Caring Homes Healthcare Group Limited

# Laverstock Care Centre

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

Laverstock Care Centre is a care home, which provides accommodation and nursing care for up to 80 older people. At the time of our inspection, 74 people were resident at the home.

This inspection took place on 8 June 2016 and was unannounced. We returned on 9, 13 and 21 June 2016 to complete the inspection.

At the last comprehensive inspection on 28 and 29 April and 1 May 2015, we identified the service was not meeting a number of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not being supported with decision making in line with the Mental Capacity Act 2005 and the planning of care was not always done in such a way to meet people's individual needs. In addition, potential risks to people's safety were not being properly identified and addressed. Following the inspection, the provider sent us an action plan, which detailed how improvements would be made. During this inspection, we noted some improvements had been made but others had not been sustained.

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

Before the inspection, concerns were raised about alleged institutional abuse within the home. The concerns were reported to the local safeguarding team and were in the process of being investigated. People told us they felt safe. However, there were some concerns raised by a relative and some staff about the attitude and practice of some staff. This feedback was given to the registered manager and the management team to consider accordingly.

Risks to people's safety continued not to be satisfactorily identified or addressed. Action in response to some incidents was not always sufficient to minimise reoccurrence. Clear plans to minimise and manage some people's challenging behaviour were not in place. Staff had not received training in managing such behaviour, which increased the risk of escalation and harm to people. There were other incidents within the inspection, which did not promote people's safety. This included a person being supported to eat, whilst not being alert. This increased their risk of choking.

Not enough staff were available at all times to meet people's needs effectively. There were times when people were not adequately supervised or supported. On one occasion, the impact of this was that people had spilt their drinks and had dropped food to the floor. There were various occasions when staff were "borrowed" from other units to assist, particularly when staff took their breaks. This did not ensure consistency of care and some staff were not fully aware of people's needs, due to not working with them

regularly.

People's medicines were not safely managed and not always administered as prescribed. One member of staff gave people their medicines but did not ensure they were taken before signing the records. Another member of staff gave medicines to another staff member to give to people. This practice was not safe due to the risk of error. The medicine administration "round" was lengthy which meant some people received their medicines late. This impacted on the timescales of the next administration. Medicines were not always stored securely and records did not demonstrate clear guidance for staff in relation to "as required" medicines or topical creams.

Care was not always responsive to people's needs or provided in a person centred manner. Pain was not always sufficiently managed and documentation did not clearly state people's wishes in relation to their end of life care. People's care plans regarding areas such as minimising the risk of pressure ulceration were not always followed. Not all people were supported to have sufficient fluids doing the period of hot weather. This increased their risk of dehydration and associated conditions such as urinary tract infections.

Staff did not always respond or interact with people in a way which promoted dignity and respect. Some staff talked to each other and over people rather than promoting involvement. Other interactions were more positive and there were complimentary comments from people and relatives about the staff.

There were a range of systems to assess and monitor the quality of the service. However, not all were effective in identifying and addressing shortfalls. Accidents and incidents were being analysed yet action to minimise reoccurrence was not always sufficient.

Staff generally felt well supported and there were formal systems in place to discuss staff's performance. Some staff felt these sessions were useful, while others did not feel such benefits. Some staff felt teamwork could be improved upon. A range of training was arranged to increase staff's knowledge and help them to do their job more effectively. Other than the omission of challenging behaviour training which was being addressed, staff were happy with the training provided.

People and their relatives knew how to make a complaint and were encouraged to give their views about the service. People had enough to eat and were able to choose what they wanted from various choices. Systems were in place to monitor people's weight and if concerns were noted, these would be discussed with the GP. People were supported to access a range of services to meet their health care needs. A record of such appointments was maintained.

During our inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for which we are taking action and will report on this when it is concluded. Three of these breaches were repeated from the last inspection as sufficient action had not been taken to address the shortfalls. 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 always safe.

Risks to people's safety were not being adequately identified and addressed.

There were not enough staff to meet people's needs effectively at all times.

People's medicines were not safely managed or consistently administered as prescribed.

Safe recruitment practices were in place.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Work was being undertaken to fully comply with the Mental Capacity Act 2005. However, staff did not have a good understanding of this area of their work.

People were not assisted to have sufficient fluids during the hot weather, which increased their risk of dehydration. People had a choice of meals and enough to eat.

People were supported by a range of health care professionals as required.

Staff had not received training to effectively support those people who displayed behaviours which challenged. Other training had been undertaken but not all staff felt fully supported.

### Is the service caring?

**Inadequate**

The service was not always caring.

Staff were knowledgeable about promoting people's rights but not all interactions demonstrated dignity and respect.

Some staff spoke over people and did not always respond in an

appropriate, caring manner.

Most people and their relatives were complimentary about the staff team.

## Is the service responsive?

**Inadequate**

The service was not always responsive.

Staff were not always aware and responsive to people's needs.

Care was not always planned and delivered in a way which ensured people's safety and wellbeing.

A range of social activity was provided but those who were not able or did not want to join in, received limited interaction.

People and their relatives knew how to make a complaint and felt issues would be addressed accordingly.

## Is the service well-led?

**Requires Improvement**

The service was not always well led.

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

Whilst there were a range of audits to monitor and assess the quality of the service, these were not fully effective, as shortfalls were not being addressed.

People and their relatives were encouraged to give their views about the service.

# Laverstock Care Centre

**Detailed findings**

## Background to this inspection

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

This inspection took place on 8 June 2016 and was unannounced. We returned on 9, 13 and 21 June 2016 to complete the inspection. The inspection was undertaken by three inspectors, two specialist advisors 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.

In order to gain people's experiences of the service, we spoke with 24 people and 4 relatives. We spoke with the registered manager, two senior managers, 15 members of staff and a health care professional. We looked at people's paper records and documentation in relation to the management of the home. This included staff supervision, training and recruitment records, quality auditing processes and policies and procedures.

Inadequate

# Is the service safe?

## Our findings

At the last comprehensive inspection on 28 and 29 April and 1 May 2015, we identified the service was not meeting Regulation 12(2)(a)(b) of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014. This was because not all risks to people's safety had been identified or addressed. The provider sent us an action plan, detailing how they would address the shortfalls.

At this inspection, there was evidence the provider had not followed their action plan or sustained the improvements made. This was because risks to people's safety remained. A safeguarding alert had been made, as one person had entered another person's room and assaulted them. The person's care plan did not clearly inform staff how to manage the person's unpredictable behaviour. Assessments had not been completed regarding the potential risks to the person and others. Staff told us and records showed the person was monitored on a 15 minute basis. The monitoring charts showed entries such as "observed". They did not show staff were proactive in distracting the person or occupying them in meaningful activity, to minimise their anxiety and potential aggression. Records showed there were further occasions of the person going into other people's rooms and other incidents of challenging behaviour. The person's care plan stated such behaviour should be managed by observation and monitoring and "walk with him". This was not sufficient. The person's support had not been reviewed or amended to ensure it was effective, in keeping people safe.

There were other incidents, which did not assure people's safety. For example, at lunch time, a member of staff placed a clothes protector on a person whilst they were asleep. They tried to wake the person by calling their name but there was no response. The member of staff then attempted to place food into the person's mouth. The person opened their mouth slightly but their eyes did not open, they were not alert and did not respond in any other way. Another member of staff was asked to assist. They attempted to give the person a drink through a straw and then placed a plastic beaker to their lips. The person continued not to respond but the staff member then tried to put another spoonful of food in their mouth. We intervened and asked the member of staff to stop what they were doing due to the risks involved. An assessment stated the person must be sat up and fully alert when being assisted with meals due to the risk of them choking. Staff had not followed this guidance and therefore placed the person at risk of harm. A member of staff assisted another person to eat. They stood in front of the person and put the loaded spoon to their mouth. Their position did not enable them to see the person's swallowing reflex before giving more food. This increased the risk of the person choking.

Another person was seated in a wheelchair but looked uncomfortable. Their knees were bent up towards them, as they were tall and had their feet resting on the footplates. The person repeatedly attempted to move their feet from the foot plates, whilst knocking their legs, as they did so. They then moved their feet to the floor and pushed backwards, so the front of the wheelchair tipped up. Records showed the person had sustained previous injuries to their ankles. There was no written plan to show how further injuries were to be minimised or how the person was to remain safe in their wheelchair. Records showed another person had sustained a red mark from leaning against their bed rails. The risk of this happening again had not been formally assessed.

Whilst some risk assessments were in place, staff did not always follow the action required. One assessment identified the person needed to have a cushion under their feet and wear cushioned boots, to minimise their risk of pressure ulceration. On the first day of the inspection, the person had their boots on but this was not the case on the second day. Staff told us the boots were no longer required but the person's risk assessment had not been updated to reflect this.

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

Before our inspection, concerns were raised about alleged institutional abuse within the home. The concerns were reported to the local safeguarding team and were in the process of being investigated. We asked people about their safety and they told us they felt safe. Relatives shared similar views although they said staff did not always respond to people in a timely manner and were sometimes seen in groups, concentrating on their mobile phones, rather than people who used the service. We had been notified of a similar concern before the inspection. Another relative told us they felt they needed to visit regularly to monitor their family member's care. They said their regular visits enabled them to be "on top of things" to ensure "all was well". There were various occasions throughout the inspection, when staff were gathered together in the dining room or office. Whilst it was not clear what was being discussed, staff dispersed when we entered. There were also occasions when staff were not talking to people but then did so when they noticed our presence.

Staff had received recent training in relation to keeping people safe.Within discussions, staff showed they understood the different forms of abuse and how to keep people safe. They were aware of their responsibility to report any concerns although one member of staff did not know about the whistleblowing procedure. Staff told us they had never seen or had any suspicion of abuse taking place.

Not enough staff were available to meet people's needs effectively at all times. On the second day of the inspection at 10am, people were sat in the lounge but there were no staff in the vicinity. One person was trying to drink from an empty cup. They had tipped their drink in their yoghurt. Another person had knocked their cup of tea over and it had spilt all over the table. This presented a risk that the drink could have caused scalding if hot. Another person was holding their plate at an angle and some of their food had fallen onto the floor. Later in the morning, a person was seated at the table in the adjoining dining room. They were becoming agitated and saying "where have I got to go? I've been sitting here all morning". At the same time, an agency member of staff was providing another person with one to one support, to ensure their safety. As there were no other staff available, the agency staff gave reassurance to the person who was agitated and offered to make them a drink. However, in doing so, this prevented them from being able to fulfil their role of providing the one to one support to the person they were allocated to. The agency staff member told us the two staff on duty, were not in the vicinity, as they were busy assisting a person to use the bathroom. This did not enable other people to be properly supervised and supported.

One person was walking along the corridor. They were upset about their deteriorating health and said they wanted to die. We located the person's room with their consent and used their call bell for staff assistance. A member of staff responded to the call bell in 6 minutes and apologised for the delay. They said they had been assisting another person in their room and had to leave them, to answer this call bell. The member of staff was positive in their manner and gave the person reassurance. However, within four minutes, another call bell rang. The member of staff apologised, said they would be back shortly and left the person. They told us "I hate leaving her as I know she's upset but what can I do? It's like this all the time. We just can't give people proper time".

At varying times throughout the inspection, staff were "borrowed" from other units to ensure sufficient cover. This meant there was some inconsistency in the staff supporting people. For example, one member of staff was assisting a person to eat. They then asked another member of staff if they could "take over" so they could have their break. The member of staff did this but the exchange interrupted the person's support and gave inconsistency. They told us they did not know the person well, as they usually worked on a different floor. This did not promote the person's safety and as the person was living with dementia, recognising an unfamiliar face, did not ensure their wellbeing. Staff confirmed they worked across units particularly when it was busy and would provide support where needed. One member of staff told us "if everyone has been assisted to get up, washed and dressed, we would then help staff on a different unit. We support each other". The registered manager and senior team told us they promoted such teamwork. However, whilst acknowledging this, the impact of moving staff around and the inconsistency of this, had not been considered. In addition, focus was being given to people's physical care needs rather than staff spending time socialising and supporting people emotionally. One person's care records stated additional staff should be called upon during the night from other units, if staff were supporting people in their rooms. This was to supervise other people who may have been awake in communal areas or walking along the corridors. This presented a risk that people in other units may not have been safely or effectively supported at these times.

There were varying views about the availability of staff to support people effectively. One person told us "staff are around to help you. You just need to use your call bell". Another person told us "I have my bell so I can use it if I need to. They do come quickly". However, another person was less positive and said "staffing is a real problem. There's just not enough of them. They're never around, particularly after mealtimes when they have their breaks". The person continued to tell us staff shortages impacted on their daily routines. They said "you don't really get a choice of when you get up or go to bed. It's reliant on the staff and when they're free. You just wait until they come to you". A relative told us they often found it difficult to find staff when they visited. They told us "there's usually one of them rushing around but there's more around today. I've never seen so many. They're able to do basic tasks but there's no time for the detail".

Some staff told us there were enough staff to support people effectively. They said they worked well as a team and focused on those people with greatest priority first. Other staff were less positive. Specific comments were "there are difficulties throughout the day and night but it's particularly difficult when staff call in sick", "mornings are busy times", "we struggle at night" and "the nurses don't help at night". One member of staff told us "we need more staff. We have a lot of very frail, dependent people and at times, there's not enough of us to do what we want or need to do". Another member of staff told us they wanted to develop the end of life care, which was provided. However, they said "I don't have capacity to do it, as we are short staffed and busy. Staff don't have time either".

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

People's medicines were not administered safely. One member of staff took the medicines from the monitored dosage system and placed them in a small plastic pot. They then gave them to another member of staff to administer but signed the medicine administration record (MAR) to demonstrate they had given them. This was unsafe practice, as there was a risk the member of staff could have given the medicines to the wrong person. Staff were not aware of the potential risks to this practice, known as "double dispensing". They told us "it is quicker this way". Another member of staff placed a person's medicines in front of them and walked away. They signed the MAR without ensuring the person had taken the medicines. This did not enable accurate recording. In addition, there was a risk the person did not take their prescribed medicines or that another person may have taken the medicines by mistake. Despite mentioning this to the member of

staff, the practice occurred with two other people. Staff dropped another person's medicines on the floor and the liquid medicines were spilt down the person's clothing. Whilst recognising this was a potential accident, the person missed a proportion of their morning analgesic medication. This presented a risk that the person's pain was not controlled as a result. One MAR was unclear and included several administration instructions that had been crossed out. There were arrows pointing to different pieces of information, which made it extremely difficult to understand what dose of the medicine should be given at what time. In addition, there were discretionary amounts to be given if the person's blood glucose was above or below certain levels. This did not ensure the information was clear, which presented a risk that staff could have unknowingly administered the wrong dose.

People's medicines were not always given as prescribed. One person was prescribed a medicine which was to be dispersed in water or juice. Staff gave the person the medicine without dispersing it. They told us the person liked taking it this way. However, this was not documented within the person's records. There was no authorisation from a pharmacist or GP to confirm this was an appropriate way to administer the medicine. This meant there was a risk the medicine was ineffective or could have caused harm. One member of staff took a medicine from a box, which had been prescribed for another person. They believed it was the same medicine but did not recognise the risks of this practice, including the person being given the wrong dose. The registered manager acknowledged this but told us when people were on the same medication, large boxes of the same drug, took up too much room in the medicines trolley. They told us they would discuss possible options with the pharmacist, to rectify this difficulty. Another person was prescribed eye drops. The guidance stated they were best applied at night but records showed the person was given these at 8.30am. Staff told us this was because the person chose to have them at this time. This conflicted with what the person told us. They said they did not have a choice and the eye drops were applied by staff when told. Records did not show the reasons why staff were not following the recommended guidance for the eye drops application. The person had two types of eye drops, which were directed to be installed at least five minutes apart. A member of staff gave these immediately, one after another. Another person was given their medicines covertly, by being crushed and placed in a yoghurt drink or cup of tea. The member of staff told us the tablets were crushed so they could be disguised and taken more easily. This was not in line with the medicine's policy, which stated medicines should not be crushed or capsules opened, unless instructed by the pharmacist, and in conjunction with the prescribing GP.

Body maps to show staff where people's topical creams were to be applied were not always fully completed. One person had been prescribed a number of different topical creams and although body maps had been completed, the name of each type of cream had not been documented. It was therefore not possible to see which body map, referred to which type of cream. The increased the risk of the topical creams being applied inappropriately.

A member of staff told us they tried to administer people's medicines when they were due, but this was not always possible. They told us this was because there was always "so much to do". Another member of staff told us they started giving people their morning medicines at 08.30 and the "round" continued to around 11.30. This meant some people received their medicines very late and there were implications for the next "round", which started at 12.30pm. One person needed their medicines to be given at regular intervals in order to adequately control their medical condition. The medicines were to be given at 12.30pm but during our inspection, the person did not receive them until 1.40pm. The specific time the medicines were administered were not recorded on the MAR. This meant there was a risk the duration between doses was not followed.

Some people were prescribed medicines to be taken "as required" but these were not consistently offered to people. The medicines did not always have protocols, which ensured staff administered them as prescribed,

to ensure maximum effectiveness. Some medicines had variable doses such as one or two tablets. Staff had not consistently documented how many tablets had been administered. This increased the risk of people not receiving the optimum dose for their pain relief. Alternatively, there was the risk that people could be given a higher dose than prescribed. The medicine policy stated "The registered manager or nurse must ensure when the MAR is completed, the maximum dose is indicated and that it is clearly marked". This was not being consistently followed.

People's medicines were not always safely stored. The office door, which led to the medicines room was consistently open unless the room was occupied by staff. The room storing people's medicines was not always locked. Cartons containing medicines for disposal and four full sharps boxes, which housed used needles, were stored in an empty room in an area where people living with dementia, had their bedrooms. The room was untidy and the door was not locked. This meant people could access the area and be at risk of harm from the contents within.

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

Staff did not always demonstrate good hand hygiene. Not all staff washed their hands before serving food. One member of staff did not wash their hands prior to or following the application of a person's eye drops. The home was generally clean although this was not so with less visible areas. This included a sleeve, which contained the piping and wires running from a pressure relieving mattress in a person's room, which was dirty and stained. The flooring in two kitchenette areas were "sticky" and untidy. When a registered nurse asked if the kitchenette had been cleaned, one member of the care team said "the domestic had been out on the corridor but not in here". Staff did not know if the area would be cleaned later. General housekeeping and cleaning was being done in communal areas and people's rooms, during the inspection. Hand sanitisers and personal protective equipment such as disposable gloves and aprons were available for staff to use, when required.

Organised recruitment procedures were in place, to ensure people were supported by staff with the appropriate experience and character. All applicants provided evidence of his or her identify and their right, if applicable to work in the United Kingdom. Disclosure and Barring Service (DBS) checks were undertaken. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people. This enables safer recruitment decisions to be made. Applicants were subject to a formal interview and their previous employers were contacted to provide details about their past performance and behaviour.

Requires Improvement

# Is the service effective?

## Our findings

At the last comprehensive inspection on 28 and 29 April and 1 May 2015, we identified the service was not meeting Regulation 11 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014. This was because people were not being appropriately supported to make decisions when lacking the capacity to do so. The provider sent us an action plan, detailing how they would address the shortfalls.

At this inspection, there was evidence the provider had made some improvements, although work was still in progress. The registered manager told us discussions were taking place within the organisation about how to fully comply with the Mental Capacity 2005 (MCA) and what progress was required. The MCA provides a legal framework for acting and making decisions on behalf of individuals who may lack the mental capacity to do so for themselves. The Act requires as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS).

The registered manager was aware of their responsibility to ensure they complied with the MCA. They were able to explain how, if someone lacked capacity to make a specific decision, they would deal with this. Staff had received training in the relation to the MCA and DoLS but did not all have a clear understanding of the topic. One member of staff who worked with people living with dementia, told us "I haven't heard of it". Another staff member said "If they don't [have capacity] to make the decision, we make it for them or ask their family". This was not appropriate practice. Another member of staff said they were unaware a mental capacity assessment was required as part of the assessment for a DoLs. Some staff were aware that a number of people had a DoLS but were not aware of how many or why.

Whilst noting there were some best interest decisions and DoLs applications recorded in people's records, decision specific capacity assessments were not always in place. In addition, some records were signed by relatives on behalf of a person but information did not evidence they were lawfully able to do this. Applications to authorise restrictions for some people had been made as appropriate by the service and were being processed by the local authority, the supervisory body.

Not all people were given sufficient fluids, in accordance with the hot weather. This increased the risk of people being thirsty and dehydrated. In some areas, people had a drink with them for most of the day and when the volume reduced, staff offered an alternative. This was not the case for all. Some people were given drinks with their meals and during the mid-morning and afternoon "drinks round". Additional fluids were not offered in between, which did not ensure people were properly hydrated. A member of staff told us one person ate and drank well so their intake was not monitored. A food and fluid chart was not in place. However, there were various entries in the person's care records, which showed poor fluid intake. The person's continence assessment highlighted a reluctance to drink and constipation due to lack of fluid. This conflicted with what staff had said, which did not ensure the person's hydration needs were met. Another

person had a fluid chart, as they were prone to urinary tract infections. The chart had been consitently completed but not reviewed by a registered nurse. A member of staff told us the daily fluid intake of 3150mls had been recommended but this was unrealistic and unnecessary, so probably needed to be modified. This had not been previously identified. Some staff completed food and fluid records later in the day rather than at the time of assisting people. In addition, they asked other staff about the amounts people had eaten or drunk, rather than documenting what they saw. These practices presented a risk that the information was not fully accurate and therefore not effective when monitoring a person's intake.

This was a breach of Regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were offered a choice of meals and desserts at lunch time and snacks such as biscuits with their mid-morning or afternoon drinks. The meals were nicely presented and served according to people's particular appetites and preferences. There was a good variety of choices from a daily menu. People told us the food was satisfactory. Specific comments included "it's ok. You're never hungry", "the food is quite good" and "reasonable". One person said "lovely" as they were given their meal. Another person commented when their lunch was taken away, "it would have been lovely if it was hot". A member of staff replied "sorry about that". They did not explore the person's feedback further. People had been assessed in relation to their risk of malnutrition and their weight was regularly monitored, as required. Records showed people's weight was generally satisfactorily maintained. There were clear instructions for the use of prescribed thickened fluids, to minimise some people's risk of choking.

Staff were supported on an informal day to day basis and more formally, by meeting with their line manager to discuss their performance and any concerns they might have. Staff gave us various views about the effectiveness of their formal supervision. Their comments included "supervisions are useful and I put my views across" and "they're useful. I've raised concerns about staffing". However, other staff did not always feel they were listened to or their views were followed through. They told us "[supervision is] not useful, things are written down but not addressed, nothing happens" and "it depends who you have it with". One member of staff told us "I don't think I have had one". Another member of staff said they could not remember when they last had a supervision session.

The registered manager had a schedule to show when each staff member's supervision session was due. However, the registered manager had not always stuck rigidly to the timetable of supervision sessions. Focus was being given to this and improvements were being made.

Staff told us they were happy with the training they received. They said it was sufficient for them to be able to care for people effectively. However, they had not been provided with training in managing challenging behaviour. Some staff told us this would be invaluable, as they often worked with people who were challenging and did not always know how best to manage such behaviour. We asked staff to explain what they did if presented by a person who was challenging. Their responses were "we tell them it's not acceptable and leave them for 5 minutes", "we try to calm them down" and "we go in, in twos and one holds their hands but we haven't been told what to do". One member of staff told us "we won't put people together who are possibly aggressive". These explanations did not show staff were confident and competent in managing challenging behaviour. This was further evidenced within some people's daily records. For example, one entry stated " was aggressive to me, tried to hit me. I escaped the room and called for help". Another record stated "very aggressive and not cooperative". The entry was not specific but did not show an understanding of the person's needs. At the end of the inspection, the registered manager told us training in relation to the management of challenging behaviour would be arranged.

Staff told us they were able to request training in specific areas, if they felt they needed it. They said requests were followed up and arranged. The majority of staff told us they had completed training in mandatory topics such as health and safety, safeguarding people from harm, infection control and the MCA. One staff member told us they had just finished dementia care and fire safety training . Another member of staff who had been working with people living with dementia for the first time, told us "the dementia training was very good". Another staff member told us the training to move people safely was "very good". They said the training was specific to people's needs and the trainers used scenarios such as what to do if a person fell in the lift.

Registered nurses told us they had completed training to keep their clinical skills up to date. This included the verification of death and catheter management. One registered nurse told us they had recently completed documentation training, with the local authority. Staff told us they had received training in the safe management and administration of medicines and had their competency assessed at least six monthly. Certificates of training and competency assessments for the administration of medicines were kept in staff files.

There were positive comments from staff about the support they received when they first started employment at the home. Newly appointed staff told us they shadowed more experienced members of staff, undertook "on line" training, a fire drill and spent time completing the Care Certificate. This was a recognised induction programme for staff working within social care sectors. One member of staff told us their induction was "very good" but they were then moved to a different unit to start working independently. They said this was difficult and would have been more appropriate, if they had stayed on the same unit for a while to build their confidence. Another member of staff told us they were "put on" a dementia unit without dementia care training. They said this was hard. Another member of staff said they worked both days and nights but only had one shadowed night shift, when they were new. They said their induction could have been improved, if their supervised time had been split more evenly.

Systems such as daily handover sheets, review meetings and more formal staff meetings were in place. These were intended to assist with good teamwork, effective communication and the sharing of information. However, records showed there were very few meetings for care staff. The majority of meetings involved registered nurses. The registered manager told us this was intentional, as they thought it was better to concentrate on the senior team, with the expectation they would cascade information to the care team. Some staff raised concerns about these systems, particularly about teamwork. Specific comments included "the nurses don't help out. It's been raised but not listened to", "staff clash and don't get along well", "there is often an atmosphere between staff" and "there is some friction between some staff". One member of staff told us "management don't organise staff on shifts, as per their skill mix and this can be quite frustrating". Another member of staff told "we do our bit, they do theirs". They did not feel staff always worked well as a team. Another member of staff had a similar view saying "nurses and carers coming together more" would improve the service. The registered manager told us they felt the majority of staff did work as a team but they had recently addressed some issues by moving staff around. They said this meant some staff were no longer working on units they were more familiar with. The registered manager told us they felt this had minimised complacency, over familiarity with people and improved the skill mix of the team.

People had access to a range of health care services such as chiropody, dentistry and optical care. Records showed other specialised services such as the diabetic specialist nurse, the local hospital diabetes service and speech and language therapy team were used. During our inspection, a GP visited the service. They told us they visited weekly on a planned basis and staff rang appropriately at other times, to gain advice or request a visit. They said during their regular visits, they usually met with the same member of staff to ensure consistency. They said this worked well. The GP told us staff were always ready for their visit and followed

instructions and treatment plans well. They said staff kept them well informed of any improvement or deterioration in each person's health.  A record of all consultations with health care professionals was maintained.

Inadequate

# Is the service caring?

## Our findings

Five staff raised concerns about the attitude and poor practice of some staff. Such comments included "some colleagues are not caring", "most staff are attentive", "a few staff shout at people", "everyone is different (colleagues) but carers are caring" and "on the first floor, some people are aggressive and I don't like how some staff speak to them or deal with it". One member of staff told us "everyone tries their best but staff don't always do the job they should be doing. Personal care is rushed". The member of staff continued to say "they give people a wash not a shower, as it is quicker. People get angry if I tell them to do it decently but nothing gets done. They say you can't tell me you're not a senior". This information was shared with the registered manager and the senior team so they could consider the comments further. Prior to the inspection, we asked the registered manager to investigate similar concerns, which had been reported to us. The registered manager found no evidence to substantiate the concerns within their investigation. One relative told us in the past, they had heard staff being "offhand" with people and "not being friendly or patient".

Staff did not always respond to people appropriately and in a caring manner. Staff talked between themselves and not always to people. One senior member of the care team had a lengthy conversation about their holidays to another member of staff. They "talked over" people and did not include them in the conversation. The same member of staff called loudly across the room, to gain the attention of other staff. One of the staff responded and sat behind a person. They started talking to them but as they were out of the person's field of vision, the person began to look from side to side to determine where the voice was coming from. The member of staff acknowledged we were observing interactions within the lounge. They then moved their chair appropriately to the side of the person and continued to talk to them. The person relaxed when they saw the member of staff and responded to them in a positive manner. Another person was assisted to move from their chair to a wheelchair using the hoist. Staff talked between themselves, whilst intermittently telling the person "going up" or "going down". They did not give focused attention or reassurance. Staff did not have the wheelchair next to them so the person was suspended in the air, whilst it was repositioned. No reassurance was given during this time. Some people were assisted back to the lounge after participating within a social activity. A member of staff supporting people, asked another member of staff "where do you want me to sit them?" The response was "on opposite sides of the table". Staff did not consult with people to find out where they wanted to sit. This did not promote dignity or respect.

At lunchtime, one person raised concern as another person was kicking them. The staff member was abrupt and said sharply "she didn't mean to. Move your foot away". After about five minutes the staff member asked the person if they were ok but had not been very sympathetic or caring at the time of the incident. They did not check to see whether the person had sustained any injuries from being kicked. Staff asked people whether they wanted to wear a clothes protector at lunchtime. However, one person said they did not want one. The member of staff took no notice and continued to put the clothes protector on the person, despite their objection. Another member of staff asked the person if they wanted assistance with their meal and tucked a paper serviette into the clothes protector. This did not respect the person's wishes.

Some staff spoke about people, whilst in the vicinity of them and others. One member of staff told another "she's eaten so much today, toast, more toast, biscuits. She just keeps eating". Another member of staff said "he loves that green book" whilst standing in front of the person. Another staff member called out to another "I'm going to do X". This was in relation to supporting a person with their personal care. The comment did not show a personalised approach.

Staff were confident when talking about how they promoted people's rights to privacy and dignity. They told us they always shut curtains and doors when assisting people with personal care and made sure people were covered when having a wash, bath or shower. One member of staff told us they always covered the lower part of a person if they were washing the top. Another member of staff told us they felt it was important to "tell people what you're doing". Whilst acknowledging staff's knowledge, not all practices encouraged people's dignity. A member of staff tested a person's blood sugar level at the table before their lunch. They did not ask the person if they wanted to go somewhere more private. Another person inappropriately had their name and a "L" and "R", indicating left and right, on their slippers. After discussion, the registered manager told us they would discuss this with the person's family. Another relative told us their family member's dignity was maintained on a wider sense but compromised at times, as their clothing and bedding were not always properly ironed.

This was a breach of Regulation 10(1) (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other interactions were more positive. Some staff gave people compliments such as "you look nice". One member of staff supported a person who said they were not very well. They leant down towards the person, spoke softly and offered solutions that might make them feel better. Another person was showing signs of being disorientated and agitated. Staff offered ways to help them feel more settled. This included offering a drink and giving reassurance by explaining what they could do to help them. A member of staff supported and offered reassurance to another person who was mobilising with their walking frame. They told the person "when you've had enough, just tell me, the wheelchair is behind you" and "if you want to sit down, the chair is here". The person walked the length of the corridor and then sat down. The member of staff congratulated the person on their achievement. Another member of staff spoke to a person who was being nursed in bed. They asked the person how they were or if there was anything they would like. The member of staff reminded the person to call them if they needed anything. At lunch time, those people who required assistance to eat were given this in a kind, courteous and friendly way. Some staff explained the meal to people, as they placed the food in front of them. They asked people if they were enjoying their meal and encouraged them to take their time. The meal time was pleasant and relaxed, with various conversations taking place.

People and their relatives gave positive feedback about the staff. They described staff as "friendly", "very nice" and "caring". Other comments were "staff work hard and are caring", "when I need help and support it is forthcoming" and "everyone is most helpful". One person told a member of staff "you're very kind", as they gave them a drink. Another person said "it's a nice place here". A relative told us "the staff are all ok but some are lovely. X is fantastic, very caring". Another relative told us they were pleased with the staff and the care their family member received. They said staff regularly read their family member a poem, which they knew was a favourite in their early years. They said this made their family member's face "light up." The relative told us staff had taken time to get to know their family member and had created a file, which included their personal preferences. They said staff took their family member into the garden, which they enjoyed. Relatives told us staff kept them informed of any ill health, consultations, incidents or accidents. They said they were able to visit at any time and were made to feel welcomed.

Inadequate

# Is the service responsive?

## Our findings

At the last comprehensive inspection on 28 and 29 April and 1 May 2015, we identified the service was not meeting Regulation 9 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014. This was because planning of care was not always done in such a way to meet people's individual needs and ensure their safety. The provider sent us an action plan, detailing how they would address the shortfalls.

At this inspection, there was evidence the provider had not followed their action plan or sustained the improvements made. Care plans and daily records were not always clear and sometimes included conflicting information. In addition, staff were not always knowledgeable about the actual care people required.

Pain assessments were not undertaken on a day to day basis or at times of symptoms, such as agitation, which could indicate pain. Records showed some people were identified as having pain but this was not defined and there was no information about the areas affected. One person had a specific pain relieving medicine but there was no pain chart to monitor the person's pain levels. This was potentially unsafe, as there was no guidance to indicate if the medicine was effective or if it was causing drowsiness. One person's care plan stated they had a particular health care condition, which was known to be very painful. Due to this, regular assessment was required to monitor the effects of the disease as it progressed. This was not in place. The person's care plan stated they could verbalise pain but at other times may use facial expressions, which staff needed to observe. There was no guidance regarding what facial expressions were likely or what they meant. Staff told us one person was regularly experiencing pain but had been refusing their medicines. Records did not show what measures had been taken to find a solution to this. Staff had not signed the medicine administration record, to show they had administered the person's pain relief. For 22 days, a straight line had been written across the record. This was instead of staff signatures or the reasons for the person not taking their medicines. There was no information to explain this or to confirm the person had taken any pain relief during this period

Another care plan stated the person needed to go to the bathroom before meals. At lunchtime, the person was supported directly from the lounge to the dining room table. They were not assisted to the bathroom. The person was prone to constipation and there was a management plan in place. However, their bowel monitoring record showed they had not had a bowel action for seven days. There was no record to show this had been identified and addressed. The person's care plan in relation to sleeping stated they may be challenging. The action to be taken to address this was "change over or leave him to settle". This did not give staff clear information to support the person effectively. In addition, there was an error with the record, as the person was female so "him" did not apply.

People were not always appropriately supported in managing their "End of Life" care. One person had been admitted to the home for this care, but a care plan to inform staff of their wishes had not been completed. Two staff told us the person would "tell us what they want, like they do now". This was not appropriate, as potential deterioration in the person's health, might compromise their ability to express their wishes. A GP had prescribed anticipatory drugs to manage the person's pain and agitation if required, but there was no

information about how and when they should be used. Another person was approaching the end of their life. There was no information about their wishes or whether their preferences and choices had been discussed. The person's care plan stated they could be anxious but there was no guidance for staff about the best way to manage this. The person's emotional or spiritual needs, were not addressed in their care plan. Staff were not sure if there was an End of Life policy. The registered manager told us "we do not need a specific one, it is included in the care of the dying one". The policy did not show a person centred approach, based on the individual's wishes and preferences.

Another care plan stated the person needed to sit in an armchair between meals, as they were at risk of pressure ulceration. The person did not do this and remained in their wheelchair all day. They were leaning forward and looked uncomfortable. Staff gave us varying reasons why the person did not sit in their armchair. One member of staff told us the person liked to propel themselves around in their wheelchair . However, foot plates were fitted which would have made this difficult to do, without the risk of injury. Another member of staff told us the person's recliner chair was out of order, whilst another said the person "kept falling out of it". There was no information about this within the person's care records. The person's moving and handling care plan stated they could take a couple of steps with a walking aid although another record stated they were unable to walk and required a wheelchair. One member of staff confirmed the person could not walk. However, on the second day of the inspection, the person was making a few steps along the corridor from their room with their walking frame.

The registered manager told us in order to enable people's care plans to be more person centred, a new format called "bubble profiles" had been developed. These gave a "snap shot" of what was important to each person and details about their history, likes, dislikes and personal preferences. Some of the "bubble profiles" were detailed. However, this was not consistent across all profiles. In addition, some of the registered nurses were not able to tell us about the profiles or where they were located.

Staff were not always fully responsive to people's needs. One person called out "oh my shoulder, my shoulder hurts". A member of staff was in the vicinity of the person but did not respond. The person again called out "my shoulder hurts" but the staff member did not ask the person what was wrong. We asked the member of staff if the person needed any assistance to which they replied, "no, they often make comments like that". They told us they would inform a nurse so they could give the person some pain relief. We asked the member of staff how they identified people were in pain, if they could not verbalise this. They said they did not know. This did not ensure a person's pain was properly identified and addressed. Another person kept touching the person who was sat next to them. A member of staff responded by saying "keep your hands to yourself please". They did not attempt to distract the person or ask if they would like to move, to another area.

Care was not always person centred. This was particularly apparent in relation to assisting people to manage their continence. As a way of improving the service, one member of staff told us "we need someone after lunch to help with toileting, it's quiet after lunch when we have toileted the residents". Another member of staff told us "we usually toilet residents before or after meals". Assistance to use the bathroom was not given on an individual, needs led basis. One person had been seated at a dining room table for over two hours. Staff did not ask them if they wanted to use the bathroom but as lunch was being served the person asked for this support. Within a care record it was documented "X should be encouraged to drink at every drink round". This did not encourage staff to offer the person regular drinks or when they wanted one.

Staff asked people what they wanted to eat for the following meal. They gave descriptions of the food but pictures or photographs were not used to enhance people's understanding, enabling an informed choice. Staff asked one person if they wanted a "brownie" for their dessert. The person responded by saying

"brownie? What's a brownie?  Speak English". The member of staff aimed to describe what a brownie was and the person said "I don't know what you mean but I'll have it anyway".

Staff were not always aware of people's needs. When asked about specific aspects such as whether a person had a fluid chart in place, many responses from staff were "I'm not sure. I don't usually work on this floor". One member of staff was carrying a blood sample kit in preparation for taking a blood sample. When asked, they told us they thought the reason for the sample was because the GP had requested it as part of their review for their health care condition. However, another member of staff said this was not the case. They said it was for an investigation into another medical condition. Another person had a chart in place to monitor their pressure care, as they required frequent repositioning to prevent pressure ulceration. The chart had not been consistently completed. Staff did not know how often the person needed to be repositioned. In addition, they were not aware of where this information could be located.  When asked, it took a member of staff five minutes to locate information in the person's care plan about the assessment of risk regarding pressure ulceration. However, the assessment did not detail how often the person required repositioning, to minimise the risk. This placed the person at risk of harm.

There were designated staff to arrange social activities for people. The activities were undertaken in various parts of the home and people from the different units were supported to attend if they wanted to. Staff told us in addition to group activities, "one to one" chats were undertaken with people who were unable or did not wish to participate in group activities. Staff told us this was done to try to help prevent people from becoming socially isolated. During the inspection, there were musical sessions and seated exercises, which people enjoyed. On the second day of the inspection, there was a party to celebrate the Queen's birthday. This took place in the car park, with tables and chairs under a large number of gazebos to replicate a street party. Many relatives, friends and the Mayor attended. People were offered a selection of drinks and buffet style food and interacted in a positive manner with those around them. Some people had their photograph taken with the Mayor, which they appeared to enjoy. The scale of the event demonstrated the registered manager and staff had put a lot of effort into the occasion. People and their relatives were positive in their comments about the day. On the third day of the inspection, the local clergy visited and undertook a religious service.

Whilst some people enjoyed the activities, those who were frailer or living with more advanced stages of their dementia, were not involved and received limited stimulation. Other than a board game on one unit, no other activity was undertaken. This meant some people spent the majority of their time in the lounge or in their room, either sleeping or unoccupied, looking ahead but not engaging.  One person held a sensory cushion but no other such equipment was seen. One member of staff told us social activities for everyone, was an area they felt the home could improve upon. Another member of staff told us they would like to see more sensory items for people. One member of staff told us "certain people" were supported to go out to places such as the beach. They said these were people who were independent and could acknowledge "what's around them". The member of staff told us not everyone was offered the opportunity to go out, which they did not feel was fair.

Staff told us there was always a member of staff allocated to a lounge, to monitor people and minimise the occurrence of any incidents. This was not always the case although when there was a member of staff in the lounge, they sat next to people but did not engage with them. They had limited conversation with people and did not undertake any activity to promote involvement. This was a missed opportunity, as the time available could have been spent undertaking meaningful activity or interaction with people.

This was a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us they would talk to staff if they had a problem about the service. They said shortfalls were often quickly resolved although one relative told us "sometimes you have to keep on to get things resolved properly". Another relative told us they had raised concerns in the past, which had been properly resolved although sometimes "things crept back to how they were" and further reminders were required. During our conversation with a person, we identified their glasses, finger nails and duvet cover were not clean. We asked the registered manager to ensure these matters were raised with staff and addressed accordingly. The next time we visited, the person told us staff were "very nice about it and very willing". They said "they sorted it all out without any fuss". Staff told us they aimed to address any concerns or complaints as they arose. One member of staff gave us an example of a person's slippers going missing. They said they immediately searched for them until they were found. Another member of staff told us they had raised a concern about medical assistance not being gained in a timely manner. They said this was noted and taken seriously.

People had a copy of the home's complaint procedure in their room. The procedure showed who to contact if unhappy about the service, as well as detailing how complaints would be managed. The procedure was not available in different formats to assist those with cognitive impairment. The information pack given to people on their admission also included what to do if there were any questions or concerns. A record of the formal complaints which had been made were securely stored in the office. However, the documentation did not always show how the complaint was investigated or what lessons had been learnt to improve practice.

Requires Improvement

# Is the service well-led?

## Our findings

At the last comprehensive inspection on 28 and 29 April and 1 May 2015, we identified the service was not meeting a number of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we identified the improvements made to address the shortfalls, were not sufficient or had not been sustained. There continued to be breaches in regulation, which did not evidence a well-led, effectively managed service. For example, risks to people's safety continued not to be sufficiently identified and addressed. This was in particular attention to the management of some people's challenging behaviour. In addition, information within people's care plans did not contain clear guidance for staff on how they should manage the challenges. Staff said and records showed they were not confident in this area of their work. This had not been identified and as a result, training in relation to the management of behaviours had not been given to staff. This increased the risk of any aggression being poorly managed and escalating, which increased the risk of harm.

There were a range of audits to monitor the safety and quality of the service. These covered areas such as medicine management, infection control and the suitability of equipment. Whilst the audits were taking place on a regular basis, not all were fully effective. This was because the shortfalls raised in this inspection had not been identified or addressed. For example, there had been a recent audit of the medicine administration systems and each staff member's competence with medicines had been assessed. However, despite this, unsafe practice such as staff not observing people taking their medicines and staff giving medicines to another member of staff to administer, had not been identified.

To minimise the risk of reoccurrence, the registered manager had attempted to identify common trends, when accidents and incidents had taken place. However, the assessments did not always look at the complete causes of some accidents and incidents. For example, where there had been a high number of falls, the timing of these had been considered but the location, staff deployment and other such factors, had not. The assessment's conclusion was often that people were living with dementia. This did not allow for an appropriate risk assessment to be put in place to prevent further falls occurring. Within some accident forms, the action taken after the incident was not sufficient to prevent recurrence. For example, there was a sensor mat in a person's room to alert staff when they got out of bed during the night. This was because the person had been inappropriately going into other people's rooms. A record showed a further incident had occurred as the sensor mat had broken and therefore staff were not alerted to the person's whereabouts. The record showed the mat had been repaired. However, there were further incidents of the person going into other people's rooms, four and eight days later. It was stated on the incident report that the sensor mat was broken and had not sounded to alert staff, as required. This lack of monitoring and action had not prevented further occurrences. This did not ensure people were properly safeguarded.

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

The registered manager told us the ethos and culture of the home was to ensure people had a purposeful day and meaningful life, with an emphasis on independence, choice and respect. The registered manager

told us they felt this was achieved. However, staff were not able to describe the ethos or vision of the home. Not all staff were clear about how independence was promoted. One member of staff told us "we've only got a couple that are [independent]. We keep an eye on them". Another member of staff told us "we have one resident X who is very independent. We have to stay out of their room so we go behind their back when they're out of the room to change the bed". This was not good practice and did not promote respect or independence. One member of staff told us they promoted independence by enabling a person to do some household chores such as washing up.

Some people, their relatives and staff told us they felt the registered manager was not sufficiently visible and not regularly seen within the units, on a day to day basis. They felt this would be an improvement, as it would ensure practice was consistently maintained to a good standard. The registered manager confirmed they spent some time on the units but due to the size of the home and the volume of their work, this was not as much as they would like. The registered manager told us the organisation's management structure was in place and designed to enable them to be kept informed of key issues whilst concentrating on management responsibilities. They told us they were committed to the service and passionate about providing good quality care.

One person told us "I am very happy here and the manager is lovely". Another person told us "I've seen the manager a few times but not often. She's very nice". Staff told us they were well supported by the registered manager and the senior team although one member of staff said they were "mostly" supported. Another staff member said "the manager is approachable. The service is on the whole managed well but gaps appear when we are short staffed". Other staff described the registered manager as "approachable", "fair" and "accommodating" but said for general matters, they would usually discuss issues with the deputy manager or registered nurses. Staff told us the registered manager had an "open door" policy and encouraged them to raise concerns or gain advice at any time.

The home support manager told us they had read the home's previous report and had undertaken a programme of improvement. This had included specific wound care folders and weekly wound care audits. The information within the folders showed a description of all wounds and their treatment. This had improved practice and minimised the risk of wounds not being dressed at the required frequency. In addition, the system enabled any deterioration in a wound to be identified at the earliest opportunity.

Records showed equipment such as the passenger lift, mobile hoists, nurse call bell system, fire alarms and emergency lighting were regularly serviced by external contractors. This ensured they were effective and in good working order. There were systems to monitor the safety of the hot water and regular checks to minimise Legionella. Staff checked and documented the temperature of the water whilst assisting a person to have a bath or shower, to minimise the risk of scalding.

People and their relatives were encouraged to give their views about the service. This was informally on a day to day basis, within meetings or more formally with completing questionnaires. The registered manager told us questionnaires were sent out as a matter of course but could also be collected from the main entrance area of the home, when required. The registered manager showed us they had recently purchased a suggestion box, as another way in which people could give their views. They told us this was to be placed in a visible area of the entrance area within the next few days. There was a file which showed the collated feedback from the most recent surveys. Each area was shown in written and a pictorial format so the levels of people's satisfaction could be seen at a glance. The majority of the feedback was positive. There were various notice boards in the entrance area of the home, which contained a high level of information. However, there was no information about the feedback from people from the questionnaires or how the service was to be further improved as a result.

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<br><br>Planning of care was not always done in such a way to meet people's individual needs and ensure their safety and welfare. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>Not all staff responded to people in an appropriate, caring manner and interactions did not always demonstrate dignity and respect. Regulation 10(1)(2)(a). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Risks to people's safety were not being adequately identified and addressed. Regulation 12(2)(a)(b). People's medicines were not safely managed or consistently administered as prescribed. Regulation 12 (1)(2)(g). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>Not all people were assisted to have enough to drink and their risk of dehydration was insufficiently monitored. Regulation 14(1). |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Whilst there were a range of audits to monitor and assess the quality of the service, these were not fully effective, as shortfalls were not being addressed. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Sufficient staff were not deployed to meet people's needs effectively and safely at all times. |