Cedars Care (Winscombe Hall) Limited

Winscombe Hall

Inspection report

Winscombe Hall Care Centre
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 06 and 07 June 2017 and the first day was unannounced.

We inspected Winscombe Hall in November 2014. At that inspection we found the provider to be in breach of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider was not supporting staff with appropriate training and supervision. Records did not show how specific decisions were made in people's best interests. Records did not contain accurate information. Areas identified for improvement were not being followed up.

We carried out an unannounced comprehensive inspection of this service on 21 and 22 January 2016. Breaches of legal requirements was found where restrictions were in place because the provider had not ensured effective processes were in place to make best interest decisions in accordance with the Mental Capacity Act 2005. Medicines were not always administered safely and the service was failing to monitor and mitigate the risks relating to the health, safety and welfare of people. Sufficient numbers of staff had not been deployed to respond to people's needs and accurate, complete and contemporaneous records were not kept in respect of each service user.

After the comprehensive inspection, we used our enforcement powers and served Warning Notices on the provider on 4 March 2016. These were formal notices which confirmed the provider had to meet the legal requirements by 14 July 2016.

We undertook a focused inspection on 24 October 2016 to check they met these legal requirements. At the inspection in October 2016 we found action had been taken to improve the areas of the service looked at but some areas required further improvement. These included the need for further information relating to risks around the use of bed rails and further improvements were necessary to ensure people's rights were fully protected where they lacked capacity to make decisions for themselves. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Winscombe Hall on our website at www.cqc.org.uk

Winscombe Hall is a care home which provides accommodation for up to 39 people, some of whom are living with dementia. At the time of the inspection there were 34 people living at the home. The home comprises of two areas; Stable Cottage provides care to people living with dementia and The Halls which provides nursing care. The home is situated on the outskirts of the village of Winscombe.

There is 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. There were also two managers; one responsible for clinical management, the other responsible for business management.

Where people were given their medicines covertly, they were not always given in line with pharmacy guidance. Medicines were not always stored safely.

People had not been referred to the falls team after suffering multiple falls. Records of treatment provided for people who had pressure ulcers did not give information whether the wounds were healing or deteriorating. Air mattresses were not set to the correct setting to be beneficial for people with pressure areas. Safeguarding referrals to the local authority were not always made.

People were not protected from risks in the general environment. Some areas of the home were dirty and could pose a fire risk.

There were suitable recruitment procedures and required employment checks were undertaken before staff began to work at the home. Staff did not always have the training they needed to provide appropriate support for people.

The staff understood their role in relation to the Mental Capacity Act 2005 (MCA) and how the Deprivation of Liberty Safeguards (DoLS) should be put into practice. These safeguards protect the rights of people by ensuring, if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Where people needed decisions to be made on their behalf, best interest records did not record what the decision was.

Accurate records were not always kept. There were gaps in records such as food and fluid charts. People were not always referred to healthcare professionals according to their individual needs. Care plans did not always give staff the information they needed to support people.

Staff did not always support people with personal care. Some people were observed wearing dirty clothes.

Where shortfalls in the service had been identified, actions were not always followed up to monitor improvements.

We found seven breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 during our inspection. 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.

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.

People could not expect to receive their medicines as they had been prescribed because safe systems were not always followed for the management of medicines.

Risks to people were identified, however assessments did not contain enough information to keep people safe. People were not always moved safely when hoists or wheelchairs were used.

Personal emergency evacuation plans did not give staff realistic guidance they could follow. The laundry area was dirty.

Although people had mixed views about whether there were enough staff, our observations were that there were not enough staff at certain times of the day.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always have the skills and knowledge to meet people's needs. They were aware of the requirements of the Mental Capacity Act 2005.

People had mental capacity assessments in place but best interest decisions were not recorded.

Staff did not maintain accurate records where people were identified 'at risk' in relation to pressure ulcers. People's nutritional intake was not always recorded.

People did not always receive the support and assistance they required to eat their meals.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always receive personal care when they needed it.

The home had links to local advocacy services to support people if required.

People told us they were happy with the care they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People or their relatives were not involved with developing their care plans.

Staff did not have all the information they needed to be able to support people who may be anxious.

Relatives felt the staff and manager were approachable and there were regular opportunities to feedback about the service.

People could be confident concerns and complaints would be investigated and responded to.

Is the service well-led?

Inadequate

The service was not always well-led.

Previous inspections have shown non-compliance with regulations. The provider has not made sufficient improvements following these inspections. Four of the breaches identified at this inspection were repeat breaches from the last comprehensive inspection in January 2016.

Quality audits had not identified all of the shortfalls we found. Where audits had identified shortfalls, actions had not always been followed up to monitor improvement.

Staff were supported by their manager. Staff felt comfortable discussing any concerns with their manager.

Winscombe Hall

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 06 and 07 June 2017 and was unannounced. The inspection was brought forward due to information of concern being raised. It was carried out by two adult social care inspectors and a specialist advisor. The specialist advisor was a nurse.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the home before the inspection visit.

Some people who were living with dementia were not able to speak with us directly about their experience. We therefore made observations throughout the day in order to see how people were supported and their relationships with the staff.

We spoke with: three people, seven relatives, two registered nurses, seven staff, one district nurse, one GP, one agency carer, one chef. We also spoke with the provider, the business manager and the clinical manager.

We looked at eight staff files, the registered manager's file, nine care plans and associated records, complaints, quality assurance, policies and procedures, training records, minutes of meetings and other management records.

Inadequate

Is the service safe?

Our findings

Peoples' medicines were not always managed and administered safely. Although some of the Medicine Administration Record (MAR) charts had photographs at the front to aid identification, these were not used consistently. This meant that staff administering medicines who were unfamiliar with people using the service, such as agency staff, might not be able to recognise people who were unable to confirm their own identity. The managers told us they had used a lot of agency staff recently. In addition, people's preferences in relation to how they preferred to take their medicines had not been documented for everyone. Again, this could make it more difficult for staff who were unfamiliar with people to ensure they took their medicines. Some people may need to be given their medicines on a spoon while others may prefer them to be put into their hands so they can take the medicine themselves. Nursing staff said that they were in the process of implementing this, but at the time of our inspection, preferences had not been noted for everyone.

Nurses did not follow pharmacist's guidance when giving covert medicines. We looked at the records for two people who were having their medicines administered covertly. Where people lack the capacity to take medicines or to understand the consequences of refusing to take medicines, healthcare professionals may follow a formal process to allow them to act in the best interests of the person. They may decide the person's medicines should be disguised in food or drink. Although there was documentation in place to demonstrate how the decision for two people had been reached, the information and guidance from a pharmacist on the form relating to one person conflicted with the information the nurses told us. As the pharmacist had been consulted in December 2016, this meant that staff had not been following the pharmacist guidance for six months. We discussed this with the nurses on duty who said they would discuss this with the pharmacist and the GP at the earliest opportunity.

Nursing staff said that the GP reviewed people's medicines as required, and that full medicines reviews were undertaken annually. They also said that discussions had begun for medicines reviews for certain groups of medicines to be carried out more frequently. A GP we spoke with confirmed they completed annual reviews for people who were registered with them.

We looked at the MAR charts for two people who had been prescribed medicine for Parkinson's disease. This medicine needs to be given on time in order to control the symptoms. The Parkinson's Foundation explains that when the medicine is not taken on time, "freezing" and other sudden and debilitating symptoms can occur. The medicine had been transcribed onto the chart by a staff member, and the timing of doses was written as "breakfast, lunch and dinner". We discussed this with the nurse on duty and suggested that they liaise with the GP and/or pharmacist in order to confirm the exact times these medicines should be given. This was to ensure that the timings between doses were maintained to maximise the effectiveness of the medicine. One person told us, "They're very late with medicines sometimes." A relative said, "They've given [name] their medicines between half past ten and 11 o'clock at night, and had to wake [name] for their medicines."

Other concerns regarding medication were that staff were not able to say what an acceptable temperature was for storing some medicines and there was no guidance for them to follow. Nurses did not undertake

regular stock checks for controlled medicines, as required by the provider's policy. Staff were not aware that people taking anti-coagulants should avoid cranberry juice and this was available for people to drink in the home. Staff did not always have the correct guidance in place to show them when someone might be in pain so they could receive pain relief medication.

People were not being protected against all risks and action had not always been taken to prevent the potential of harm. Care plans contained risk assessments for areas such as mobility and falls. However, when risks were identified, care plans did not contain enough guidance for staff on how to reduce these risks. For example, for one person who was at high risk and had sustained 13 falls, staff had reviewed their care plan every month but had not documented if any changes were needed to the care plan. Although the service had put two hourly checks into place for some people, these checks were not recorded effectively and could not therefore be used for analysis.

Where people had pressure ulcers, information was not always recorded to show whether the wounds were healing or deteriorating. Care plans for wounds were basic, lacked detail and were not person centred. The lack of detail meant there was a risk that people's needs were not always being met. For example, information regarding the size of wounds was not recorded so staff would not be able to accurately assess if wounds were healing or deteriorating. Another person's care records showed there were conflicting entries in relation to the person's skin integrity. Also the care plan made no reference to how staff could have prevented the pressure ulcers developing. In addition, there was no guidance within the plan on how staff should promote wound healing or prevent further skin damage. Pressure relieving mattresses were not set correctly or were turned off and routine checks had not been undertaken. Pressure relieving mattresses help to relieve the pressure and reduce the risk of pressure ulcers.

Care plans did not always inform staff how frequently they should be assisting people to change their position. Changing position helps to relieve the pressure on bony prominences. Although daily records indicated that people's position's had been changed, there were no checks to ensure that this happened.

There was a risk that people losing weight would not be monitored properly. Staff did not weigh people in accordance with their care plans. One person's care plan noted they should be weighed weekly, they had been weighed three times in May 2017 and these records showed they had lost weight. They had not been weighed since. Three other people required weekly weights to be monitored, however for two people there were no records of them being weighed after May 2017, and for the third there was no record of them being weighed after 3 June 2016. Weight records on their own do not give information about whether the weight is appropriate for the person. Royal College of Nursing guidance states the importance of monitoring Body Mass Index (BMI) BMI's is because scores that lie outside the normal range for height, gender and age can be associated with health problems. BMI's were not recorded.

Staff told us a list on the servery wall provided information about people's diets. Three people were not shown as needing soft diets, although information in their care plans contradicted this. This meant there was a risk staff who might not know them could give them the wrong texture of food, such as a biscuit, which may make them choke.

Good practice was not always followed when staff moved people. We observed three instances when staff moved people in wheelchairs without using the footplates to stop people's feet from dragging on the floor. Staff did not always inform people when they were moving them or talk them through the process. The provider told us about the work they were doing and told us about the improvements they had made. They said, "Some staff had been here six months and not had manual handling training. Manual handling support plans were non-existent; there were no individual slings and no information for staff how to use

them. We've put all new, bespoke slings in place and new hoists." Training records showed 19 staff had current manual handling training in place, and 27 staff had this training booked.

The provider had a business continuity plan in place. This set out the arrangements to be followed if the home had to be evacuated for any reason. The plan included what would happen if, for example the premises caught fire or if there was failure of any utility services. Personal emergency evacuation plans (referred to as PEEPs) had also been prepared for each person. The PEEPS were not realistically achievable in relation to procedures staff were expected to follow in the event of an emergency. For example on the day of the inspection, 30 out of 35 people living in the home had been assessed as requiring assistance to mobilise in the event of a fire. As most people required the use of equipment to mobilise, staff would not be able to evacuate everyone from the building as stated in their PEEPS. Staff said, "I think PEEPS are how to evacuate people in a fire; I've seen one and would like to read more."

The above concerns amount to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from risks in the general environment. Some areas of the home were unsafe. During our tour of the home with the manager on the first floor, we were able to open the lift doors with a key whilst the lift was on the ground floor. There was a one story drop to the roof of the lift. The manager made this area safe the same day it was pointed out to them.

On the first floor of the home we observed doors which opened onto 'service' stairs used by staff. We also observed an unmonitored door propped open on the ground floor which led down some cellar stairs. These stairs did not meet The Health and Safety Executive (HSE) guidance for stairs in health and social care settings. Where stairs present a significant risk and are not be suitable for use by people suitable controls should be put in place to reduce the risk of falls. These were not in place at the time of the inspection. We pointed this out to the manager and stair gates were purchased as a temporary measure to prevent access to the stairs.

Staff did not separate clean and dirty laundry appropriately. The processes for laundry management did not meet the Department of Health guidance for the prevention and control of infection in care homes. The system did not ensure that clean and soiled/fouled linen were physically separated throughout the laundry process. Clean laundered items were also stored in the laundry area contrary to good practice. We observed that there were areas in the laundry that were dirty. An open sash window had collected lint which was blowing outside and back in through the window and airing vents. Work surfaces and walls were cluttered and cracked making it difficult to keep them clean. The last laundry audit on 28 February 2017 stated 'good practices in place'. This audit was ineffective as it failed to identify the shortfalls we found which were not meeting standards. After the inspection, the provider had assured us that appropriate processes for laundry management were in place and the laundry area was clean and tidy.

There were poor practices in place with regards to cleanliness and infection control in the bathrooms. For example we found used personal care gloves left on a radiator, personal toiletries, and used towels in bathrooms. This meant people were exposed to the risk of infection. The last infection control audit on 25 February 2017 said there was a robust cleaning schedule in place stating 'daily, weekly schedules in place.' When we checked these schedules we found that daily cleaning was not being recorded on a daily basis. Personal protective equipment such as gloves and aprons were left out in places where people with dementia could access them. We asked the provider to move these because there was a risk people could pick them up and put them in their mouths, which could be a choking risk.

A visitor told us, "Staff told me I could help myself to tea in the servery area next to the dining room, it's usually filthy but it's gleaming today." The cleaning records for this area showed there were no records of the servery being cleaned 21 days in April, 27 days in May and 4 days in June. Pots of jam and marmalade in the servery fridge did not have dates of opening on them. This meant staff could not ensure the cleanliness of the environment had been maintained.

The above concerns amount to a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had mixed views about whether there were enough staff available to support people. Our observation was that there were not enough staff to support people in the mornings and lunchtime. Two people told us they had waited for staff to help them get up in the morning and had not been offered a drink before breakfast. At 10.16am one person was asked what they would like for breakfast and said, "Cup of tea more than anything!" They told us this was their first drink of the day. At 10.20am another person told us, "I was awake quite early and not had a drink yet." One relative told us they were concerned about lack of care and said, "They're always late with food. I come here on Sundays and people can still be waiting for breakfast at 11.30." Other comments included, "There have been so many staff leaving", "There seems to be enough staff" and, "They come and go so quickly." Staff also had mixed views about staffing levels and said, "I think it works pretty well", "Lately there have been more staff because we've got more residents, but a lot of us feel we need this number of staff all the time" and, "Office staff will come and help us if necessary." The provider told us they had increased staffing levels since the last inspection.

A visitor told us, "Staffing is horrendous; staff look so stressed." They told us they didn't feel the person they visited was receiving the care and support they needed because they had been unable to find staff to assist the person with personal care needs. A healthcare professional told us, "Sometimes it's very difficult to find staff so I usually phone before I come. Staff always do as I ask though." Other relatives said, "There are less staff at weekends but always enough", "They're very busy but accommodating and they work very hard." The provider had a dependency tool which they said informed the decision how many staff were needed. The dependency tool listed people's names and showed everyone needed assistance with care. The tool showed 14 people needed supervision and 27 people needed the assistance of two staff. We asked the managers to provide an explanation of how this information was used to determine the staffing levels; however, we did not receive this information.

The manager told us they were committed to maintaining good levels of staffing and had employed high numbers of agency staff to meet this need. There is a risk when using high numbers of agency staff that warning signs of peoples deteriorating health may not be noticed. They said, "We're selective about which staff we employ. It's also about getting the skills mix right; we want the right staff in the right position." The provider told us how they had listened to staff and changed the rotas, which meant staff had alternate weekends free. The two managers were supernumerary and were available to help staff when required. The manager told us extra staff were available when new people came to the home.

The manager told us nurses were given one day a week to perform administration tasks. This meant there were sometimes two nurses in the home although only one was covering nursing duties. The clinical meeting minutes from 11 April 2017 stated, "Both nurses feel that we need two Registered Nurses on for at least part of the day as the workload is too much and things are getting missed and forgotten. This is mainly due to high dependency, complex needs residents and the majority of service users being nursing."

The above concerns amount to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst staff had a clear understanding or what may constitute abuse and how to report it, managers had not used the systems and processes in place to take appropriate action immediately upon becoming aware of certain allegations of abuse. We saw incidents that should have been referred to the local safeguarding authority and notified to the commission. We discussed these incidents with the managers who told us they believed the incidents would have been referred and notifications made to the commission. Where people had been at risk of potential safeguarding concerns, the risks had not been satisfactorily addressed. The lack of referrals to the local safeguarding authority and lack of notifications to the commission meant that external agencies had not been able to have oversight of any concerns to ensure incidents had been handled correctly.

This was a breach of Reg 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a robust selection procedure in place. Staff recruitment files showed that the service operated a safe and effective recruitment system. An enhanced Disclosure and Barring Service (DBS) check had been completed. The DBS check ensured that people barred from working with certain groups such as vulnerable adults would be identified. We saw that the recruitment process also included completion of an application form, an interview and previous employer references to assess the candidate's suitability for the role. The provider said, "We've improved the recruitment process and have improved on the quality of staffing. We have taken action where staff have not passed probation."

Requires Improvement

Is the service effective?

Our findings

Staff did not always have the training they needed to meet people's complex needs and ensure their safety. For example, staff we spoke with confirmed they had not had training around caring for people with diabetes. Training records showed one nurse was up to date with training for diabetes. Training records also showed the provider expected diabetes training to be covered by all other staff by completing workbooks; however the records did not show if staff had completed these. We asked two staff how they would recognise if a person with diabetes was becoming unwell due to their blood sugar becoming high or low, they told us, "I've got to be honest I'm unaware of what to look out for" and "I don't know." Guidance for staff on how to support people with diabetes was not included within care plans.

Staff told us, "We have people with conditions such as Huntingdon's Disease, but we've not been given any training for this." This meant there was a risk that care staff would not know how to meet people's needs. One person required the use of specialist medical equipment to help them eat. There were no records of staff having completed training for this, although the manager told us the local authority would provide training for this. Two people used catheters; the manager told us staff received training during induction for managing catheters, however the training records did not show this.

Nursing staff said they had access to training and development in order to meet their professional registration requirements. This included venepuncture training, catheter training, dementia, multiple sclerosis and diabetes training; however, training records did not support this. Training records showed four nurses, two of whom were bank staff, did not have up to date training for catheters.

We raised these concerns with the manager who told us staff completed refresher training every year for topics the provider considered necessary. If someone made a mistake, for example with manual handling, the manager said staff would be re-trained. Nurses also received specialist training for wound care and venepuncture. Staff said, "They do specialist training every so often and will tell us who's doing it."

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

People had not consistently been protected against the risk of poor or inappropriate care because accurate records were not being maintained. There were gaps in records where staff should have documented the care they had provided. This included personal care records, food and fluid records, tools to assess people's risk of pressure ulcers and bowel monitoring charts.

Various tools were used to assess the risks to people of malnutrition and skin breakdown. These records, when used together accurately, should give a clear picture of the person's health. The information they contained was not being used effectively to inform staff about the care and support people needed. For example, one person who was recorded as 'very high risk' in relation to their assessment of risk for developing pressure ulcers, did not have their weight record monitored alongside this for two consecutive months. Their records stated they required weekly weight monitoring. Monitoring people's weight

alongside the tool to assess risk is important if people are at risk of developing pressure ulcers, so that appropriate care can be provided. The provider told us, "We're not an effective staff team at the moment, but we're in a far better position now than we were 18 months ago."

Some people were having their food and fluid intake monitored. There did not however appear to be any accountability for checking and acting on the information that was recorded. We looked at the food and fluid intake charts for one person over a month period. The person was eating a soft diet and was nutritionally at risk; their care plan stated they required constant monitoring of their food and fluids. Staff had consistently not documented what the person had eaten and had simply recorded 'soft diet'. There was not always a target fluid intake documented and the daily documented intakes were below the target in the person's care plan, however staff recorded in the person's daily notes they had drank well. The information also contained miscalculations and very long gaps between drinks after 5pm until the next day. On one day the person was recorded as having a drink at 13:00 hours and then not again until 08:00 the next day. There was nothing documented within the daily records to show that staff had recognised the below average fluid intake or whether they had escalated their concerns to a senior member of staff.

Another person's daily nutritional chart showed they did not have anything to drink after 6pm until 9am the following day. On one day, staff had not recorded the person had eaten or drunk anything after breakfast. Although this person's fluid intake had been below their target, staff had not taken any action to address this. Staff had failed to record the person had eaten or drunk anything one day.

One person's care plan contained contradictory information. One part of their care plan said the person remained on a soft diet, while another part instructed staff to offer chocolate and cake if the person refused their medicines. One member of staff said, "Yes he has a soft diet but we give him soft biscuits." This person's relative told us the person ate a pureed diet but could manage soft cake. This meant the instructions in the care plan gave no instructions for staff how to adapt snacks for them, however staff could say what the person needed.

The food storage temperature chart for the servery fridge had not been completed for June 2017. This meant there was a risk food had not been stored at optimum temperatures to keep food fresh.

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

Staff did not always fully understand the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. Staff said, "I've done training for this, it's about doing capacity assessments and offering choices", "If someone wanted to leave the home we'd have to consider if they had the capacity to make that decision" and "If people made a decision which was maybe not safe we look at if we can make it safe so it's their idea." 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.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The principles of the MCA were not being followed. Where MCA assessments had been completed they did not always include enough information about how staff should support the person or record what the best interest decision was. We

saw examples of records titled 'best interest assessments'. These records showed a clear assessment of people's mental capacity to make decisions. These records did not, however, record what the decision was, how it would be implemented and where applicable who else was involved in making the decision. For example, consent was not appropriately sought around restrictive equipment such as bedrails. One person's relative had signed a bedrails consent form and was named on a best interest assessment for bedrails. We were told the person lacked capacity and that the relative had a lasting power of attorney (LPA). We asked the managers to produce a copy of the LPA agreement to verify whether the LPA was an appropriate person to give consent for bedrails. The managers were unable to find a copy of the LPA or say what type it was. An LPA is a legal document that lets a person appoint one or more people to make decisions on their behalf. There are two types of LPA; one type is for health and welfare and the second is for property and financial affairs. A person can choose to make one type of LPA or both. This meant people were at risk of receiving care and treatment which was not in their best interests.

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

The provider had met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. 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 Mental Capacity Act 2005 (MCA). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that in relation to DoLs people's capacity to make decisions had been assessed where needed and appropriate DoLS applications had been made. The provider told us, "Everyone on the dementia unit used to stay in bed; now there are not many who do. People have choices whether to stay in bed or sit out."

Staff did not always provide appropriate support for people who needed assistance to eat. One person waited 25 minutes for their lunch on the second day. Their meal was served to them, but they didn't eat it. After waiting another 15 minutes a carer put their cutlery into the person's hands, and they started to eat their meal. Another person waited 40 minutes for their lunch, while staff assisted other people to eat. When their food was brought to them, a carer sat next to this person to assist them to eat, but got up after a few minutes to cut food up for another person and didn't return. Staff didn't offer to cut food up for one person, who ate some food whole. A member of staff offered to cut this person's food up for them after they had struggled for 15 minutes. One person who sat in the lounge for their meal, sat with their meal in front of them for half an hour with no offer of assistance.

During lunch we observed one member of staff standing up and chatting with two other people while assisting one person to eat. They left this person before the person had eaten very much. Other people sat in front of their meals had not eaten much. One member of staff said, "We had 'In Their Shoes' training where I was given a drink and some yoghurt; it was a big eye opener. I've noticed staff are asking people more now." One person was feeling sleepy at lunchtime, so staff offered for them to have lunch in the lounge where they were sitting. One person told us, "The food was wonderful." A relative told us, "The food is exceptional; there's plenty of it and they enjoy it."

Records showed that people had been reviewed by the GP who visited the home if people were registered with them. The manager provided two referrals for assessments by speech and language therapists. A district nurse visited daily to provide care for a wound for one person. They told us, "Staff don't need to do anything but they will let me know if the dressing needs to be changed." One relative told us, "Staff have been extremely tolerant; they've always involved other professionals and I'm always involved in any

meetings." Staff said, "If I notice any changes such as if people haven't eaten well or had a drink, I'd tell a nurse." The provider told us, "People will have a named nurse who will ensure care plans are up to date and make any necessary referrals to healthcare professionals."

New staff were supported to complete an induction programme before working on their own. The training provided included first aid, infection control and food hygiene. They told us, "Induction was okay; it was spread over a few days." Staff currently employed had worked in care previously so did not need to complete the Care Certificate. However, the manager had an agreement with a local college to provide training for other qualifications such as diplomas, and the Care Certificate would be provided if necessary. The Care Certificate is a nationally recognised standard which gives staff the basic skills they need to provide support for people. The provider told us, "Staff who come here with no care background do the Care Certificate. Most staff employed have come from a care background."

Staff said they received supervision and felt well supported. We looked at the supervision records of four members of staff. We found that staff had received supervision, although the frequency of supervisions was not always in line with the provider's requirements. There had been some recent improvements due to an increase in monitoring by senior staff. Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff. Staff said, "It's a good place to work" and "[Name's] a great boss, he's lovely."

Requires Improvement

Is the service caring?

Our findings

People's personal care needs were not always attended to in a timely way. We observed that some people wore stained clothing and had food debris on their faces. We saw one person who had a continence accident was sitting and walking around in stained clothing from 9am until lunchtime on the first day of inspection. The same person was again wearing wet trousers the next day. We also noted that there was a strong unpleasant odour in the home close to a particular bedroom. We asked senior staff about this and were told that the person within this room was a private person and resisted support; they preferred to undertake their own personal care. We were told the room was regularly cleaned however as the room was carpeted the odours persisted.

Due to the significant recording gaps in personal care notes we asked the service to carry out a personal care audit for the previous four weeks as we were not assured that people received the appropriate assistance with their personal care. This information was not provided by the provider following our inspection.

Staff told us people were able to have a bath or a shower whenever they wanted. The provider had received one complaint from a visitor who was concerned the person they visited was always wearing the same clothes despite having others, which were rarely buttoned up properly and always very dirty. This complaint had been resolved.

The service did not consistently treat people with respect. Staff spoke about people who required assistance with eating using inappropriate language. For example, staff said, "We have general assistants who help us with feeding people" and "There are a lot more 'softs' the other side."

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

Staff we spoke with said that their understanding of showing respect for people's privacy and dignity included making sure people were covered when receiving personal care and they ensured the door was shut and curtains closed.

Information about advocacy services was available to people. The home had links to local advocacy services to support people if they required support. Advocates are people who are independent of the service and who support people to make decisions and communicate their wishes.

People made choices about where they wished to spend their time. Some people preferred not to socialise in the lounge areas and spent time in their rooms. People told us they were able to have visitors at any time. Each person who lived at the home had a single room where they were able to see personal or professional visitors in private. Peoples' bedrooms were personalised and decorated to their taste.

Requires Improvement

Is the service responsive?

Our findings

People or their relatives were not always involved in developing their care, support and treatment plans. One person told us, "No, I don't have anything to do with it." One relative said, "I'm aware of the care plan but not involved with writing it. I think they would listen to my input though." Other relatives confirmed they did not contribute to the care plans. Care plans contained some information about their dietary, social, personal care and health needs and considered their life histories, personal interests and preferences. One person's care plan gave information for staff how to support the person with communication and said, "Allow [name] time to process information." The provider said, "We know there are issues with the care plans; we are planning on using electronic records and have been holding off for that."

Behaviour management plans were in place for some people. These provided information about the situations the person found difficult, what behaviour they may display and what staff could do to avoid difficult situations. Care plans identified situations people may have found difficult, these included noisy environments and crowded areas. Staff told us about one person who could exhibit anxiety and distress and said, "[Name] doesn't always respond to support or reassurance and can take several hours to calm down." This person's care plan instructed staff to play their favourite music if they displayed challenging behaviours, but did not say what kind of music that was. The member of staff we spoke with did not know to play music when the person was anxious.

People were not always able to take part in a range of activities according to their interests; however a new activities leader had very recently been appointed. Individual and group activities had not been recorded between April and May 2017. One relative told us, "There looks to be a lot of activities on paper, but we rarely see any of it happening, it's all for show." The home had a sensory room where people could sit and listen to music, or watch coloured lights to relax them. The sensory room log had nothing recorded since March 2017, one entry in January 2017 and one entry in October 2016. The provider said, "The activities leader has a budget which they can spend on anything they like."

The activities leader told us about the range of activities they were arranging, these included carpet bowls, listening to music and singing and going out into the garden. Outings for cream teas and to places of interest were also planned. People also had access to electronic devices such as an iPad and a Wii. The activities leader had recently surveyed people to find out about their likes and dislikes. The activities room contained a range of resources for activities such as arts and crafts, board games, tapestry and creating memory boxes. A visiting healthcare professional said, "There are always activities being provided, such as a themed lunch." Relatives told us, "There are lots of activities going on." On one of the days of our inspection, a puppy was being taken around the home for people to fuss; three people in the lounge area enjoyed this very much. On the second day, six gentlemen took part in a gentlemen's club in the morning, then two ladies made salt dough figures in the afternoon. The provider told us, "We're very proud of the programme, it's 100% better." Staff were able to wear 'fiddle aprons' when they supported people who may become upset. These were aprons with a variety of fabrics and attachments to distract people while staff provided personal care. Staff told us about one person who benefitted from staff wearing a 'fiddle apron' when they were offered personal care. The corridors in the dementia unit had a range of tactile decorations

which people could touch. Providing such tactile stimulation for people with dementia can decrease agitation and restlessness, as well as improve sleep.

Handover between staff at the start of each shift ensured that some information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. Staff said, "Handovers are very useful because we find out about people who've not slept, been restless, had falls or any sores." The provider told us, "We've made changes so all staff can be updated. Handovers used to be between the nurses and no-one else. The whole team now gets together twice daily, including cleaning staff." Handover records confirmed staff discussed people's needs and noted if any appointments were booked.

People were supported to maintain contact with friends and family. The manager sent regular emails and photographs to families to keep them in touch with their loved ones. A newsletter also kept families informed of various topics, and this had been well received by families. Relatives said, "We're very happy, no concerns" and, "We're very impressed with the home, the manager has turned it around from one year ago." Staff said, "Staff are always willing to help and are very friendly" and, "I really enjoy working here."

The service had received compliments via email, letter and thank you cards. People and their relatives felt able to complain or raise issues within the home. Relatives said, "If we had a complaint we'd go to the manager, she's approachable" and, "No complaints." The home had a complaints procedure available for people and their relatives. Each person received a copy of the complaints policy when they moved into the home. The managers had received 14 complaints in the past year, although four of these had been safeguarding issues which had led to the complaints process being opened. We saw that complaints were followed up and responded to as per the provider's policy. There were some issues raised as complaints that should have been referred to the local safeguarding authority and the commission; there is further information about this in the 'Safe' section of this report. People we spoke with said, "I don't have anything to complain about" and "No, I'm not worried about anything." The provider had also received 14 compliments in the past year, which included thanking staff for providing newspapers.

People were encouraged to provide feedback on their experience of the service to monitor the quality of service provided. People who used the service, their relatives, staff and professionals were given questionnaires for their views about the quality of the service in February 2017. We saw the results of surveys had been analysed and there was an action plan in place to improve on areas identified as needing further progress.

Inadequate

Is the service well-led?

Our findings

Our findings from previous inspections have shown a history of non-compliance with the regulations. When we undertook a comprehensive inspection in November 2014 we identified four breaches of regulations. These were because staff had not been provided with appropriate training and supervision, staff were not following appropriate procedures where people lacked capacity to make decisions about their care, records were not maintained accurately and the provider's quality assurance processes had not identified the shortfalls we found.

We undertook a comprehensive inspection in January 2016 and identified four breaches of regulations. This was because where restrictions were in place the provider had not ensured effective processes were in place to make best interest decisions in accordance with the Mental Capacity Act 2005. Medicines were not always administered safely and the service was failing to monitor and mitigate the risks relating to the health, safety and welfare of people. Sufficient numbers of staff had not been deployed to respond to people's needs and accurate, complete and contemporaneous records were not kept in respect of each service user. After the comprehensive inspection, we used our enforcement powers and served Warning Notices on the provider on 4 March 2016. These were formal notices which confirmed the provider had to meet the legal requirements by 14 July 2016.

We undertook a focussed inspection in October 2016 to check the provider was meeting regulations. We found action had been taken to improve the areas of the service looked at but some areas required further improvement. Some further information relating to risks around the use of bed rails was needed in some people's rooms. Whilst some improvements had been made to ensure the principles of the Mental Capacity Act 2005 were being followed we found that further improvements were necessary to ensure people's rights were fully protected where they lacked capacity to make decisions for themselves. However, when improvements had been made, these had not been sustained.

At this inspection we identified a number of breaches of regulations, four of which were continuing breaches from our last comprehensive inspection in January 2016. This demonstrated the provider had failed to take sufficient action in response to shortfalls previously identified.

The provider's quality assurance systems and processes had not been effective in assessing and monitoring the quality of care. They were also not effective in mitigating the risks relating to the health, safety and welfare of service users. The managers had reviewed issues such as; medicines, care plans and training, their observations identified some good practice and some areas where improvements were required. However, these audits had failed to identify the concerns we found in relation to medicines, lack of guidance for staff and in care plans, concerns around availability of staff, lack of training for staff and best interest decisions concerns. The provider said, "We know we have failings, we have an amazing management team who are driven and passionate about what we do. Our goal is to be the best that we can be."

There were systems in place to ensure regular maintenance was completed and audits to ensure that the premises, equipment and health and safety related areas such as fire risk were monitored and that

equipment tests were completed. However, these audits had not identified the shortfalls we found in relation to infection control and risks to the environment

We saw that where actions were required to improve the service there were action plans in place, however the action plans were not always followed up. Some actions being noted for follow up were not subsequently reviewed at the next audit or completed. These systems had failed to ensure that improvements were consistently sustained. For example, we looked at the action plans from operational service reviews between January 2017 until the inspection date in June 2017. These reviews were undertaken by the senior staff. The action plans referred to issues we found across the home which had not been rectified some months later such as failures to update information in care plans relating to peoples specific needs around falls. Poor wound care records were highlighted in the February and March 2017 reviews and action had not been undertaken some months later.

Accidents and incidents which occurred in the home were recorded but not analysed. Where people had multiple falls, this had not been followed up. This meant people did not receive the care and support they required to meet their needs.

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

Staff survey responses scored low in relation to there not being a strong feeling of teamwork or feeling their opinions mattered. Senior staff said there had been a high turnover of staff and staff were now working more cohesively.

We saw records that demonstrated that staff had opportunities to give their views through staff meetings. These meetings had not been as frequent in recent months due to an increased staff turnover. There were communication systems in place regarding staff handovers to ensure that staff were kept up to date with any changes within the home. Staff told us they felt well supported by the registered manager and their colleagues.

Not all staff we spoke knew what the vision or values of the home were. Two staff told us they didn't know what these were. One member of staff said, "It's about putting residents first before anything else" and another said, "For people to be happy, safe, warm, fed and watered and cared for." The values of the home state, "We strive to create happy and stimulating homes where the standards for care and services improve the quality of life for everyone; adding life to years."

The provider had introduced a senior team of four seniors/managers. The four seniors/managers were responsible for business, clinical, care and administration areas. The provider also introduced three floor managers, a full complement of domestic and kitchen staff and an activity leader. This meant senior staff were better able to concentrate on the improving the service and care staff could concentrate on providing care. Staff said, "The manager is very approachable", "[Name] has put quite a lot in place", and, "The manager is very approachable, supportive and listens to me." One relative said, "There have been lots of changes but I've never felt the care has been affected or diminished; I've seen a massive improvement." The provider said, "If staff want to talk to management we're always available."

We saw the results of surveys had been analysed and comments from people were mostly positive. Requests for an increase in activities was a theme across the residents meetings and surveys. The provider had responded to these requests by appointing an activities leader. Relatives were invited to meetings to contribute to improve the service. One relative told us how the managers had developed a relatives' support

group. They said, "They've got relatives together so we can support each other. The manager and provider come as well so they keep us updated."

The provider told us about the changes they had made in the last year. The staffing structure had been changed to create two managers' roles, one manager being responsible for clinical issues and the other manager responsible for business management. The provider said, "I'm proud of what we've done; we're on the right course." The manager had developed links with the local community and hoped this would lead to shared activities such as carol services at Christmas.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users were not always treated with dignity and respect.

The enforcement action we took:

Conditions were imposed on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent was not appropriately sought. Decisions made in people's best interests were not fully recorded.

The enforcement action we took:

Conditions were imposed on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not receiving safe care and treatment.

The enforcement action we took:

Conditions were imposed on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There were not sufficient numbers of suitably qualified, competent, skilled and experienced persons in order to meet requirements. Staff did not always have the training they needed to meet

people's complex needs and ensure their safety.

The enforcement action we took:

Conditions were imposed on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not maintained appropriate standards of hygiene.

The enforcement action we took:

Conditions were imposed on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not established and operated effectively to ensure compliance with requirements.

The enforcement action we took:

Conditions were imposed on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent, skilled and experienced persons in order to meet requirements. Staff did not always have the training they needed to meet people's complex needs and ensure their safety.

The enforcement action we took:

Conditions were imposed on the providers registration.