Alpha Care Castlemaine Limited

Castlemaine Care Home

Inspection report

4 Avondale Road
St Leonards On Sea
East Sussex
TN38 0SA

Tel: 01424422226

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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

Castlemaine Care Home provides care and support for up to 42 older people living with dementia. The care needs of people varied, some people had complex dementia care needs that included behaviours that challenged. Other people's needs were less complex and required care and support associated with mild dementia and memory loss. Most people were fully mobile and able to walk around the home unaided. At the time of this inspection there were 22 people living at the home and one person in receipt of respite care.

Following our inspection in November 2015 warning notices were issued. The provider sent us an action plan that told us how they would address these. We inspected again in September 2016 to check the provider had made improvements and to confirm that legal requirements had been met. We found that the provider had not addressed the breaches found. We also identified further breaches in relation to staff support, procedures for reporting safeguarding matters and deprivation of liberty. The provider sent us an action plan telling us how they would make improvements. We met with the provider and received two monthly updates on progress made in meeting the regulations. This inspection was carried out to check what progress the provider had made to ensure legal requirements were met. We found the provider continued to be in breach of legal requirements. 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.

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.

At this inspection there was a lack of managerial oversight to ensure that documentation was kept up to date and ensured that people received safe, effective, caring and responsive care. The audit systems had not identified the matters we raised during this inspection. For example, it did not identify the shortfalls we found in relation to the management of medicines. Some matters identified at our last inspection had been addressed, for example new audits had been introduced. However, matters raised as a result of these audits were not always followed up. For example, actions to address recommendations from the medicine's audits had not been completed.

The provider's action plan included two monthly updates that told us improvements had been made. A number of improvements had been made. For example, each person's needs in relation to how they would be supported in the event of an emergency had been assessed. However, no overall assessment had been made to determine how this would work in practice. Improvements had been made to record keeping in relation to health and safety. However, the provider told us that care plans had been audited. At the time of inspection we were told that no audits had been carried out. They said they would ensure fluid charts were completed accurately by April 2017. The last update stated that this would be ongoing.

There was no effective system to accurately monitor that people who had been assessed at risk of dehydration received enough to drink. There were no records that staff checked pressure relieving mattresses and cushions for two people at risk of developing pressure sores. We found both had been set at levels that were not in line with the people's individual needs and this increases the risk of people developing pressure areas.

There were unsafe procedures for the storage, handling and disposal of medicines. There was no protocol for the safe administration of one person's medicine that was prescribed to be given on an as required basis. This meant it was given every morning without an assessment to check if it was needed.

Guidance for staff to follow in care plans was not detailed, accurate and up to date and staff had not received training to care for people with particular health conditions. This meant people were at risk of receiving care that was not appropriate. Over half of the staff team had not completed training in nutrition or dementia awareness training.

The provider was not meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). DoLS are used when it is assessed as necessary to deprive a person of their liberty in their best interests and the methods used should be as least restrictive as possible. We found restrictions had been imposed on people. Best interests meetings had not been held and applications had not been made to the local DoLS team to agree with the restrictions. Staff were not sure who had or did not have a DoLS.

Staff were not always observant and this put people at risk. For example, staff had not noticed one person ate their meal with their knife. Some practices did not respect people's dignity. Plate guards were provided to assist people to maintain their independence with eating but had been positioned incorrectly. This resulted in food spilling over the plate and a loss of dignity for those using them. However, we also saw care that respected people's dignity, such as when people were supported to move by hoist from one area to another. Staff spoke to people with kindness and showed them respect. They talked and communicated with people in a way they could understand.

There was a varied programme of activities to suit people's different tastes and interests. The weekly plan was flexible and adapted as needed. There was an Elvis impersonator at the home during our inspection and people were encouraged to engage and dance along to the music. People and visitors spoke well of the activities provided and thought highly of the activity coordinator. One person told us, "My favourite is listening to the singers who come in." Another said, "I love it when they bring in animals." A visitor told us that their relative "Loves the kittens, lambs, & dogs."

People were supported to attend a range of health care appointments. Feedback from professionals was positive with comments such as, "I have never had any problems. The manager knows clients really well. If staff have any problems they will ring me. Staff are used to dealing with people with dementia needs." Another professional told us the home, "Take some people that other homes would not consider and seem to be able to manage and just to get on with it. Castlemaine is a home that I always consider as a first port of call and I suppose I trust their care."

The overall rating for this provider is 'Inadequate'. At the inspection in 2015 the provider was placed into special measures by CQC. This has remained the case. At this inspection there was not enough improvement to take the provider out of special measures and there are still breaches of regulations. 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 safe.

People's medicines were not stored, administered and disposed of safely.

There was a lack of monitoring to ensure people received enough to eat and drink.

Pressure relieving mattresses and seat cushions were not always set in line with people's individual needs.

There were enough staff to meet people's needs safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Although there was training available some staff did not have appropriate training to fulfil their role.

Documentation did not always show that staff had information to ensure they acted in line with the Deprivation of Liberty Safeguards.

People were supported to access a range of health care professionals to help ensure that their general health was being maintained.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were not always observant to people's needs and this resulted in loss of dignity for some people.

Staff communicated with people in a way they could understand.

People's privacy was promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care plans did not provide accurate and up to date information about how to support people.

There was a wide range of activities to meet people's individual needs.

There was a complaints procedure in place.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of oversight to ensure that people received safe, effective, caring and responsive care.

Quality assurance systems were not effective.

There were good systems for monitoring health and safety.

Castlemaine Care Home

Detailed findings

Background to this inspection

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

We visited the home on the 18 and 23 May 2017. This was an unannounced inspection. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who used this type of service.

During the inspection, we spoke with nine people who lived at the home, three visitors, the activity coordinator, maintenance person, four care staff, the registered manager and deputy manager. We spoke with or received correspondence from five visiting health or social care professionals.

Some people were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) at lunchtime on the first day of our inspection. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority, looked at safeguarding concerns that had been raised and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority to obtain their views about the care provided in the home.

During the inspection we reviewed the records of the home. These included staff training records and procedures, audits, three staff files along with information in regards to the upkeep of the premises. We also looked at six care plans and risk assessments along with other relevant documentation to support our findings. We 'pathway tracked' people living at Castlemaine Care Home. This is when we looked at their care documentation in depth and obtained their views on how they found living at Castlemaine. It is an important part of our inspection, as it allowed us to capture information about a selected group of people

receiving care.

Inadequate

Is the service safe?

Our findings

At our last three inspections in 2014, 2015 and 2016 the provider was in breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following the inspection in November 2015 warning notices were issued that required the provider to be compliant with Regulation 12 by February 2016. At our inspection in September 2016 the provider was still not meeting the requirements of this regulation. This has remained the case.

At our inspection in 2014 the provider was issued a requirement notice in relation to not reporting safeguarding matters to the local authority. In 2015 the provider had addressed this matter. In 2016 we identified further examples of this as part of that inspection. At this inspection the provider had met this aspect of the Regulation.

In the 2015 inspection the provider was in breach of Regulation 18 as there were not enough staff on shift to meet people's needs. In 2016 we found that whilst there were enough staff deployed on each shift, one staff member had worked excessive hours and there was no proper system in place to assess the impact of this and the high use of agency staff on shift. At this inspection the provider had met this regulation.

People told us they felt safe. Comments included, "I feel safe because there are a lot of people around." Another said, "I feel safe because I have no worries or troubles." A third told us, "They come if you call them and I sleep very well." A visitor told us, "I think they feel safe because I have never seen any 'aggro' and if residents are physically or verbally abusive the staff deal with it very calmly and manage the situation well." Despite these positive comments we found that people did not always received care that was safe.

There was an up to date personal emergency evacuation plan (PEEP) that described the support required by each person in the event of a fire or emergency. This was located on the home's electronic care plan system and a list of each person's support needs was available at the front door should they be needed in an emergency. We asked if the evacuation procedure had been reviewed to take account of people's support needs. For example, the numbers of people who needed two carers to evacuate or the numbers of people who required wheelchairs, but this had not been done. One of the directors carried out a fire risk assessment in January 2017. This stated that fire evacuation drills would be held six monthly. We were told that a drill had been carried out in March 2017 as part of fire training, but no unannounced drills had been carried out to check that staff knew the procedure to follow. One recommendation from the risk assessment had been to ensure that all staff were familiar with the night evacuation procedure. The deputy manager told us that there was no specific night evacuation procedure. Another action had been to 'ensure an adequate level of assistance is available during day time for evacuation to take place within an acceptable time.' As no unannounced drills had been held it was not possible to establish if staff could achieve this safely and there was no guidance on what an 'acceptable time' meant. This left people at risk of harm.

People's medicines were stored in locked trolleys within a locked room. There was advice on the medication administration record (MAR) about how people chose to take their medicines. Some people had been prescribed 'as required' (PRN) medicines. One person was prescribed PRN medicine twice a day if required

and additionally when required for personal care. However, there was no written protocol related to how staff should assess whether the medicine was required. The deputy manager described the steps that they would have expected staff to take to assess if the medicine was needed. These were not recorded within the care plan. Two staff told us that the medicine was given every morning without assessment. Records confirmed that within a one month period the medicine had been assessed in the mornings as not required on one occasion only. To the rear of the MAR chart the record showed that the person had been 'agitated' on 14 occasions with no further information provided. The person's personal care risk assessment stated that the person, 'Is more agreeable to personal care earlier in the morning after medication.' This medicine had not been given in line with the prescription and this left the risk of the person receiving medicine that was not required but suited the needs of staff.

There were unsafe practices for the storage of controlled drugs (CDs). (CDs are classified by law based on their benefit when used, and their harm when misused. There are stricter legal controls that govern the storage of CDs.) There were CD medicines for two people that were no longer used and had not been returned to the pharmacy. Two of these medicines were stored in an unlocked box within the medicine's room. There was a box of CD pain patches that had been delivered the day before our inspection but these had not been locked in the CD cabinet. Medicines for one person had been stopped the day before our inspection. They had been removed from the blister packs and were in an unnamed or dated clear packet in the refused medicines box. When this was pointed out to staff they were removed and placed in the CD cabinet. One person's medicine was in a refused medicine's container. However, the records for that day showed that this had been signed as given.

The care plans directed staff to monitor seven people's fluid intake as it had been identified these people were at risk from dehydration. Records were incomplete and not added up to provide the total amount of fluids taken. Therefore the records would not be an effective way of monitoring how much they had drunk. There was also no guide amount for staff to aim for individual people, such as against the person's body weight. There was no record that drinks were offered or taken after 4.30 to 5pm each day. Over a 12 day period one person's fluid intake was recorded between 250 mls to 850 mls on seven days. This placed the person at risk of dehydration. Following our inspection a new system was introduced to record people's fluid intake.

Pressure relieving mattresses and seat cushions were used for two people that had been identified at risk. These need to be set in line with people's individual weights and according to the manufacturer's instructions. The systems to check that the mattresses were set correctly were ineffective. Records for one person showed they had last been checked in July 2016. This mattress was set at 60Kgs but should have been set at 55Kgs. Records for the second person showed that they had last been checked in March 2017. This mattress was set at 30Kgs. This person's cushion was set at 100Kgs but had not been turned on. On the second day of our inspection the records showed that the mattress should be set at 51Kgs but the setting was still showing 30Kgs and this had been signed as correct. One of these people had recovered from a pressure sore in March 2017. This left the people at increased risk of developing pressure sores.

One person had a care plan for the management of epilepsy. The care plan did not state what type of epilepsy they had and the records related to seizures did not describe the seizures. This would not assist a GP or other professional to monitor seizure patterns. The care plan advised that if the person had a seizure, 'staff will lay (them) on (their) side and support until the fit subsides. Staff need to record the length of the fit, and seek advice if the fit goes on too long.' There was no reference to what too long meant. General advice would normally be to not move the person (other than to move them away from anything that could cause injury) until the seizure has stopped. This person needed to be hoisted for all moves. There were four seizures recorded since December 2016. Records for one seizure showed that the person was 'left in the

recovery position until fit subsided.' There was no reference to whether a hoist had been used or how the person had been placed in the recovery position. Moving a person during a seizure could cause significant harm to the person. We asked a staff member if they had ever seen the person have a seizure and they said no. We asked them if they knew what to watch out for but they said they did not. None of the staff had received training on the management of epilepsy. As part of an evaluation of the person's care plan in March 2017 there was reference that urine infections 'appear to trigger a seizure.' This person's fluids were meant to be monitored but had not been recorded appropriately as stated above. This placed the person at increased risk of having a seizure. Whilst one staff member told us they would call a paramedic, another us that they would not as there was a Do not attempt resuscitation form (DNACPR). However, the DNACPR related to resuscitation and did not mean that the person would not recover from a seizure. This could place the person at risk of severe harm.

One person's behavioural care plan stated that the person should be prompted to use, 'coping strategies as identified where necessary.' There was no reference to what the coping strategies included. It went on to say that in a heightened state of anxiety the person, 'Will need to be removed from situations' and 'physical prompting may be required.' It did not state how this should be done. Whilst all staff received training on prevention and management of violence and aggression (PMVA), any form of restraint used should be agreed before use and assessed as in the person's best interests.

The above issues had not ensured that people were protected from unsafe care and were a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities).

People were not always protected by a safe recruitment system. Staff told us they had an interview before they started work and the provider obtained references and carried out a criminal records check. We checked three staff records and saw that these were in place. Each file had a completed application form listing their work history as well as their skills and qualifications. Two of the staff did not have a contract of employment. One had been employed in January 2017 and one February 2017. One staff member had declared they had received a police caution that had the potential to affect their employment. The registered manager had discussed the declaration and a letter had been written to provide an explanation. Based on this, the staff member had been employed. However, the letter was not on the file and a risk assessment had not been carried out. Following the inspection we recommended the provider examine the documentation to satisfy themselves about the appointment.

There were good systems to ensure that equipment was serviced, checked and maintained. These included checks on the hoists and slings, weighing scales, wheelchair maintenance and the lift. There were monthly checks of the nurse call system and window restrictors. Water temperatures had been tested weekly and portable appliances annually. Checks were also carried out in relation to gas and electrical servicing and legionella. Due to the reduced occupancy numbers the home was no longer using the top floor of the home.

There were enough staff working in the home to meet people's needs safely. In addition to the registered manager, the head of care had been promoted to the position of deputy manager and had worked the previous two weeks in an office based role. There was at minimum one senior and three care staff on duty throughout the day and three waking night staff. Since the last inspection a number of staff had been recruited and retained. The numbers of agency staff used had been significantly reduced and this was now limited to mainly night time on occasions. There were enough ancillary staff to cover catering, maintenance, cleaning and laundry. An activity coordinator also worked 11 to 4pm Monday to Friday. Staff told us that staff levels were sufficient to meet people's needs.

Staff had received safeguarding training and had an understanding of their responsibilities in order to

protect people from the risk of abuse. They were able to recognise different types of abuse and told us what actions they would take if they believed someone was at risk and how they would report their concerns. They told us they would report any concerns to the registered manager or deputy manager for referral to the local safeguarding authority.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in September 2016 the provider was in breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because there was no proper system to ensure that all staff were suitably trained and to ensure that they were appropriately supervised and supported. Following the inspection the provider sent us an action plan detailing the improvements they would make to meet this regulation by January 2017. Following an update in April 2017 the timescale was changed to May 2017. Whilst some improvement had been made in this area the provider was still not fully compliant with this regulation.

Not all staff had received essential training to meet the specific needs of the people living at Castlemaine. The registered manager told us that essential training included training in dementia awareness and nutrition. Records showed that 16 staff still needed to complete the dementia awareness and 14 staff the nutrition training. At the time of inspection we identified that no staff had received training on epilepsy. We were not confident that staff knew how to support a person with epilepsy. One staff member was not able to tell us how they would support a person should they have a seizure. Advice in the person's care plan did not follow recognised guidance in how to support a person during a seizure. The provider confirmed at the time of writing this report that since our inspection eight staff had completed eLearning on this subject.

There was a training programme for what was known as mandatory training. Staff received training in looking after people, for example in safeguarding, food hygiene, fire safety, health and safety, moving and handling and infection control. Staff showed that they understood how to assist people living with dementia through the use of good moving and handling techniques when they supported people to move about the home. The registered manager told us they had difficulty with attendance numbers for staff training so in the days before our inspection a system of eLearning had been introduced. At the time of inspection the records showed that in some areas for example, food hygiene and health and safety high numbers of staff had yet to complete training. At the time of writing this report the provider had provided an update that showed significant progress had been made in ensuring that staff had received training in all of these areas.

Whilst progress has been made in these areas, the training in epilepsy had only been brought forward at our request and a number of the eLearning courses were completed after our inspection. The above areas remain a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Despite the shortfalls we also found evidence of positive training. All staff had received training on prevention and management of violence and aggression (PMVA). The last group of staff had received training on the day of our inspection. We were told this was a bespoke course that took account the needs of the people living at Castlemaine. They looked at low and high levels of intervention, prevention and de-escalation techniques. A staff member told us that the training had been very helpful and gave advice on how to support people appropriately. The PMVA had been translated into another language to assist one staff member whose first language was not English. The deputy manager told us the provider had given training to all staff on the use of the computer system.

A staff member told us that they felt supported. "There are very good people, management are helpful." Another told us, "I look forward to coming to work and I get regular supervision." A third staff member said, "It is really nice working here, there is really good support from management." They went on to say that they received regular supervision from management. We were told that senior staff provided supervision to care staff.

The staff training programme showed that eight staff needed to complete training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However the deputy manager told us training received had been, "Poor" and eLearning would be offered to all staff. However, all staff needed to complete mandatory training first and then they would complete MCA and DoLS. One staff member had an understanding of DoLS and was able to describe its principles and some of the areas that may constitute a deprivation of liberty. Another had no understanding of DoLS and a third staff member told us, "I think I had it." They knew that the care plans for DoLS were not appropriate and were being rewritten.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). 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 and there was appropriate documentation. People's liberty was restricted in that there were keypad locks at the entrance to the home. Stair gates were fitted on stairs and there were sensor mats in bedrooms for those at risk of falls. There were lap belts on some wheelchairs. One person used a recliner chair and would not have been able to leave the chair without assistance. Applications for Standard authorisations had been submitted to the local DoLS team for 15 people, five of which had been granted and the remainder were awaiting processing. Applications had yet to be completed for seven people. Staff did not know which people using the service had a DoLS authorised. The deputy manager told us, "They know the majority have a DoLS but they wouldn't know specifically what for except in relation to the front door." The specific conditions for those who had authorisations granted were not documented in their care plans. At the time of inspection there were seventeen people who did not have a DoLS granted and whilst restrictions may have been considered to be in people's best interests, they had not all been assessed as necessary and were not documented in care plans. Staff need to know which people using the service have a DoLS authorised, and what the conditions are so that they know what restrictions are lawful and how this influences how they provide care.

One person's behavioural care plan stated that they can appear, 'restless and agitated. Indicating a wish to go home (verbally or standing by the door).' Daily records showed that on one occasion they had been agitated, 'Trying to get out of here, ' and 'Trying to match door codes and going backwards and forwards to door and window.' There was a risk assessment for 'absconding.' This stated 'keypad doors are shut to prevent (the person) from gaining access to the outside. Try to distract if agitated and (person) tries to leave the building.' However, no application had been made for a DoLS and no best interests process followed in accordance with the MCA 2005.

The above area is a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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.

The format for each care plan gave space to record assessed needs, the aims and agreed plan, and a statement about the person's mental capacity. Generally the statement about mental capacity was a generic statement for each person and did not reflect that the person had the capacity to make some decisions. For example, 'I have dementia and I am unable to process information given to me due to a lack of mental capacity.' There was however, information within agreed plans to the person being able to make some choices. We observed staff giving people a range of choices throughout our inspection.

There was a four week menu which was displayed in the dining area. People's views and preferences were sought at resident's meetings. There was a main meal choice each day and a vegetarian option. Menus were varied and well balanced. However, on the vegetarian menu there was a heavy reliance on Quorn for two of the week's menus and although flavoured differently, Quorn was the choice four days a week. In the evenings there was a choice of soup and sandwiches or a hot meal alternative. Whilst this may have been the person's preference there were no records to demonstrate that this had been assessed.

People were offered a choice of drink with their meal. Four people were supported on a one to one basis to eat their meals. Two people did not want the meal and bacon and eggs were provided as an alternative. One person left their seat on several occasions and a staff member brought their meal to them in their new chosen seat. Tea and cakes were served in the afternoons. We were also told that further drinks were served at teatime and a choice of sandwiches and cakes were served at 7pm.

People were supported to have access to healthcare services and maintain good health. One person told us, "I have seen a GP twice because I have problems with my chest. The Chiropodist and Hairdresser come in as well." The optician had visited the home the week before our inspection. When there was an assessed need people saw a district nurse, dietician or a community psychiatric nurse. When people attended appointments there were detailed notes kept and these showed that relatives were kept fully up to date with the outcome.

Requires Improvement

Is the service caring?

Our findings

One person told us, "I can go to bed when I want but they keep to certain times." A visitor told us, "Personal care is carried out in an appropriate manner with care and kindness." Another visitor said, "Care is good but never 100%." A social care professional told us, "I have never had any problems, the manager knows clients really well. If staff have any problems they will ring me. Staff are used to dealing with people with dementia needs." Although we observed that people were treated with kindness and staff were attentive to people's needs, there were times when this was not always the case.

Staff were not always observant. The SOFI and general observations showed that one person ate the majority of their main meal with their knife. There were three staff in the vicinity supporting other people. One staff member stopped to ask the person if they were ok but didn't notice that they were using their knife. Some food had been spilled. Near the end of the meal the person picked up their spoon and proceeded to eat the rest of their meal with ease. Some people had plate guards to enable them to continue to eat independently. However, on both days of our inspection staff positioned the plate guards in a way that made the food inaccessible to people. This also resulted in food falling from the plate and a lack of dignity for people. On one occasion we repositioned a person's plate to enable the person to eat independently. However, soon after a staff member altered the plate again. We discussed this with a staff member. They had not realised how the plate should be presented. This was also raised with the deputy manager to ensure all staff were advised and as an area for improvement.

Within the controlled drugs cupboard there were items of jewellery, a wallet and money in a zipped bag. There was no name on these items. These were handed over to the registered manager who had been unaware that they were in the cupboard. As an inventory had not been made of the items in the safe this showed no respect for people's possessions and left the potential for items to go missing. This is an area that requires improvement.

However, there were good examples of supporting people to eat. One person was supported with a small plastic spoon and their food was pureed. The staff member said they found this type of spoon easier for the person to manage. Staff sat with the people they supported and maintained eye contact. They interacted with people throughout and people responded warmly to them. One person left their seat and moved to a different location. A staff member saw this and moved the person's dinner to the new location where it was then eaten.

Staff gave us examples of how they maintained people's dignity. One staff member told us, "Bedroom doors are always closed when personal care is given. We always keep one half covered when we are providing care and would never leave someone exposed. We encourage people to do what they can for themselves. We also use screens in the lounge when hoisting people to protect their privacy and dignity." As in our last inspection if someone needed a hoist to move from a wheelchair to a chair, a privacy screen was used. Staff explained what was happening and offered regular reassurance as they guided people to their changed position. People who wanted to spend time in the garden were supported to do so.

Staff continually treated people with respect. When staff approached people they did so respectfully and spoke to them using their chosen name. This meant people knew staff were addressing them.

Staff talked and communicated with people in a way they could understand. When people were frustrated or agitated they spoke calmly to them and provided reassurance. Bedrooms had been personalised to reflect people's individual tastes.

Requires Improvement

Is the service responsive?

Our findings

People and visitors spoke well of the activities provided and thought highly of the activity coordinator. One person told us, "My favourite is listening to the Singers who come in." Another said, "I love it when they bring in animals." A visitor told us that their relative "Loves the kittens, lambs, & dogs." A visitor told us, "If I had any complaints I would talk to the manager, she is easy to talk to. If it was about health I would speak to the nurse."

A social care professional told us, "The manager knows people's needs without having to look at the care plans." Another social care professional said, "They take some people that other homes would not consider and seem to be able to manage and just get on with it. Castlemaine is a home that I always consider as a first port of call and I suppose I trust their care. My only slightly negative comment would be the care plans as these are computer based but I understand that is the way we are all going."

A visitor told us, "I revised my mother's care plan with the manager recently and it is now up to date. At one time I wanted to take her away from here but in the last nine months everything is much improved. Now they ring me and keep me well informed." Despite these positive comments we found shortfalls in the care planning systems. Care plans were not all up to date and had not been updated as changes occurred. Care plan documentation was stored on the home's computer system. This included information about people's medical needs, support needs and ability to give consent. The records contained information and guidance about people's routines, and the support they required to meet their individual needs. Within care plans about the provision of personal care, there was emphasis on ensuring that people were given choice and that their dignity was maintained. Most people had care plans and risk assessments in relation to their mobility. However, as the care plans were not up to date or accurate staff would not have been able to rely on the information contained to meet people's needs. The registered manager told us there were systems to ensure care plans were evaluated by senior care staff on a monthly basis. We were told if an evaluation was overdue, for example, if the staff member was on leave, this prompted signals on the computer so that the manager would be aware and the task reallocated. Whilst evaluations may have been completed they did not always trigger an update to individual care plans. One person's care plan whose needs were assessed as high had last been updated in March 2017 and their personal care, care plan February 2017. This person's care needs had changed within this time. For example, it stated to suggest to the person they clean their teeth but this person would have needed staff support with this task. Information regarding diet and nutrition was not up to date and misleading. It referred to monitoring the person's weight but this had not been done. This person received a pureed diet but this was not recorded. This could mean that the person received support that was not in line with their needs.

A health professional told us, "We give advice regarding the management of behaviours but don't always check the care plans to see how it's written and followed through." One person's care plan had been updated recently but some areas, for example, the mental health/behaviour care plan was last updated in March 2017 and did not provide enough information to enable staff to provide person centred support if the person showed behaviours that challenged. Staff recorded daily records that stated how people had been, what they had done and any support they had provided.

One person needed physical support with a particular health condition. There was no care plan for this condition that described how to actually provide physical support and how to reduce the risk of infection. However, there was a care plan regarding pain associated with the condition; a night care plan that made reference to the need to check the person and a risk assessment that advised staff to be aware of signs of infection and to report any changes. The information provided was basic and the deputy manager confirmed that they or none of the staff team had received any training in this area. Records were not consistent in demonstrating the person's wound site was monitored regularly. When bleeding was noted there was no record about how much blood and no record that the wound site or skin integrity had been checked following this. A lack of clear documentation giving advice and support to staff on how to meet this person's individual needs had the potential to leave this person at risk of harm.

On 12 May 2017 one person's care plan had been completely updated. The deputy manager told us this was the standard they were hoping to achieve with all care plans. However, there were still shortfalls in the care plan. For example the person was prone to a particular health problem. There was no care plan related to this. There was no information about how likely this was to be a problem and what action staff should take either to prevent this or to deal with if this happened. This left the potential for staff missing signs that the person's health needs were changing.

The registered manager told us that between the two inspection days staff had been supported to complete a number of evaluations and to update a number of care plans. However, this action had been taken as a result of our visit and had not been completed in line with the provider's action plan. The areas above are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a monthly activity programme. This showed a wide variety of activities were provided within the home. During our inspection we saw a mixture of group activities and time spent on a one to one with people. The activity coordinator told us they tried to tailor activities to people's particular skills or favourite things. A visitor told us their relative had followed a particular profession until recent years. They said now staff, "Sit with and go through (the person's) photo albums and memories are recalled." A staff member told us they had taken four people for fish and chips on the seafront the day before our inspection and this had been a very enjoyable experience. Another trip had been to a garden centre to buy tomato seeds.

A visitor told us, their relative, "Likes the flower arranging on Fridays." Other favourites were organists, Elvis, music bingo and animal bingo but the activity coordinator told us, "A great success has been aqua painting. It is like magic painting which can be used many times." The Elvis impersonator performed on one of our inspection days and this session was enjoyed by all. People were encouraged to engage and dance along to the music.

There was a complaints policy which was displayed so that visitors were clear about how they could raise concerns should they wish to. We were told that no complaints had been received since our last inspection. The registered manager told us visitors and relatives continued to have opportunities to speak with them as soon as they arrived at the home and this way any minor concerns were addressed before they escalated. For example, one person's new jumper had been ruined in the wash and the home repaid the cost of the jumper to the relative.

Inadequate

Is the service well-led?

Our findings

At our last three inspections in 2014, 2015 and 2016 the provider was in breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following the inspection in November 2015 warning notices were issued that required the provider to be compliant with Regulation 17 by February 2016. We inspected in September 2016 and found the provider was still not meeting the requirements of this Regulation. Following our inspection the provider sent us an action plan that showed how they would meet the Regulations. Updated actions plans were sent to us in February and April 2017. At this inspection we found the provider was still in breach of this Regulation.

A health professional told us, "The home is very good, professional, caring and well led. They always ring if they have any concerns and engage well with me. They take some people that are difficult to manage and respond well to their needs. I've never seen anything that has concerned me at all." A visitor told us, "The owners hold a lovely barbecue and buffet for all residents and families in the summer. Visitors are made welcome." Despite these positive comments we found that the home was not always well led.

There was a registered manager in post. At our last inspection there was a lack of oversight and leadership in the home. Since then a representative from East Sussex County Council's quality monitoring team (QMT) visited the home on a regular basis to provide guidance and support to the registered manager. They told us, "Although work is undertaken to make improvements this has been a slow process." In the two weeks before our inspection the Head of Care had been promoted to deputy manager so instead of one day office time each week they were now office based. The registered manager confirmed that the providers visited the home regularly and checked on the running of the home. They also told us that since the last inspection they had introduced additional audits to monitor the care provided. Staff told us they felt supported. One staff member said, "We have staff now that really want to work here. Our care is now really person centred and the manager is supportive." Despite these positive comments we found that although some progress had been made, this had not been sustained and the quality assurance processes were not robust or effective in ensuring that shortfalls identified were addressed in a timely matter.

Systems for ensuring care plans were up to date, accurate and regularly audited were inadequate. There was no system for auditing care plans at our last inspection. The provider's action plan and updates to this told us that care plans were monitored. In April 2017 they said, 'Completion of audits been checked to ensure that service users are receiving appropriate care.' The QMT identified concerns about a lack of detail in care plans two weeks before our inspection. The registered manager told us that audits of care plans had not been carried out as care plans were, "Work in progress." Senior staff continued to write monthly evaluations of the care plans and had been asked to update the care plans to include information from the monthly evaluations. The deputy manager told us that one care plan had been completely updated since the QMT report was received and this was used as a template to set the standard for other care plans. Between the two days of our inspection staff had carried out additional work to update areas of care plans. Care plans that do not include up to date, accurate information leave the potential for people to receive inappropriate care and treatment and at risk of harm.

A medicines audit was carried out on 16 February 2017 and received by the registered manager on 6 March 2017. Shortfalls included to write clearly on the MAR, photographs were needed for some people and that a check should be made at the end of each shift to monitor medicine refusals. We found five people did not have photographs on the MAR. There was a daily MAR check list that had been completed up until 19 April 2017. This had included a check on PRN medicines and if the reasons for giving these had been recorded. A check had been made to see if there were any gaps, refusals and if running totals were correct. During our inspection we found medicine for one person in the refused medicines box that had been signed as having been given. We found that explanations for the giving of one person's PRN medicine were not always recorded to the back of the MAR chart. Medicines audits had not identified shortfalls we identified in relation to the lack of record keeping related to topical creams. Although progress in this area had been made initially, this had not been sustained and the systems had therefore not been embedded into everyday practice. This left people at risk of harm.

A nutrition audit was carried out 31March 2017. This included a check on peoples' weight to see if people had lost or gained weight. There was information about specialist diets and advice about what to do if people refused meals. Advice for one person was to await recommendations from the dietician and to continue to weigh the person weekly. There were no records to show that any check had been made since the audit to check if the person's weight had remained stable. Another person's diet and nutrition care plan stated they had a varied diet and had plenty of fluids daily. There was no reference to advice the dietician had given to provide milky drinks and smoothies. During the inspection, this person's main meal was served pureed. However, there was no reference in the nutrition care plan to this or to the person having any difficulty swallowing.

As part of their role the provider expected the registered manager to send monthly updates on the running of the home. These had not been completed in a timely manner and information provided was basic. For example, it stated meetings had been held but not the outcome, QMT had visited but there was no information about the outcome, actions taken, or to be taken as a result. Due to delays in receiving the reports from the manager, this meant that the provider did not receive a timely update on matters.

Organisational quality assurance systems were in place, however they remained ineffective. The provider's action plan stated the areas that the registered manager needed to address. The registered manager had no plan or monitoring tool that reflected the actual progress made to date and still to be made in each area. Such a plan would give confidence that the registered manager and provider had a clear understanding of the tasks that needed to be completed to ensure the delivery of safe, effective and responsive care. For example, a clear audit of care plans would have established what areas of each care plan were inaccurate and misleading and from there staff would know which areas to update as a matter of priority. The QMT told us that they had, "Advised the Manager that to write an action plan and use this to monitor the progress in the home. This has never been written."

Record keeping related to MCA and DoLS was ineffective. The provider's action plan for compliance in this area was dated January 2017. The April updated plan stated, 'There is better understanding of MCA and DoLS amongst the management and necessary changes are being implemented on CMS (the home's computer) to record.' Each person had a DoLS care plan. However, this was a generic document and was not person centred. The care plans referred to the use of 'curtain chairs,' there were none in the home. (Kirton chairs have a tilt-in-space facility. Some people would not be able to move from these easily without staff support and if this was the case they could be seen as a form of restraint). Plans also referred to using a 'strap' on chairs to prevent falling and to people who were mobile, being strapped in a wheelchair. The care plans were inappropriate and did not reflect people's individual needs. The deputy manager told us that in the past week they had asked staff to stop generating these care plans. By the second day of our inspection

the deputy manager told us that the provider was working on designing a more appropriate care plan for DoLS. It remains a concern that the provider, registered manager or staff had not assessed that these records were inappropriate until a week before our inspection and that the care plans were still showing on the system on the first day of our inspection.

The provider did not have effective systems in place to asses, monitor and improve the quality of the service being provided to people. The issues above are a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the last inspection a number of positive changes had been implemented and it was clear that some improvements had been made. There were systems to seek the views of relatives of people living at Castlemaine. A relatives survey report carried out in February 2017 showed that 10 out of 15 people's relatives responded. Positive comments included, 'I am very happy with the care my mum receives' and 'The management always keep me up to date with mum. The staff are very kind and I wholly trust my mum into their care. They always let me know if she requires anything.' Another comment included, 'I am very happy with the care my mum receives. The food is wonderful and varied.' A suggestion for change related to increasing the number of toilets available on the ground floor. The provider's response was, 'This will be considered in the future by the management and will undertake feasibility and possible solution when time is right.'

There were effective systems for the monitoring of health and safety. Records were up to date and showed regular monitoring of the systems and procedures were carried out. Maintenance meetings were held in February and March 2017. Actions that required attention were listed in the maintenance book and most had been completed.

Residents' meetings were held two monthly. Records showed that a range of matters were discussed and that people were encouraged to make suggestions. People suggested outings for example fish and chips. Four people had been taken for fish and chips the day before our inspection. People made suggestions about the food served and were updated on matters such as staff, housekeeping and activities. A relatives meeting had been held in March 2017 but only two relatives attended. Relatives were updated on developments in the home and an explanation had been given to them of all income generated and spent on activities. A further meeting had been planned to be held in June 2017. Staff meetings and senior care staff meetings were held regularly. It was noted that care plans were discussed and seniors were asked to ensure that care plans were updated as and when evaluation of care plans were carried out.

The deputy manager referred to the staff team as, "Much more positive and solid. They are reliable and working as a team." They said senior staff had lacked motivation but with firmer boundaries and clear guidance things were running well.