unsafe if the person had been injured. Following this, the registered manager had assessed that this person was at risk of falls when they were being assisted by staff to move or transfer. They had concluded that the person needed to use their frame and have support from one member of staff to do this safely. However, we saw one staff member assist the person from their armchair to a wheelchair without using their frame. Staff were therefore not following guidance about managing the risk safely

Records showed that a third person had experienced three falls at night from their bed at night time since March 2017. One had resulted in a cut to their head and another to their ear. This person was sleeping in a bed of normal height. The registered manager told us they had not considered whether any other actions could be taken to reduce the risk of injury to this person. For example, having a bed that could be lowered low to the floor or bedrails to prevent falls from out of the bed. They told us they would consider this if the person fell from their bed again.

During a recent outside event held at the home, another person had fallen when they tried to exit the home to get into the garden. The doors, which the registered manager said were not usually open, did not have safe access such as a ramp or handrails. Staff had not assessed the risk appropriately regarding leaving the doors open and therefore the person had fallen and sustained an injury to their skin. A ramp was subsequently being installed.

Incident forms showed that one person had fallen four times in three days. The action to be taken in response to this had been recorded as '[Person] does not sleep much at night and it is usually less than a couple of hours. During the day [person], sometimes falls asleep so staff have been informed to advise [person] to sit in an armchair rather than dining room chair.' This had been repeated as the required action after all four falls had occurred. In addition after three falls, a further line had been added to say that day and night staff checked on the person regularly. No other possible actions to prevent these falls from occurring had been explored. This demonstrated the investigation into these falls and their future prevention had not been robust.

The above evidence demonstrated a breach of Regulation 12, parts (1) and (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our observation around the home we found that toiletries, razors and steredant tablets were not kept secure within people's rooms. The registered manager told us they had not assessed whether leaving these items out in people's rooms was safe.

On one occasion in a communal area we found a cupboard that was unlocked. This contained a number of cleaning products including disinfectant, bleach and toilet gel. We also found a tin of thickening agent that had been left on a tea trolley which was unsupervised. There were some people living in the home who were mobile and may not have understood the risk these items potentially posed if they ingested them accidentally. The registered manager told us these items should have been locked away. On the second day of the inspection visit, we found this to be the case.

Some people's en-suite bathrooms and a communal bathroom had exposed piping. The registered

manager told us they had not assessed whether this piping posed a potential risk of burns to people. Most of the radiators within the home were low heat emitting which reduced this risk however, a radiator on the landing upstairs was not of this sort. No risk assessment was in place to determine whether this posed a risk to people should they fall against it. There were people within the immediate vicinity who were mobile and at risk of falls.

On the first day of our inspection visit, we noted that a number of doors to people's rooms were wedged open whilst the person resided there and that a fire door to the laundry was wedged open. This meant that should the fire alarm sound these doors would not close to protect people from the risk of fire or smoke. Also a fire exit was blocked with a small table. A sign had been placed on the door stating that the exit needed to be kept clear at all times. As it was blocked, this would hamper any evacuation that was needed.

We brought these issues to the registered manager's attention. They told us that people's doors should not be wedged open and that the cleaners only did this when they were cleaning a person's room. They also said the fire exit was not actually a fire exit and that therefore, it was not an issue that it was blocked. They told us they would take the signs down and that people would be evacuated from a different exit if needed. However, on the second day of our inspection visit the fire exit remained blocked by both the table and in addition, a large number of toilet rolls that had been delivered to the home. Some doors to people's rooms also remained wedged open.

We checked some people's personal evacuation plans (PEEPs). These are in place to guide staff how to evacuate someone from the building in the event of an emergency. Some people's PEEPs stated that this blocked exit was one of the routes staff should take when evacuating people. Therefore the risk in relation to fire was not being appropriately managed to keep people safe. We referred our concerns to a local fire safety officer. They subsequently visited the premises and issued the provider with an enforcement notice under the Regulatory Reform (Fire Safety) Order 2005 due to concerns they had with regards to fire safety in the home.

The premises were not secure. A window within a downstairs lounge could be fully opened and was easy to climb out of due to the low sill. This window was at the front of the building that led to the busy road. The registered manager told us there were no restrictors on these windows and therefore, they should have been locked when closed. There were people living in the home who would not have been safe outside on their own. This risk to people's safety had therefore not been managed appropriately.

We asked the registered manager for a copy of the gas safety certificate for the home. They told us they did not know whether one was in place. They handed us a folder of health and safety checks. This contained three warning notices that the provider had been issued with from a gas engineer following their visit in June 2017. They had raised concerns in relation to the oven in the kitchen, a boiler located in an outhouse and the flue to another boiler that they had not been able to gain access to. All of these areas had been deemed a risk by the gas safety engineer that required the provider's attention.

We noted that all of these issues had previously been raised by the same gas company as concerns during their inspection in September 2016. The registered manager told us that the safety of the premises was the responsibility of the provider and that therefore, they were not aware whether any remedial action had been taken to reduce the risks identified by the gas company. We reported these concerns to the local authority health and safety team. They subsequently visited the home and issued the provider with improvement notices under the Health and Safety at Work Act 1974.

The above evidence demonstrated a breach of Regulation 12 (1) and (2) (a), (b) and (d) of the Health and

Social Care Act (Regulated Activities) Regulations 2014.

After the inspection visit, the registered manager sent us a gas safety certificate for the property that had been issued in September 2016. We shared this with the local authority health and safety team. They subsequently advised us they were investigating into this further.

People had not always received their medicines as prescribed. One person was prescribed a particular medicine for administration once a day. There were three missing signatures on the medicine administration record (MAR). We therefore checked the balances of medicines remaining for use. We found that the person had three more tablets than they should have. This meant they had missed their medicines three times. The deputy manager was unaware of the omissions as staff giving subsequent doses had not reported them.

It was noted in the care records that one person experienced considerable back pain. To manage this they were prescribed pain medicine to be taken two times per day. We found that they had not always received this as the prescriber intended. On one occasion, the person had not received their evening dose. This was because the morning medicine round had been late and a sufficient gap could not be given before the evening dose had been due. This meant the person had been without pain relief for up to 24 hours and their pain may therefore not have been well controlled.

Another person had a blank signature for a medicine to assist them with their dementia. This was to be given once a day at lunch time. We found that the medicine was missing from the blister pack, indicating staff had likely removed it to give to the person. However, they had either not followed a safe process for administering it and then signed the record, or had not recorded whether it was refused and sent for destruction.

From 7 August 2017, one person had been prescribed a regular medicine to help them sleep. This had followed a trial of the medicine for the previous week. We asked a staff member why they needed the medicine. They told us about the person's anxiety and behaviour at night time and said this was why the medicine had been prescribed to help them sleep. However, the records completed by night staff during July 2017 did not support that the person did not sleep well. This fact had only been recorded on one occasion after 11 July 2017. The person's care records about their needs in the afternoon and evening stated that they had usually slept well before this medicine had been prescribed. This did not support that the person had more than an occasional disturbed night requiring regular sedation.

Medicines for oral use were for the most part stored safely in locked trolleys to one side of the dining area and staff responsible for administering them retained keys in their possession. However, we noted that the trolleys were not always secured when staff were administering medicines within the dining room.

Staff left two trolleys with their doors wide open and medicines on top of one when they went to give people medicines elsewhere in the dining room. Although the medicines were potentially in eyesight of staff, this presented the potential for someone to pick up and remove medicines or to damage them if they were anxious or distressed. Creams that had been prescribed for external use had not been stored securely for the safety of people living in the home.

Insufficient information was in place to guide staff on how to give people their medicines safely. None of the medicine records contained photographs of people as an aid and prompt for staff to help them ensure they were giving the correct person their medicine. The list of specimen signatures and initials did not always match the signatures on MAR charts although the deputy manager was able to explain which of the staff had

completed the records.

Staff did not use body maps when they applied medicines contained in patches as is good practice. This meant that staff could not be sure they varied the site of application of the patches to avoid possible skin problems. It also meant they could not easily monitor it was still attached and seek medical advice if it was missing. They would not be able to easily and quickly locate a patch containing any residual medicine that they needed to remove before they applied a new one.

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

Prior to the inspection, we had received a concern that there were not enough staff working in the afternoon/early evening to keep people safe or to meet their needs. We found that staff had not been deployed effectively to keep people safe or to consistently meet their needs.

Four of the five people we spoke with told us they did not feel there were enough staff to meet their needs in a timely manner. One person when asked whether staff answered their call bell quickly told us, "Usually but sometimes I have to wait. Obviously if they are busy elsewhere I just have to wait." Another person said, "I think they're a bit short staffed, I often have to wait. If they're busy with someone else you have to wait, you have to be patient." Visitors to the service also told us people sometimes had to wait for assistance. One visitor told us, "I think there are enough staff but [person] has said they sometimes have to wait." Another visitor said their family member often had to wait for personal care.

All of the staff we spoke with told us they felt there were enough of them to keep people safe and to meet their needs. However, we observed this was not always the case. Staff were not able to check that one person was safe when their sensor mat went off because they were assisting another person in their room. Another person rang their call bell as they wanted to be moved from their room to the dining room but staff told them they were busy helping other people. The person was eventually brought to the dining room 33 minutes later. During mealtimes, some people had to wait for over 30 minutes to receive their meals. One person in frustration started to sing, 'Why are we waiting?'

One staff member was observed sitting with a person who had been assessed as requiring prompting to eat their meal. The person was managing to eat independently. However, after they had taken one mouthful the staff member left the person to assist another staff member with a task. They told the person they would be back in 'a few minutes'. The person then dropped their knife on the floor which they tried to retrieve. We alerted another staff member who was administering medicines as we were concerned the person might fall or injure themselves trying to reach the knife. The staff member who had left then returned and stayed with the person whilst they ate their meal.

Call bells appeared to be answered quickly during both days of our inspection visit. However, we saw that staff turned the bell off at a central panel before answering the call. This made it difficult to judge whether people had received assistance in a timely manner. A staff member told us this was usual practice and that the call bell would re-ring again after a couple of minutes if it was not turned off where it had originated from. We spoke with the registered manager about this. They told us staff should only turn the call bell off when they had visited the person and not at the central panel. At one time, we saw a staff member turn two call bells off at the same time.

Records showed that 12 of the 17 falls people had experienced since April 2017 in communal areas, had been un-witnessed by staff. We spoke with the registered manager about this. They told us they had

recognised that a number of un-witnessed falls had occurred within the dining room in the afternoon/early evening. In response, they had placed another staff member to work from 3.30pm to 7.30pm specifically within this area. However, this still meant that only three staff worked from 2pm to 3.30pm and 7.30pm to 9pm. We also observed that staff were not always able to be present in communal areas to monitor people who were at risk of falls. One person was seen walking without their frame which they had been assessed as requiring to reduce the risk of them falling.

We checked the staff shift rotas for the two weeks prior to our inspection. We found that for five days in the morning, the home had one less staff working than the registered manager said was needed. In the afternoon, this had occurred on two days. The registered manager said that this had been caused due to staff sickness. They said that when this happened either existing staff, themselves or the deputy manager were utilised to cover the shortfall.

Even when the staff numbers were at the level the provider said they should be, staff had very little time to sit and engage with people. They were often very busy providing people with personal care or assistance. The deputy manager told us the required staffing levels had been calculated based on the amount of care each person required. They said they had timed how long it took staff to provide people with tasks such as personal care, bathing, breakfast and medicines. However, other factors had not been taken into account when calculating these figures. This included the layout of the building, that staff had to complete other tasks such as domestic or catering duties after 1.30pm each day which we observed them completing. Consideration had also not been given to the fact that some people were at risk of falls so may require a higher level of monitoring. Furthermore, no provision had been made for staff to spend time with people to provide them with stimulation when there was not activity person working.

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

Recruitment processes were not robustly applied to contribute to protecting people from the employment of staff who were not suitable to work in care. We found that the employment histories of staff, gaps in employment and reasons for leaving previous employment had not been explored with new staff when they applied to work in the home. This information is required by law.

One staff member's application form listed they had worked in three previous jobs at the point of applying to work at The Close. Dates of employment or reasons for leaving had not been recorded or explored. The registered manager had sought references about the staff member's conduct in their previous roles. However, we saw that the staff member had worked within care previously but no reference had been requested from this employer to help the registered manager judge their conduct within this profession. The date the references had been requested by the registered manager was the same date the staff member started working in the home. The staff rota for this day showed they had been on their induction and included as one of the four members of staff who were required to work that afternoon. This had been done before all the appropriate checks had been completed on this staff member. Furthermore, there was no full, enhanced disclosure with the vetting and barring service (DBS) to confirm they were not legally prevented from working in care. There was a disclosure translated from the staff member's home county abroad, but this was insufficient to demonstrate their conduct in this country. Both other staff files we checked showed that gaps in their previous employment histories had not been explored.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All of the people we spoke with told us they felt safe living at The Close. One person said, "I do feel safe here, I've got my emergency button if I need help." Another person told us, "Yes it seems secure here." The relatives we spoke with agreed with this.

The staff we spoke with had a good understanding of how to protect people from the risk of abuse. They understood the different types of abuse that people could experience. They all said they would have no hesitation to report any concerns either to the registered manager, provider or outside of the home. All of the staff said they felt confident that any issues they raised would be dealt with appropriately.

We saw that when people were in their rooms or a communal area, they had access to a call bell so they could request assistance from staff. Also, the lifting equipment that was used to support people to move had been regularly serviced to ensure it was safe to use.

Requires Improvement

Is the service effective?

Our findings

We visited the home in September 2016 and rated it as Requires Improvement in effective. The rating remains the same following this inspection.

At our previous inspection in September 2016, we found that the provider had not ensured that people's consent had been sought in line with the relevant legislation. This had resulted in a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that no improvements had been made and that the provider continued to be in breach of this regulation.

We received mixed views from people as to whether staff always asked them for their consent before performing a task. One person told us, "I think they ask permission to come into my room, well most do." Another person said, "Often they just do things without asking."

The registered manager told us that some people living in the home lacked capacity to consent to and make decisions about their own care. Therefore the staff had to comply with the Mental Capacity Act 2005. 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.

Staff had mixed knowledge in relation to the MCA and its principles. Some told us they always offered people choice and would support them to make decisions such as showing them what clothes to wear. However, other staff were unclear and said they thought relatives made decisions for people. We noted that staff had not all received specific training in this area.

We observed that staff practice in supporting people to make decisions about their care was variable. When a person found it difficult to make a decision about whether to have some tomatoes with their tea, the staff member took the time to show them the bowl of tomatoes to help them make a choice. However, another staff member did not engage with a person when they moved them in their wheelchair. Although we could see they were repositioning the person's chair so they could reach a drink, they walked up behind the person and moved them without explanation or asking. The person asked, "What? Where are we going?" Only then did the staff member offer an explanation.

The correct procedure had not always been followed when action had been taken to restrict people for their safety. One person had a seat belt on their chair. At one time this was done up but on another occasion it was not. We asked the deputy manager about this. They told us the person would have the belt done up when they become upset of distressed as they would try to get out of their chair which put them at risk of falling. They explained however, that sometimes when the person was calm they did not need the seat belt.

The deputy manager said the person had fluctuating capacity but no assessment of this had been

conducted to see if they were able to consent to having the seat belt. There was no evidence that any less restrictive options had been considered or that other people, such as those close to the person, had been involved in making this decision.

Another person also had a seat belt that strapped them in their arm chair. The registered manager had completed a capacity assessment and a decision made with their family that it was in the person's best interests to use this. This was to prevent them from experiencing falls. However, the registered manager had not considered any less restrictive practice such as ensuring staff were available to support the person to stand if they wanted to, take them for a walk or out in a wheelchair. The person's care record in relation to their mobility stated they could walk a few steps with a frame. The staff we spoke with confirmed this. This person also had bed rails on their bed for which no capacity assessment had been conducted.

The registered manager told us they felt they were depriving this person of their liberty in their best interests and had therefore made an application to the appropriate authority to do this. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

A number of people had sensor mats in their rooms to alert staff to their movements. Staff told us this was so they could reduce the risk of people having falls. However, no assessments of people's ability to consent to having these mats had been completed. Where they may not have been able to consent, relevant people had not been involved to discuss whether this was in the person's best interest. There was no information in people's care records detailing what decisions they could make themselves and for those they required support.

This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some areas of the environment were not suitable to meet people's individual needs, particularly those who were living with dementia or who had poor eyesight. Some corridors in parts of the home were poorly lit. No identifiable items such as photographs or items that were special to people were either on or near their door to help them find their room. Although the bathrooms had a written sign depicting what they were, there was no use of pictures to help people distinguish these areas. The doors to the bathrooms and communal toilets were the same colour as were all of the other doors in the home. One staff member told us how a person regularly could not find their room. We observed another person walking up a gloomy corridor looking confused.

There was a pleasant, secure outside garden area at the home. However, not all people were able to access this independently. This was because the doors to the garden had a small step that people had to negotiate which made it unsafe for some. One person had previously had a fall when they tried to exit the dining room to the garden and had sustained an injury. A ramp was now being put in place at this exit.

The drawers in one person's chest of drawers were all broken. We asked the registered manager if they were aware of this and if so, when they would be fixed. They told us that any issues would be in the maintenance book. We asked for the maintenance book but were told it was not on the premises and that the maintenance person must have had it. Some lights in a communal bathroom and the main entrance hall did not work when we tried to switch them on.

We noticed that some strip lights in the dining room contained a large number of dead insects. The registered manager told us these had been cleaned two months earlier and that they could not prevent flies

from entering the lights. We asked why they had not been cleaned sooner than two months. The registered manager said the appropriate equipment was not kept at the home and that only the provider had the relevant equipment that was stored elsewhere.

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

Improvements are required to ensure that staff provide people with consistently effective care. People told us they felt staff had received sufficient training to meet their needs. One person told us, "I rely on the carers because I can't walk. They use the hoist and seem to know what they're doing; there are normally two of them." A visitor said, "I'm pretty sure they know what they're doing."

All of the staff we spoke with said they felt they had received enough training. They told us this had been completed in various subjects such as moving people safely, safeguarding people from abuse, dementia and fire safety. Staff told us they had initially had induction training with the deputy and registered managers. Here all topics were covered over a three day period and then they had external training with outside trainers. Some staff said they had not yet completed the external training but felt competent in their roles.

Staff gave us mixed views as to whether their competency to perform their role effectively had been assessed regularly. One staff member told us it had but another said they could not recall this having been completed recently. Records were available to show that some staff had received checks of their competency in respect of hand washing and catheter care. However, the records did not show which staff had completed catheter care assessments or what other areas of staff competency had been assessed.

The registered manager told us they regularly checked staff member's competency but during the inspection we observed some staff using poor or incorrect practice. This demonstrated that all staff did not have the appropriate knowledge to provide people with effective care. For example, using unsafe techniques when helping to move a person, not ensuring pressure cushions were always in place, leaving sensor mats unplugged and leaving a window open which was unsafe.

The registered manager told us that some staff were behind with their external training. Records showed that two staff who had worked at the home for over nine months had yet to attend this. The registered manager said that a number of training sessions had been organised for October and November 2017. These were in the subjects of moving and handling, hearing loss, safeguarding adults, food hygiene, health and safety, infection control, end of life care, dementia and the Mental Capacity Act 2005.

This was a breach of Regulation 18 (2) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Prior to the inspection, we had received a concern that there was a lack of choice of food available for people, particularly during the evening meal. We found this to be the case. People did not always have a choice of food or receive the prompting and support they needed to enjoy their meals. Improvements are required in this area.

We received mixed feedback from people about the quality of food on offer. People also told us that they did not feel they had a choice of food. One person told us, "You get what you're given." Another person said, "its fish and chips today and they know I don't like fish of any kind so I'll probably get sausages or something." When asked if they were asked what they would like instead, the person told us, "Well, they know I'll eat

sausages so they just give me them." A further person told us, "Sometimes it's not very hot and it is pretty unimaginative, also I wouldn't call it generous." They continued, "The trouble is I'm a very slow eater and they bring my pudding at the same time so it might be cold, I eat it anyway." People also told us there was not much variety on offer for the evening meal. One person told us, "Usually it is sandwiches, perhaps some crisps and cake. There is not really any variety."

The chef told us they spoke to people in the morning to ascertain what they would like for lunch. However, we saw that no choice of meal was offered. People were told what the main meal was and also what was for tea. Where people may not have liked the main meal, an alternative was suggested by the chef. We saw that the chef knew two people would want something different and said they would make them omelette. We heard them tell one person, "Fish and chips today [Person's name]. Although I will give you mash as the fish might be a bit hard." They also said, "I'm going to make cheese and cucumber sandwiches for tea and there is Swiss roll for dessert." There was no open exploration with people about what fillings they might like in their sandwiches or if they would prefer something other than a sandwich. We also noted that Swiss roll was served for dessert two days before, suggesting a lack of variety.

We noted that one person asked not to have mushy peas with their lunchtime meal but to have garden peas. The chef said they could do that for them but added that they tended to do mushy peas because it was easier for people to manage. However, when lunch was served the person was given mushy peas.

We asked the chef about choice of food. They told us people used to be offered two types of main meal at lunchtime but that some people did not eat either. Therefore, they now only made one main meal. They said however, they gave an alternative if people asked for this or if they knew people did not like the main meal. Where people may not be able to make a choice or remember what the meal was, no alternative methods were used to obtain this information such as showing them pictures of different meals. The chef said they did not do this due to time constraints. They explained this was because they were the only staff member who worked in the kitchen.

During our observations of the teatime meal, we saw that some people did not eat much of their sandwiches. We later saw staff clear people's plates away without offering any encouragement or exploring whether they wanted an alternative.

People were offered a choice of drink with their tea time meal which was orange or lemon squash but we did not see that people were offered a choice of drink during their lunchtime meal. Also, people were not routinely offered additional drinks at mealtimes. When one person knocked theirs over by accident, staff did replace it and gave the person sharing their table another drink.

One person asked if they could have a drink. A staff member told them they would go and get them a cup of coffee without asking them what they wanted. The person said that they did not drink coffee. Instead of ascertaining what the person would like, the staff member assisted someone else in the toilet. A second staff member, who had heard this, did go and make them a cup of tea and one for the other person sharing their table. Although they had responded to this person's request, no one else sitting within the dining room was asked whether they would like a drink.

People could not always have a drink when they wanted one and had to rely on staff providing them with drinks at certain times of the day. This may not have been in line with their individual preference. One person was observed asking for a drink during the afternoon. They said, "Is there no tea yet?" A staff member told them, "No, at three o'clock." A further person who was in their room told us in the morning they wanted a cup of tea. They said they had not had a drink since breakfast which had been over four hours earlier. We

asked them if they had rang their call bell to ask for a drink. They told us they had not as they did not want to bother the staff as they were always busy. They added, "I am usually told to wait." We saw they had a jug of water in their room which was not within their reach. They told us they did not drink water as they did not like it. We encouraged them to ring their bell which they did and staff then brought them a hot drink.

We noted that some other people who resided in their rooms had either empty glasses or drinks that were out of their reach. We asked one person what they would do if they were thirsty. They told us, "Well I have to ring for them to pour me a drink." Another person said, "They do bring round tea or coffee in the morning and afternoon but only once, I could use more sometimes." The registered manager told us that these people could help themselves to drinks. They could not provide an explanation as to why the drinks were out of these people's reach. After the inspection visit, the registered manager told us that having the drink out of their reach was one person's individual choice so they could easily recline their chair.

We saw that, when staff did bring the drinks trolley round they served people either tea or coffee but without asking them what they would like. The staff told us this was because they knew what drinks people liked and how they liked to take them. However, it is good practice to always ask people in case they would like something different. We also noted that at mid-morning drinks, no one in one lounge was offered a choice of biscuits. They were presented with their drinks with two digestive biscuits already on the saucer.

The chef was aware if people had any specific dietary or cultural needs in relation to their food and drink. They told us about one person who they had been informed required to have their food fortified with extra calories as they were not eating much. All of the staff also knew about this person's increased needs.

People were supported with their healthcare needs. People told us they could see the GP or other healthcare professionals if they needed to. Records showed that people were supported to attend hospital appointments and receive advice or support from other health professionals. This included the district nurse, optician and their doctor. A visiting healthcare professional told us that staff were good at referring any concerns to them in a timely manner. They added that the staff always followed their guidance in relation to supporting people's health. However, we found that for one person, staff had not followed the advice of a speech and language therapist that had placed the person at risk of choking.

Requires Improvement

Is the service caring?

Our findings

We visited the home in September 2016 and rated it as Good in Caring. At this inspection we have rated it as Requires Improvement.

Most people we spoke with said they felt they were treated with dignity and respect One person told us, "The staff help me with most things. I need the hoist and they are careful and I think they're considerate." Another person said, "They treat me with respect, they do that every day when they get me up." A visitor told us they though the staff treated their family member with respect. However, some practices within the home compromised people's dignity and they were not always treated with respect.

The chests of drawers in people's rooms were labelled on the outside for various types of undergarments including 'pants and vests'. Staff told us that they 'toileted' people before mealtimes. Both of these practices were not dignified.

We noted that the registered manager had told staff in an undated memo to stop putting two or three incontinence pads on people at night. However, at a subsequent meeting with staff it was recorded that staff were still using two pads. This was unlikely to make people feel comfortable and did not support people in a dignified manner with their continence needs.

The complaint records we viewed showed that a complaint had recently been made about a staff member emptying a person's catheter in the lounge. This did not promote the person's dignity or that of others who may have been in the area at the time.

One staff member was not as discreet as they should have been when they prompted people to go to the toilet. We observed three people being asked in a way that was easily overheard by anyone in the vicinity which compromised their right to privacy. Another staff member asked a person if they were okay. The person said they were not but the staff member walked away and did not take the time to enquire why this was the case. This person had therefore not been treated with respect.

After the inspection visit, the registered manager told us the staff member had to speak to some people in a loud and clear voice so they could be understood. However, no other strategies had been considered to promote people's dignity such as being closer to the person so they could understand, writing the question down or showing them picture cards. These strategies would have been more dignified for people.

People were not always given the opportunity to be independent. People who could have helped themselves to drink, food or condiments were not given this opportunity. For example, during the lunchtime meal a staff member went round with a bottle of tomato sauce and vinegar and asked if people wanted any. If they did they put this on the person's meal, asked if it was enough and then moved to the next person. At the tea time meal people were asked if they wanted tomatoes and crisps with their meal. Those that said yes had these given to them rather than being able to help themselves. All of the meals were plated up and given to people.

A staff member told us that one person who spent most of their time in their chair was able to walk short distances with a frame and one member of staff. This was consistent with what was written in their care record. However, we did not see this occur during the inspection. The person spent all of their time strapped in their chair apart from when they were assisted with personal care or left the dining area to go to their room in the evening.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people to describe the staff and the care they received. One person told us, "Most are very nice, none are not nice. They do their best." Another person said, "They're reasonable, they don't have a lot of time but they do help me." A further person told us they felt confident to talk to staff but added, "that doesn't mean they always listen."

For most of the inspection, staff did not have time to engage with people in a meaningful way. When they did, we saw this was of variable quality. For example, one staff member was seen speaking with a person in a kind manner. They got down to their level so they could make good eye contact and spoke with them in a quiet and polite tone. Another person was feeling unwell. The staff quickly comforted this person. However, we saw that one person who had been singing, was left for a prolonged period sitting in the same position at a table without staff interaction. They became anxious and started to shout out. A staff member sat next to them, made eye contact and touched their hand. This calmed the person however, immediately after this had occurred the staff member moved away. They did not spend much time with them and did not engage them in any type of activity. The person then became anxious, shouting out again.

We asked people if they felt the staff knew them well and had built up caring relationships with them. One person told us, "I don't think they've got a lot of time for that, although some of them are good and sometimes we have a talk about things." A visitor told us, "I don't think anyone has asked what [family member] used to enjoy. She loves music and does join in when the chap comes to sing."

Records showed there was variable practice in recording people's backgrounds, interests and family histories. This compromised the way that staff could engage with people in a meaningful way. For example, one person's background contained information about the number of children they had but not their names.

People said they could see relatives or visitors when they wanted to except at mealtimes. This was because the registered manager operated a 'protected mealtimes' policy within the dining room of the home. The registered manager told us this had been implemented following their observations of the mealtime experience for some people. Here they had found that some people were not eating their meals which they felt was due to the increase in noise and on occasions, large number of relatives being present in the dining room.

They told us that relatives were still welcome to stay over lunch and dine with their family member in other areas of the home but not in the dining room. One visitor we spoke with told us they did not agree with this approach. They said, "There has been a change quite recently which I understand but don't think they've got right. They don't want relatives to be present at lunch because they say it disrupts the residents. They won't allow us to stay unless we're actually having a meal." They did not seem to be aware they could eat with their family member but just not in the dining room.

We received mixed feedback from people regarding whether they could make decisions about their care.

One person told us, "Well, mostly I like to stay in my room and they (carers) know that so I suppose I can." A relative said, "I mostly leave it up to the staff, after all they're the experts aren't they." Records showed that people's relatives had been involved in an annual review of their family member's care and asked for their opinion on how the care should be delivered. We saw during our inspection that some people were not always actively involved in making decisions about their care.

We saw that people's rooms contained items that were of importance to them. This included photographs, pictures and various ornaments. One person told us they liked their room very much. They said, "I like my room, it's a good size and it has a lot of my things in, I am comfortable here."

People told us that their spiritual needs were being met. They said a church service was conducted within the home each month and that they were able to attend this.

The service had received a number of written compliments this year from relatives about the caring attitude of staff. One said, "We would like to express our thanks to you all for caring and comforting [family member.]" Another, received in March 2017 said, "Thank you for the care – in the truest sense of the word – which you gave to [person]. We know [person] was always treated with dignity and respect and everyone gave [person] every kindness."

Inadequate

Is the service responsive?

Our findings

We visited the home in September 2016 and rated it as Requires Improvement in responsive. However, at this inspection we have rated responsive as Inadequate.

At our last inspection in September 2016, we found that the care provided was task-based and did not always meet people's individual needs. We told the provider they needed to improve the quality of care provided within this area. However, at this inspection the required improvements had not been made. Care had not always been planned and delivered to meet people's individual needs.

People gave us mixed views as to whether the care they received met their needs and individual preferences. One person told us, "They come and get me up, I have been told if I want an extra half an hour in bed that's okay." Another person said, "I can get myself up and get dressed without help so I can choose when I do that. It's the same going to bed. They know I like to sit and watch my television in the evening so I usually go to bed about 8.30pm to 9pm. If I'm having a bath I prefer a female carer to help me and they respect this." However, another person said, "They get me up too early, I mean really early. I don't want to get up at six o clock."

The staff we spoke with said they felt they provided care to people based on their individual needs. They told us that people had their own routines which they respected and could tell us about people who liked to get up either early or late in the day. However, we found there were not enough staff to provide people with person-centred care. This led to some institutional practices being in place such as taking people to the toilet before mealtimes, people having to wait for the tea trolley for their drinks and night staff using extra pads to deal with people's continence needs.

One person told us, "We're a bit restricted when it comes to movement, you know, getting around the home is difficult." Another person said, "I don't like not being allowed to go out, why can't I go out when I want to?" This person told us they liked to go for walks and was frustrated that they could not do this as often as they wanted to.

People did not have free to access the secure outside garden. We noticed that on the second day of the inspection, the doors to this area were locked in the morning even though it was a nice warm day. When we asked a staff member why, they told us it was because one person would try to get over the fence. When they opened the door we noted that it was alarmed. This would have alerted staff to the fact that someone may have gone outside. They could not explain why the door was locked. After lunch one person told us they wanted to access the garden but had to wait for a member of staff to open the doors. Once they were open we saw some people utilising the garden. One person told us they very much enjoyed sitting out in the garden. Another person told us they could go into the garden if they asked to but not on their own.

Some people may not have been able to freely access their rooms without assistance from staff. This was because their rooms had a push button key pad on it that some people would not be able to reach or manipulate. The deputy manager told us that if people wanted to gain access to their room during the day

they would have to ask the staff. However, some people living in the home may not have been able to ask this.

Once people were inside their bedrooms, and if they wanted their door shut, there was a risk that people with difficulties with fine motor skills would not be able to open their own door to come out. This was because where keypads were fitted, people needed to be able to operate a handle on the inside of the keypad as well as the internal door handle simultaneously. Also, this was not at wheelchair height. In communal areas we found that the windows were locked with no key available. This was because they were not fitted with restrictors and would be unsafe as people could get out of them. However, this meant that people were not able to open these windows themselves if they had wanted to.

One area of the home was only accessed by a push button keypad. This area was a long winding corridor that contained approximately eleven rooms. These rooms were divided by a further two doors that were also only accessible by a keypad. On the second day of our inspection these doors were all kept closed. This limited the access people had within the home. We asked a staff member why there were codes on these doors. They told us this was because one person regularly tried to get out of the home. The deputy manager said they were in place for fire safety issues. This demonstrated that people did not have free access around the home and that staff were confused as to why this was the case.

After their evening meal, we saw that a number of people remained in the dining room. There was no music and it was very quiet. No one spoke with each other. One staff member asked another if they could remove one person from the room. The staff member who was giving people medicines said they could. We asked this staff member why the other had asked them this question. They told us people were only being taken out of the dining room once they had received their medicines. Staff returned to the dining room to either take people to their rooms or the television lounge. No one was asked if this was what they wanted to do.

One person's care record said that staff should use a notepad to write things down for the person. This was to help them understand and express themselves but also because of their hearing impairment and refusal to wear hearing aids. We noted that, on none of the interactions we saw between staff and the person, did they do this to deliver care that took into account this aspect of their individual needs.

We noted that staff had discussed with one relative that their family member was not eating well. The relative explained that, for most of the person's adult life, they had eaten their main meal in the evening. They were not used to eating more than a sandwich in the middle of the day and after their breakfast. The deputy manager told the relative that they could try the person with a sandwich at lunch but not all the time, to see if that made a difference. We noted that staffing levels were not sufficient during the evening to offer a hot option other than pre-prepared soup at that time if this was people's preference.

There was variable practice in assessing and recording people's preferences. Although the care records we reviewed showed most people's preferred time to get up, there was no mention of their preferred evening routine. For example, the time they liked to go to bed, whether they wanted windows open or closed, or how many pillows they preferred.

After they had finished their evening meal, we observed that one person was not asked if they wanted to leave or where they wanted to go but told, 'we are going to take you to your room.' The staff told us this was the person's routine. However, the time they liked to go back to their room and to bed was not recorded within their care record and they could not tell us themselves. We noted the curtains had been closed at 6.45pm on one corridor where this person resided and that they were going to bed at this time even though it was still daylight.

We saw both a memo from the registered manager and minutes of a staff meeting that contributed to a lack of understanding about person centred care and respect for people's individual preferences. One memo stated that the teatime assistant should remain in the dining room when care staff started taking people to bed. This risked contributing to the acceptance that staff would start putting people to bed straight after tea.

Arrangements for assisting people with bathing did not take into account individual needs and preferences. There were allocated room numbers on a bath book with the days that staff should bath them. This, together with a lack of information about people's preferred routines, did not reflect people received care focused on their individual needs. Some of the records we looked at in relation to people receiving baths had gaps indicating they may not have received a bath as often as had been planned. The staff told us that people usually only had a bath or shower once a week but this could be done more if people asked. After the inspection visit, the registered manager told us that a number of people were reluctant to have baths. However, the records in place did not support that people had been offered baths but had refused.

We received mixed feedback from people about the level of stimulation on offer. One person told us, "I love to read and listen to music. I sometimes watch the television but reading is what I really enjoy." Another person said, "I like to listen to the radio." However another person told us, "There really isn't enough to do, and I get bored." although they did add they enjoyed some of the external entertainers that visited the home and the bingo.

People had access to some activities such as crafts, bingo and listening and singing to music which people said they enjoyed. They were also able to go on the occasional trip such as to the local café or to the coast for fish and chips. People's birthdays were celebrated and seasonal events arranged around Easter and Christmas. One the first day of our inspection visit an outside entertainer was playing music to a number of people. On the second day, people spent some of their time playing hoop-la in a large group. However, outside of these times some people received very little stimulation.

We saw that some people spent long periods of time in the same areas such as the dining room. They had little stimulation and spent most of their time staring around the room. There was a lack of tactile objects for people to access and touch to help stimulate their senses. Staff did not ask people what they wanted to do or if they wanted to move to another area of the home. We asked staff about this. They told us that if people asked to be moved or made any other request such as for a drink, that they would respond. However, a number of people living in the home may not have been able to make such a request without prompting.

People's care needs had been assessed but all of the appropriate information regarding how these needs were to be met had not been recorded. This is important so staff have correct and appropriate information available on how to meet people's needs. For example, the amount of thickener a person needed in their drink had not been planned for. The setting that two people's specialist mattresses needed to be at to be effective were not in place. Actions that needed to be taken to reduce the risk of a person losing weight and what actions staff needed to take to reduce the risk of people developing a pressure sore were not all recorded. There were no care plans in place to guide staff on how to meet people's care needs if they used a catheter.

People's likes, dislikes and interests were not always well recorded so that staff could support them to do things they would enjoy. One person told us, "I like reading. My friends bring in books." We saw that the person had a soft toy cat in their chair with them. They told us, "That's very important to me. He was given to me by a dear friend and I should hate to lose him." We found that the person's information did not contain information about this as of importance and a possible source of anxiety if it was mislaid. Their records only

recorded that they liked gardening and knitting. It did not contain anything about the person's interest in reading and the sorts of books they enjoyed so staff could talk to them about it.

All of the evidence above demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback from people in relation to raising concerns or complaints. Some people told us they felt confident to raise concerns if they needed to and felt assured these would be dealt with. One person told us how the registered manager was sorting out an issue they had with their daily newspaper. However, other people did not feel this way. Also through observation we saw that some people were hesitant to complain or raise an issue with the staff. Improvements are required within this area.

One person who had asked for garden peas with their lunchtime meal did not raise a concern when they received mushy peas. Another person told us how they did not want to ring their call bell even though they were thirsty and wanted a cup of tea. A further person said they were got up too early for their liking by the staff but said that they did not like to complain. This did not demonstrate a culture where all people felt empowered and confident to raise concerns.

We noted that the provider's complaints procedure lacked detail about how people could expect their complaint to be dealt with and how to properly escalate this. The provider or registered manager had not reviewed this, based on the date on the bottom of the document, for almost 12 years. Although there was separate guidance in the registered manager's file about the ombudsman, the complaints procedure that was available to people did not refer to people's rights to escalate their concerns to the ombudsman.

The only means outlined for people to escalate their complaint, was to address it to the Care Quality Commission (CQC). This was not strictly accurate and potentially misleading. Although CQC does take people's concerns about the quality and safety of care into account, we have no statutory powers to investigate and address individual concerns.

The registered manager told us that one complaint had been received during 2016. We saw a complaint had recently been made however, they had not yet recorded or acknowledged this within the complaints record to show the investigation they were making.

Inadequate

Is the service well-led?

Our findings

We visited the home in September 2016 and rated it as Requires Improvement in Well-led. However, at this inspection we have rated Well-led as Inadequate.

At our previous inspection in September 2016, we found that the provider had not ensured there were robust and effective governance systems in place. This meant that some people received poor quality care. This had resulted in a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the necessary improvements had not been made. Some systems that were in place remained ineffective at identifying and mitigating risks to people's safety. Other systems that needed to be in place were not. This was due to the provider and registered manager having a lack of knowledge regarding some areas of regulation and requirements. This placed people at risk of avoidable harm and had not ensured they received consistently good quality care.

After our last inspection, the provider wrote to us and told us they would improve their governance systems to ensure that people received good quality safe care. We also met with the provider where they repeated this. However, we found the provider had failed to do this and therefore people experienced poor quality of care that put their safety at risk.

The provider and registered manager had not ensured that bed rails were safe. The registered manager was not aware they needed to do this and therefore, there was no robust system in place to check that bed rails were safe for people to use.

After the inspection we wrote to the provider and told they to urgently assess that bed rails were safe and not a risk to people. They sent us their assessment but our judgement is that this was not robust. This was because there was no evidence they had assessed any gaps in people's bed rails to ensure they were not a risk of causing entrapment.

The registered manager told us they did not carry out any audits in relation to people's food and nutritional needs. They said they checked some people's care records occasionally for accuracy but there was no system in place to do this routinely. We found some important omissions in people's care records about the care they needed to receive. There was no system in place to check that consent was being obtained from people in line with the relevant legislation.

An audit was in place to check that staff had undergone the required checks before they started working in the home. However, these had not identified that all of the required checks had not been made. There was no system in place to check that people's specialist pressure mattresses were set at the correct setting to ensure they were working correctly.

Since our last inspection, the provider had introduced a new system to calculate the number of staff they required to keep people safe and meet their needs. However, we found this only included physical tasks that staff completed when providing care to people. It did not have any reference to people's emotional needs or

identified risks to their safety. Therefore, it was not effective at determining the number of staff required to keep people safe and to enhance their wellbeing.

The registered manager and provider had conducted assessments in relation to the safety of the premises. However, these were also not robust. They had failed to assess issues we found during this inspection such as exposed pipework, an uncovered radiator or potentially unsafe substances being left in people's rooms.

The registered manager had noted in an assessment dated June 2017, that all windows were safe. They had not considered the risk to people's safety if these were left unlocked and therefore, what actions may be needed to mitigate this risk such as fitting restrictors to the windows. Furthermore, the fact that some areas of the home were poorly lit which may have increased the risk of people falling or failing to find their way to their room, had not been identified.

The provider and registered manager had conducted monthly health and safety audits. They had failed to identify that fire safety precautions were not adequate. They had not checked whether some fire doors within the home would close fully in the event of a fire. It was acceptable practice in the home that people had the doors to their rooms wedged open which was potentially unsafe.

The registered manager told us a fire exit in the home that was blocked was not a fire exit, even though it was clearly sign posted a fire exit. They had told us they would take these signs down although they had identified people would need to have been evacuated through that door in the event of an emergency. The fire safety officer also confirmed to us that it was a required fire exit. The provider had also failed to take sufficient action and to act on repeated concerns raised by an engineer in relation to gas safety, placing people at potential risk of harm.

The provider had failed to make some access points to the outside of the home safe and accessible for people. Action had only been taken to install a ramp at an exit after an incident had occurred. Even though a ramp was being installed at one exit, we saw that another exit still had an uneven surface which prohibited people from going outside safely by themselves. This demonstrated that learning had not occurred following the previous incident.

The registered manager told us they had reviewed the falls that had occurred each month. They said they had taken some action to increase the number of staff working in the afternoon/early evening after having identified an increase of falls at that time of day. However, they had not assessed whether this had been effective. We also found that a number of falls had occurred at night. No analysis of these falls had been completed to ascertain whether any action needed to be taken. Furthermore, no analysis had been completed in relation to the number of falls that had occurred within people's rooms. We found that actions that could possibly be taken to reduce the risk of injury to a person if they fell in the future had not always been fully explored.

During the inspection, we observed a number of areas where staff either exhibited poor practice or did not act in a manner the registered manager said they should have. This demonstrated that the leadership in the home was not robust at ensuring staff used safe and appropriate practice.

There was an issue with communication within the home. For example, the staff did not know how much thickener one person needed to have in their drink to be safe. There was some confusion between the registered manager and the provider in relation to whether the mealtimes within the home were 'protected'.

During our inspection visit, the registered manager told us these were in place similar to that of a hospital setting. The staff we spoke with confirmed they asked visitors to leave 15 minutes prior to a meal. A visitor we spoke with told us this was the case but that they were not happy with this arrangement as they wanted to stay with their relative. Minutes of the August 2017 staff meeting also stated that staff were to 'ensure visitors leave 15 minutes before the meal is served to enable staff to bring residents to the table'. When we spoke with the registered manager about this after the inspection visit, they told us that relatives could stay with people to have a meal anywhere in the home but not in the dining room. This was because they had found in the past that some people had become distracted by visitors and had subsequently not eaten their meal. However, a letter we received from the provider after the inspection visit told us there was 'no such thing as protected mealtimes in existence' at the home and that 'We allow families and friends to join in at mealtime. Some have chosen to do so but some don't as there is nominal charge for the meal.' This implied that relatives could only stay if they paid for a meal and did not reflect what the registered manager had told us. Due to this confusion between the registered manager, the provider, staff and visitors regarding the aspects of visitors attending mealtimes, we have concluded that the communication was not sufficiently robust so that everyone understood the provider's policy on the subject.

There was an institutional culture within the home that led to some people having a lack of choice or control over their lives. Some people's freedom was being unnecessarily restricted and some practices that were in place compromised people's dignity.

This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The rating from our last inspection was not displayed within the home. We verified this with the deputy manager who looked in the main entrance of the home but could not see the rating displayed. This did not demonstrate openness and transparency with the people who used the service or their relatives.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection visit, the registered manager agreed to display the rating from our previous inspection as is required by law.

During our analysis of falls that people had experienced, we found that one had resulted in a serious injury. Such an injury is reportable to us by law. The registered manager told us they had posted us a notification regarding this injury. However, it had not been sent to us until 10 August 2017 and not without delay as is required. This incident had occurred on 27 July 2017.

People's views were being gathered but not used to drive improvement within the service. People's views had been requested about the quality of care they received in the form of a questionnaire. These were stored within people's care records. No analysis of people's comments had been made to help the registered manager drive improvement within the service. The last analysis that had taken place had been in response to people's views in June 2015. However, no action plan was available to demonstrate what had happened in response to these views.

Meetings of residents and their relatives to provide feedback on their care only took place annually. The last meeting had happened recently but the registered manager told us they had not yet written up the minutes of this meeting and when asked, did not tell us what had been discussed or was being improved.

We asked people if they were happy living in The Close and whether they would recommend it. One person told us, "I'd really like to go home but it's not possible, I know it's not. Yes, I would recommend it. I think they're very good especially [name of manager], if you want help just call her." Another person said, "I'm quite easy going, I take life as it comes so I am quite content here. I'd recommend it." A visitor said, "Under the circumstances, I think it's probably the best we can hope for. I think the manager does her best to keep things going, I'd recommend because of their attitude to people."

All of the staff we spoke with were happy working in the home. They said the registered manager was approachable and that they had no hesitation in discussing concerns or worries with them. They also said that any issues they raised were dealt with quickly. They felt supported and said that morale amongst the staff was good. They added that they felt they worked well as a team.

The registered manager told us they had established some links with the local community. This included representatives from various faiths who visited the home to meet people's spiritual needs. Also the local scouts had visited to make presents for people. The WI had knitted a number of items that people living with dementia could touch and feel to provide them with sensory stimulation.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users had not been planned or delivered to meet their individual needs and preferences. People were not always supported to understand the care or treatment choices that were available to them. (1), (2), (3) (b) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Not everyone was treated with dignity and respect. People's privacy, autonomy and independence was not always supported. (1), (2), (a) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people did not have the mental capacity to make decisions, processes had not have been followed to protect people from unlawful restriction and unlawful decision making. (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Some areas of the premises were unclean and were not secure or accessible to people. (1) (a) (b) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Not all required checks had been conducted to ensure staff were of good character and safe to work within the care sector (1) (a) (2) (3) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The rating from our last inspection in September 2016 was not displayed at the premises. (1) (3) (5) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received sufficient supervision, training and support to enable them to carry out the duties they were employed to perform (2).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's safety had not always been assessed or reasonable actions taken to mitigate these risks. People's medicines were not managed safely. (1), (2), (a), (b) (d) (e) and (g).

The enforcement action we took:

We imposed a condition on the provider and registered manager's registration. This told them they had to inform us each month how they were monitoring and managing risks to people's safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Risks to people's safety had not always been assessed or reasonable actions taken to mitigate these risks. People's medicines were not managed safely. (1), (2), (a), (b) (d) (e) and (g).

The enforcement action we took:

We imposed a condition on the provider and registered manager's registration. This told them they had to inform us each month how they were monitoring the quality of the care being provided to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff deployed to meet people's needs. (1).

The enforcement action we took:

We imposed a condition on the provider and registered manager's registration. This told them they had to inform us each month how they were monitoring and making sure there were enough staff to meet people's needs.