Clarence Lodge (Great Yarmouth) Limited

Clarence Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 2 and 4 October 2018 and was unannounced.

At our last inspection on 14 and16 February 2018 we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found one breach of registration regulations.

Following the last inspection, we took enforcement action to impose conditions on the providers registration. These conditions mean the provider has to inform us of actions which have or are being taken to mitigate identified risks. We also met with the provider and registered manager to discuss our expectations going forward.

At this inspection on 2 and 4 October 2018, we found that although some improvements had been made, the service remains in breach of four regulations in relation to safe care and treatment, staffing, governance, and person centred care. We also found a new breach in relation to nutritional and hydration needs. The service had informed us of serious injuries which had occurred in the service, and is therefore no longer in breach of this associated registration regulation.

Clarence Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Clarence Lodge accommodates 28 people in one adapted building. At the time of our inspection there were 16 people using the service.

There was not a registered manager in post. The previous registered manager had left the service in July 2018. 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. An acting manager had been appointed in the service, though they were not registered with the CQC.

Some new auditing processes had been implemented. However, these had failed to identify all of the concerns that we found during this inspection. People's health and safety were at risk because the provider had failed to identify where safety was being compromised in the environment.

Risks in relation to falls, malnutrition, and pressure area care were not being adequately reviewed or monitored to ensure people were cared for in a safe way. There was not always accurate guidance in place for staff about how to manage or reduce risk.

Staff knew how to recognise abuse or potential abuse and how to respond and report these concerns

appropriately. However, the acting manager had not reported an incident to the local authority safeguarding team which should have been.

Medicine administration was not always observed as safe. Stock levels were not always accurately recorded to determine if people had received their medicines as prescribed.

The re-organisation of care plans meant that people's health needs were included in some care plans, and subsequent input from health professionals. However, further work was needed in this area to ensure records were accurate and person-centred. Records were not always completed consistently.

End of life care plans were not in place. Staff had still not received training in this area.

Food and fluid charts were not always completed fully or totalled to ensure people were receiving adequate nutrition and hydration. Feedback from people and relatives indicated that the quality of the food provided had not improved.

The acting manager and staff were not receiving regular supervision, and some staff had not received training updates. The acting manager had started to introduce observed practice of staff, however, their time was limited due to other on-going priorities.

The previous registered manager had applied for Deprivation of Liberty Safeguards when people who lacked capacity to consent, had their liberty restricted. However, care plans did not include information on how any restrictions would be managed. Some people had not signed to consent to their care where assessed as being able to do so.

The dining experience was not conducive to an enjoyable mealtime and opportunity for social interactions; the recommendation we made at the last inspection had not been followed.

We saw that staff were kind and caring when supporting people, however, staffing levels were not sufficient to ensure people's safety at all times. Staff were not always able to be responsive to people's needs.

There was a complaints procedure in place, however, the log of complaints did not always include outcomes, and actions taken in response to complaints. We were therefore not able to ascertain if complaints had been dealt with effectively.

Safe recruitment procedures were in place, and staff had undergone recruitment checks before they started work to ensure they were suitable for the role. We did however find in one case that a full employment history had not been completed.

The provision of activity was still not sufficient to meet individual and specialist needs.

The provider had begun to consider how to maximise the suitability of the premises for the benefit of people living with dementia, though more work was necessary. Some carpets and chairs had been replaced, and a 'quiet room' was now available if people did not want to sit in the main lounge area.

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

improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks associated with people's care were not always monitored or reviewed in line with their assessed level of need.

Staffing levels were not sufficient to ensure that they were meeting people's needs.

Medicine administration was not always safe. Stock levels were not accurately recorded to determine if people had received their medicines.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not received training in all areas relevant to their role, such as end of life care and dementia. Staff were not receiving regular supervision and appraisal.

Recording of food and fluids was not always accurate to ensure people received adequate nutrition.

Deprivation of Liberty Safeguards had been applied for when people who lacked capacity to consent had their liberty restricted. However, people had not always signed to consent to their care, and the service was not following the principles of the MCA 2005.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some practices did not reflect a dignified approach to the delivery of care.

Feedback from people indicated that the staff approach could vary.

There were no restrictions on visiting times, ensuring people could spend time with their relatives when they wanted to.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The provision of activity was not meeting people's individual and specialist needs.

Care plans were being reviewed and included additional information on people's health needs. However, more work was needed to ensure these were accurate and contained clear guidance for staff.

There was a complaints procedure in place, however, details of complaints were not always logged to determine outcomes.

Is the service well-led?

Inadequate

The service was not well-led.

The service has a poor inspection history and the provider had failed to adhere to their regulatory responsibilities and ensure compliance with the fundamental standards and regulations.

Quality assurance systems were not effective in identifying the concerns we found during this inspection.

The acting manager was not receiving the appropriate level of support to ensure improvements were made and sustained.

Clarence Lodge

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 2 and 4 October 2018 and was unannounced. The inspection team consisted of one inspector, an inspection manager and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of our inspection planning we reviewed all the information we held about the service. This included previous inspection reports and any notifications sent to us by the service including safeguarding incidents or serious injuries. This helped us determine if there were any particular areas to look at during the inspection. We spoke with the local authority safeguarding and quality team prior to the inspection.

At the time of inspection there were 16 people living at the service. To help us assess how people's care needs were being met we reviewed seven people's care records and other information, including risk assessments and medicines records. We reviewed two staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

During the inspection we spoke with five people who lived at the service, and two relatives, the acting manager and registered provider, and four members of care and catering staff.

Inadequate

Is the service safe?

Our findings

At our previous inspection in February 2018, we rated this key question as 'inadequate' This was because the provider had failed to sustain improvements in relation to the cleanliness of the service, and we found that risks had not been accurately recorded or monitored, which placed people at risk of harm. We concluded that risks associated with people's care and support were not safely managed, and the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this October 2018 inspection, we found that although some improvements had been made, some risks were still not being adequately assessed and updated in a timely manner. This key question therefore remains 'inadequate'.

People's care records contained risk assessments covering areas such as moving and handling, falls, malnutrition, dehydration, and risks relating to the development of pressure ulcers. However, we found that in some cases risks had not been monitored appropriately.

For example, one person's care plan stated in July 2018, that they required weekly weights. However, these had only been completed every two to three weeks. The same person had been assessed as being at high risk of developing pressure ulcers and their care plan stated that they were to receive support with re-positioning every four hours. However, the repositioning charts could not be found for us to determine if this was being carried out, and they already had a pressure ulcer. The person was also experiencing periods of distress which resulted in behaviours which challenged staff and others living in the service. Behaviour charts showed that some behaviours could potentially escalate and there was a risk of harm to others. However, there was no risk assessment in place so staff knew how to support the person and de-escalate situations.

Another person's care plan said in order to reduce the risk of developing pressure ulcers 'turns' should be carried out over one, two or four hourly periods, depending how quickly skin breaks down. The care plan did not specify the timeframe which the person should be repositioned. No re-positioning charts could be produced. The person was assessed in August 2018 as 'high risk' of developing pressure ulcers. This assessment should have been undertaken on a monthly basis, but had not been reassessed since.

Other risks such as falls were not always detailed fully. We found that one plan stated that the person should have regular checks, but did not specify how regular these should be during the day and at night. Another stated that they had a pressure mat in place (which alerts staff if the person falls) and that regular checks should be made. Again this made no reference to how often checks should take place, and where the pressure mat should be placed during the day and at night. The person had a history of falls, and therefore this information was even more important so staff had clear guidance.

One mobility plan which had been completed in April 2018, said the person should be moved using a hoist, and could be transferred to a wheelchair if they chose to. A note was added by a nurse who had visited in July 2018, stating that the person was now confined to bed. The risk assessment had not been updated to

reflect this. This meant the incorrect guidance was in place, which placed the person and staff at risk of harm were they to move the person using the hoist.

People had choking care plans in place, but these were not always sufficiently detailed. For example, to help prevent choking, one care plan said to ensure the person was seated correctly before eating, but not what this meant and how specifically the person should be positioned. There were no specific choking risk assessments in place. However, the manager showed us that they had obtained these and planned to implement them as a priority.

At our previous inspection in February 2018, we found environmental risks that could pose a risk to people's safety or welfare. At this inspection we found further risks which had not been addressed. For example, there was an unsecured store room on the first floor which people could mistakenly access, and potentially come to harm as there were trip hazards, such as a hoover, and boxed items. Empty rooms had not been secured to prevent people wandering in and potentially coming to harm without staff being aware.

We found some wardrobes in people's rooms were not secured to the walls, which posed an accident and injury risk. We also found a radiator in one room had not been covered, which could present a risk of burns, if a person was to lean or fall against it. We also found a set of stairs on the first floor which people could access and potentially fall down as they were not secured. In one person's room we found a door within the room which was not secured, and which contained the fuse box and wooden squares of wood which could splinter. The laundry room was not locked and contained the main boiler which was hot to the touch. People could walk in, and potentially burn themselves if they came into contact with the boiler.

We found one window restrictor was broken, and potentially two others which had been listed on the health and safety report as needing to be fixed. If windows are not secured appropriately it puts people at risk of a fall from height. The provider could not confirm if these had been fixed. We asked them to review this as a priority.

Some people living in the service required a hoist to be moved safely, and we saw these had been serviced periodically to ensure they were safe to use. We were told by the acting manager that hoist slings had not been serviced by an accredited LOLER (Lifting Operations and Lifting Equipment Regulations) company, but staff did visual checks to ensure they were safe for use. We advised that these should be properly serviced and the acting manager told us this would be completed.

Systems were in place to reduce the risk of legionella in the water systems. One of the ways to reduce the risk of legionella is the effective control of hot and cold water temperatures. At the time of our visit we saw that hot and cold water temperatures were being checked, however we found that some readings for hot water were too high which could pose a risk of scalding. Some rooms were empty but they had not been locked, so people could potentially use the hot water. Additionally if there are outlets which are not used frequently they should be flushed regularly to reduce the risk of legionella. The acting manager told us that the domestic staff were flushing little used outlets, however, there was no documentation to evidence this was being done routinely. The acting manager informed us they would ensure this was documented.

At our previous inspection in February 2018, we found that cleaning audits were not effective and did not fully describe what had been cleaned. At this inspection we found some improvements had been made to the documentation staff were using, and this included hand hygiene and kitchen cleaning audits. However, we still found that some areas of the service were visibly unclean. For example, we found the kitchen fridge shelving was dirty and the seal was stained, one hoist had footplates which contained debris, and some armchairs had crumbs underneath the seating. The service were waiting for environmental health to re-visit,

following a visit from them in January 2018, where they received a food hygiene rating of 3, showing that hygiene standards were generally satisfactory.

We looked at the management of medicines within the home and associated records. Records for oral medicines were in place with instructions for staff on how they should be administered. However, these records were not always accurate and kept up to date. In one person's records we found that medicines listed on their patient information record did not match medicines recorded on the Medication Administration record (MAR). This could lead to errors occurring.

We also found that for some people who regularly refused their medicines there was no record of a referral to the prescriber for advice.
We carried out an audit of medicines held in stock and found that there were some discrepancies which meant people may not have received their medicines as prescribed. This included people with short term courses of antibiotics for acute conditions.

We observed a member of staff administering medicines leaving them on the table in front of them. They then walked away to attend to another person without observing the medicines being taken. In the person's medication risk assessment, it stated that the person liked to have medication placed in their hand and needed to be observed taking it as they were at risk of not taking and storing their medicines.

Later in the afternoon we saw a second incident when medicines were given but not observed by staff being taken. This practice placed people at risk of harm. We spoke with the member of staff administering medicines. They confirmed that they had tried to give the person their medicines earlier in the day but that they had refused so they put the medicines in their pocket to try again later. When we checked the MAR chart for the person, the medicines had been signed as administered at an earlier time which was inaccurate. This is also unsafe practice.

Medicines audits were being completed on MAR's but we found these were not always accurate. We spoke with the member of staff responsible for monitoring medicines; They told us that they had recently been given a monthly audit tool but it had not yet been implemented.

We concluded that risks associated with people's care and support were not safely managed, and this was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had completed an internal fire risk assessment. The fire risk assessment completed in August 2018 identified two areas requiring attention. The registered provider told us these had been rectified, but they had not signed them off on the sheet. Due to the complex layout of the building, we contacted the local fire service and requested they visited the premises to carry out a full risk assessment as this had not been completed since 2015.

At our previous inspection in February 2018, we found the provider was in breach of regulation 18. This was because staffing levels were not always sufficient to meet both the routine and emergency work of the service. We looked at the staffing arrangements in place and found this was still not meeting people's individual and specialist needs.

We asked people their views on the staffing levels. One person told us,"If you press the bell you will normally have to wait a while, it could be twenty to thirty minutes. They [carers] often sit in there [dining area next to lounge] so they can hear us. Sometimes two or three of them are at a table and they'll say, 'we're eating at

the moment, you'll have to wait'. It depends on what you need but it can be very uncomfortable, sometimes painful." Another said, "I think there probably are [enough staff] but I don't think they use their time wisely or efficiently. Sometimes they seem to sit in the dining room chatting, I'm not sure a lot of work gets done." These comments were reflective of our observations.

A staff member told us, "We only have 16 [residents] now so staffing levels should be ok, but they aren't. This is because we have to cover the kitchen on the late shift, and we have five people who need double assist [two staff to attend to care needs]. The provider cut the staffing when the resident numbers dropped. One staff member finishes at 8pm, which leaves only three staff on shift for two hours. We wouldn't cope if an emergency happened." Another said, "There isn't enough staff, there was another staff member on until 5pm, and three on the late shift, but the numbers have dropped."

The provider showed us a staffing dependency tool which they had completed in August 2018. However, they had not recognised the experience for people using the service, or that the current staffing levels did not enable staff to meet people's specialist needs. For example, we observed that some people who were living with dementia required more time and interaction from staff. One person told us,"I'm not concerned for myself; I'd like it so that the ones like [name of person] had more attention. I think if someone spent more time with [name of person] they wouldn't keep trying to get out."

The provider had not considered other means of establishing if staffing levels were sufficient, such as asking people their views, or speaking with staff, which we highlighted in the last inspection report.

The provider remains in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received safeguarding training. Staff told us the types of abuse they might come across in their work. One staff member told us, "We can come across all sorts of abuse; physical, financial, and psychological. I would report to a senior, CQC, or I would contact social services. The contact number is on the wall." However, we found that one safeguarding concern had not been reported to the local authority and should have been. We discussed this with the acting manager who said they would contact them to discuss the situation as a priority.

Staff were recruited safely; checks had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. We did however find in one case that a full employment history was not completed. We brought this to the attention of the acting manager.

The service needed to develop their practice further to ensure that lessons were learned and improvements made promptly when things had gone wrong. For example, following our previous inspection, we found the provider was again in breach of regulations. They had however, been working closely with the local authority quality team to help them drive improvement and with their support had implemented an improvement plan. This plan linked to the areas we found as requiring improvement following the last inspection. However, some areas were noted as completed and up to date, such as moving and handling risk assessments. We found this was not always the case.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in February 2018, we rated this key question as 'requires improvement'. This was because people's care needs were not always holistically assessed to ensure care and treatment was delivered to achieve effective outcomes. We also found that staff training and supervision was not being completed at intervals to ensure staff had the necessary skills. At this inspection in October 2018, we found further improvement was needed, and have therefore continued to rate this key question as 'requires improvement'.

We checked the arrangements for staff training and supervision, and found that some additional staff training had been completed such as fire training, moving and handling, safeguarding and pressure ulcer care since the last inspection. However, the training matrix had not been updated in all areas so it was unclear which staff were due to complete specific training. The acting manager told us that they had intended to update the matrix but had not had time to go through training certificates to determine which staff required refresher training. Following the inspection they sent us an updated matrix showing a much clearer assessment of staff training requirements. However, staff had not received training in all areas relevant to their role, such as end of life care, and several staff were overdue training in dementia care. Completion of end of life care training was an area of concern identified at the last inspection.

Staff were still not receiving regular supervision. The manager of the service had only received one supervision in January 2018, and had received none since they had taken over as acting manager in July 2018. The majority of staff had also not received supervisions since January 2018. One staff member said, "My last supervision was three or four years ago." Another said, "I haven't had supervision recently, but I think we [staff] will now [acting manager] has taken over."

The acting manager told us that supervisions should be carried out every two to three months. Staff should receive appropriate support, training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

All of the above constitutes a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people if they thought staff were well trained. One person said, "I think since the change of manager, they're [staff] all getting more training so probably, at the moment, they need more." And, "More training in the way they do medicines here and just the way they look after us in general."

Since the last inspection, the manager had completed, 'train the trainer' moving and handling training, which meant they could assess staff competency in this area. They had also started carrying out observations on two staff working in the service. This included assessing whether staff were competent to carry out tasks such as supporting people with personal care, and assisting people to mobilise. The manager told us that the plan was if areas for improvement were identified, this would be discussed in future supervision sessions. They had completed two staff supervisions which they showed us. Where

training needs had been identified there was no date noted as to when this should be completed by. The supervision discussion did not include staff well-being or service changes, which we felt was relevant going forward. The manager told us they would incorporate this in to future supervisions.

People's care plans included their nutrition and fluid needs. These plans outlined people's preferences in terms of food likes and dislikes, and how calorie intake should be increased. One person's care plan said they should be offered snacks between meals. However, when we checked their food charts we did not see that these were consistently offered to the person, as many areas of the forms were blank. We were therefore not assured that snacks were being offered in line with their assessed needs. Additionally, we saw that the person had lost weight, it was therefore even more important to ensure that that staff recorded this accurately.

At our last inspection we made a recommendation that the service explores current guidance to ensure that mealtime experiences were an opportunity to support and promote independence, in addition to creating a positive mealtime experience, particularly for those with specialist needs including dementia. We found this advice had not been followed. The lunchtime experience for people had not improved and was reflective of our observations at the last inspection.

We asked people about the food provided in the service. One person told us, "I wouldn't exactly describe the food as exciting; more like it's usually ok." Another said, "It's alright, I don't mind it and we do get a choice." During lunch we saw a staff member ask a person if they were enjoying their lunch. The person said, "There's a lot here today, are you trying to fatten me up or something?" A visitor told us, "This isn't normal you know, there's more food today, they normally get one scoop of ice cream, not three."

Another person when asked if they were enjoying their meal said, "No, I don't really like it, it's not very nice, it's cold in some places and hot in others, I don't think I can eat it." The staff member said, "Alright, well you've had some, I'll clear it away. Would you like some pudding?" The person agreed and a short while later a different staff member brought a bowl of pudding. After the person had eaten it, the first staff member came back with a plate of food, and explained that they thought the person might like the pie. The person looked confused and said, "I've had pudding." The staff member said, "Never mind, do you want it? You can have it anyway."

At our last inspection in February 2018, we received feedback about the standard of food being poor, and how some relatives were bringing in additional supplies for their relatives. We found at this inspection that the same concerns had been raised, and that the quality of the food had not improved.

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

Near the end of lunch and whilst some people were still eating, one staff member came into the lounge and started to wipe down the tables with an anti-bacterial spray. They worked their way around the room, quickly wiping each table down; if people had not finished, they lifted the plate out of the way so they could clean it.

Our observations of lunch time were that the overall experience was not effective in ensuring people enjoyed their dining experience and that opportunities were taken to promote independence, choice and social interaction. Where people were assisted to eat by staff there was little interaction or care taken to encourage people, or discuss the food they were eating. Most people avoided the dining area and chose to eat in the lounge. This was due to one person who could at times upset other people by the language they

used. No thought had been given to the impact on the majority of other people who then had to eat in the lounge.

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 decision made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty.

We checked whether the service was working within the principles of the MCA, and found that this still needed to be improved. We found that people had not always consented to their care. Where a person was assessed to be able to consent to their own care, we found one care plan consent form had not been signed and this included consent to the use of bed rails and having photographs taken.

One person who was assessed as lacking capacity was refusing to take their medicines at times. There was no assessment of the persons capacity to understand the risks of not taking their medicines. Nor was there any record of consultation with a GP or other relevant persons regarding whether it was in the person's best interests to have their medicines administered in another way.

For another person also lacking capacity and refusing their medicines on occasions, we found a best interests record. However, it was not clear what decision had been made in the person's best interests or who had been consulted. We spoke with the deputy manager who told us that there should a care plan in place setting out how the person should be supported at times when they refused their medicines but the deputy manager was unable to locate this.

Where people had DoLS applications awaiting authorisation, there was no reference to this in people's care plans so staff knew how people's liberty was being restricted, and how to support people with this aspect of their care.

One DoLS application had been authorised, and conditions were in place. The acting manager confirmed these conditions were being met currently. At the time of inspection there was no care plan around the DoLS and associated conditions. Following the insepection the acting manager sent us a care plan relating to this, which clearly described how the conditions were to be met and who would support this. This ensured staff supporting the person were aware of their needs and how they would be met.

The service worked together with other organisations. This included the local authority quality assurance team, GP's and nurse practitioners. However, It was not clear in people's records that timely intervention was taken when people became unwell. We found that one person had a condition which they had previously been prescribed some topical cream for. Their records showed that the condition had worsened but there was no evidence that advice had been sought from a GP since April 2018.

At our last inspection we made a recommendation that the service explored current guidance to further improve the design and decoration of the service, and consider best practice for people living with dementia. Some thought had been given to this, however, further work was needed to ensure the

environment meets the specialist needs of people using the service.

A room at the back of the building which was previously used as a store room, had been made into a second lounge area where people could sit quietly and read or watch an alternative television programme from the one being watched in the main lounge. There were new armchairs, a single overchair table and a small nest of tables. There was a television and disc player. The room was a little sparse, but the acting manager told us they intended to add additional items to it to make it feel more homely.

The provider had replaced some carpets in the building, and some armchairs. The environment still looked in need of redecoration in some areas. We found that the chairs in the lounge were arranged around the edge of the wall instead of considering whether small clusters might be better and encourage conversation. There was a lack of age appropriate points of interest for example photographs or artworks of a size that could easily be seen, along the corridors. We did however see that the improvement plan included improving signage so peole could navigate around the service independently, and to continue to consider dementia friendly options.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in February 2018, we rated this key question as 'requires improvement'. This was because staff did not always treat people in a respectful way or promote their dignity. During this inspection we found some aspects of people's dignity were still not fully upheld, and the feedback from people living in the service indicated the staff approach could vary.

One person told us, "Some [carers] are good but others are not all that caring. I think we have to wait to go to the toilet because they [carers] don't want to do that bit of the job. Perhaps they should find another job, I think they just see it as a way of earning money but they don't want to do the work." Another said, "I think for some it's just a job and they don't put a great deal of effort in." A third told us, "Most of them are alright, I think they have quite a difficult job, I wouldn't want to do it."

We noted there were no call bells in the main lounge area where people spent most of the day, and we asked people how they got the staff's attention if they required support. One person told us, "We have to shout, there's no other way. So if I need the toilet I just have to shout out what I need." This did not reflect a dignified or safe approach to the delivery of care.

The service continued to have resident meetings which gave people an opportunity to give their views. The minutes form a meeting held in September 2018 discussed new 'key worker' roles, Halloween and Christmas events. However, the minutes were not at all detailed to see what people had said and if they had any particular views.

We observed that not all staff tried to engage with people. For example, talking to them about their meal, or otherwise trying to encourage them. We saw one staff member assisting a person with their lunch. They picked up the spoon, stirred the food around, sometimes chopping up larger pieces before putting a pile of the mixed up food onto the spoon. They did not interact with the person. Once they had done this they moved away.

In the lounge area, after lunch, we observed another member of staff sitting completing their notes. There was no interaction or engagement with people. One person was becoming agitated and started to shout at other people sitting close to them. The member of staff continued to complete their notes and just shouted across the room telling the person to stop. It was only when the person became extremely agitated and vocal that the staff member got up to attend to them.

In one persons care records we saw a care plan entitled 'personality'. It stated that the person liked to look nice and wear jewellery and make up. We observed this person during the inspection, they were not wearing make up or jewellery and they appeared generally unkempt. This did not demonstrate that people were supported to maintain their dignity in line with their preferences or that staff recognised this as important.

People's preferences in how they liked their care delivered were recorded in their care plans. This included areas of care people could attend to independently. We did not always see that people had signed their care

plans to show their opinions had been sought, but some of the detail contained in the plans, indicated people had been asked questions about how they liked their care delivered. The staff we spoke with knew the people they were supporting well and were able to describe their routines, however, due to time pressures, this was not always possible for staff to deliver. People's religious and cultural needs were recorded in their care plans. The care plan documented if the person had any needs on a religious or cultural ground.

Staff members told us that they ensured that people's privacy was respected. We saw staff members knock on doors and gain permission to enter. One staff member we spoke with said that they always go to the office to discuss any confidential information to ensure others do not hear it. Another staff member said they were discreet when supporting someone with personal care, for example, covering them with a towel, ensuring bathroom doors were closed.

Some people had personalised their rooms with items that were important to them. One person told us, "I really like my room, it's just the way I want it. Did you see all my photos? I've got lots on the wall and it makes me feel good, I like my room."

There were no restrictions on visiting and families were welcome. One relative said, "I come and go when I please, I come in regularly to see my relative here."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in February 2018, we rated this key question as 'requires improvement'. This was because care records were not updated when people's needs changed, and did not cover all areas of need. At this inspection, in October 2018, we found although some improvements had been made, discrepancies in details held in records remained, and areas for improvement were still needed. We continue to rate this key question as 'requires improvement'.

The re-organisation of care records meant that it was possible to case track people's input from health professionals. The acting manager had implemented a 'medical action review sheet' which logged input from health professionals so it was clearer when action had been taken by staff to seek advice about people's health needs. However, these records were not completed consistently. For example, in one person's medical action review sheet we saw reference to them having a high temperature. Contact had been made with the GP and they advised that the person needed to continue taking an antibiotic usually prescribed for a urinary tract infection (UTI). There was no record of any previous contact with the GP relating to a UTI or the prescribing of antibiotics.

The acting manager had implemented a new care plan format, and was trying to update one care plan per week, as time allowed. Therefore not all care plans were in the new format. For the new format care plans we could see that people's health needs were now included. For example, a care plan for specific conditions such as neurological disorders, diabetes, and high blood pressure. These included details on what the condition was and symptoms to look out for. However, we found that whilst care plans listed generic symptoms of particular conditions, they were not necessarily symptoms the person was experiencing. Whilst it is useful for staff to know what might occur in particular conditions, it would be clearer to be specific about symptoms the person is actually experiencing, and what action was needed to address these.

In the records for one person, there was a generic care plan for the management of their epilepsy. The plan lack any personalised information such as when the person last had a seizure, triggers for a seizure or how the person could present if they were about to experience a seizure.

For another person, their care plan for a neurological condition stated in the action plan that there should be regular consultation with a GP and nurse, but it did not specify how frequently this should be completed. Another care plan for high blood pressure said that this should be monitored regularly, but did not specify how regularly and who should take the readings. It also said that the person should take regular exercise, but there was no further information about this and how the person would be supported to achieve this.

Following the inspection the acting manager sent us additional documentation they had produced to record blood pressure readings and blood glucose levels where needed in the management of diabetes.

In the health and physical fitness care plan for another person, we found that it was last reviewed in April 2018. However, in September 2018 there had been a change in their prescribed pain relief but the care plan had not been updated to show this change.

Some care plans held information about people's lives before they came to live at the service. This gave staff a greater understanding about the people they were supporting. However, care plans did not make reference to people's goals or aspirations they may have for the future and how these could be achieved.

Care plans were not always kept under review and updated when people's needs changed. In the records for one person we saw an update made in January 2018 which stated the person had a catheter fitted. There was no information about how this change in need should be met. The care plan was last reviewed in April 2018. We examined the daily notes for the person and found that they no longer had a catheter in place but the care plan had not been updated.

The service had not developed their practice in supporting people in relation to their end of life care. Planning ahead for when people may no longer be able to communicate their views regarding end of life wishes is sometimes called 'advance care planning'. This involves thinking and talking about how people choose to be cared for in the final months of their life. Staff had still not received end of life care training which would equip them with the skills and knowledge they require. The acting manager told us this was being arranged, however this was an area of concern identified at the last inspection.

People told us that staff could not always be responsive to their needs. "I've been here [number of years] and it has changed over that time. There always used to be someone on the floor [a carer in the main lounge] so if we needed help they were there. Now, quite often there isn't one they sit in there [dining room]." Another said, "Not enough [carers] around now, and that [person] wanders all day. They need staff to entertain them as they walk into other people's rooms you know." We also observed that staff were unable to give people the time and attention they needed outside of delivering care tasks.

Technology in the service needed to be improved to enhance people's diginity and ensure that care was responsive. For example, there were no call bells in the lounge area where most people spent the majority of their day. People therefore had to call out to staff to request help.

We asked people if there was enough to do and if they ever felt bored. One person said, "They get me up, they bring me down, and put me in the lounge, then later they take me back upstairs and put me to bed. That's it; there's nothing else. I would watch a little bit of television but I can't hear it from where I sit. I try to read the words [subtitles] but my eyesight isn't very good. What I enjoy is what we're doing, sitting and having a chat. I think in some places people come in to talk with the residents, I'd like that." Another said, "Oh, they have some woman come in with her dog, she stays for about two minutes. Well two minutes per person anyway." And a third said, "I'd like to go out, when the weather's nice. It'd be nice to have a change from this room." A relative told us, "I don't think a lot happens to be honest, there's a woman brings her dog in now and then and they have a singer come in at Christmas."

Our observations were that people spent most of their time in the main lounge with little stimulation or activity. The acting manager told us that staff go into the lounge at 11am and offer activity such as skittles or cards. We did not observe this taking place, and feedback from people indicated that the provision of activity was still not meeting their needs. For people living with dementia, we did not observe that their specialist needs were being met. One person constantly walked around the service looking for interaction and wasnt sure what to do. Though staff interacted as the person walked through the different parts of the service, staff did not have time to give them one to one attention or find out if they wanted to take part in a particular activity.

All of the above constitutes a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We asked people if they knew how to complain, and if they were comfortable in doing so. One person said, "Well, we complained about [person] coming into my room and they did fit a lock." A relative said, "There was an issue with the laundry, we do it ourselves now its just easier."

The provider had systems in place for managing complaints, however, we could not tell from the records at what stage of the service's complaints procedure the complaint was at. Documentation we saw from one complainant showed that they did not feel that their concerns were satisfactorily resolved, and had taken their on-going concerns to the local authority.

Providers must maintain a log of all complaints, outcomes, and actions taken in response to complaints. This had not been completed in all cases.

Inadequate

Is the service well-led?

Our findings

At the last inspection in February 2018, we rated this key question as 'inadequate'. This was because we found shortfalls in the service which indicated that the auditing and monitoring of the service had again failed to identify the issues we found during our inspection, and had not recognised where people were at risk of harm or where their health and wellbeing could be compromised. We found four breaches breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and one breach of Registration Regulations 2009 in relation to the notification of incidents. We rated this key question as 'inadequate'.

At this October 2018 inspection, we found that although some work had taken place to improve the identified risks, not enough progress had been made to ensure people were protected from the risk of harm. We also found four repeated breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and one new breach in in relation to nutritional and hydration needs.

We have continued to rate the service as 'inadequate' overall. This is the fourth consecutive inspection which has identified that the service needs to make improvements, which means we have not seen evidence of adequate leadership in place to ensure improvements are sustained. As a result we have rated this key question as 'inadequate'.

The registered manager had left the service in July 2018. An acting manager was appointed soon after this but had not registered with the CQC. They were supported by a deputy manager. The registered provider visited the service on a daily basis.

The acting manager told us that staff had been supportive of their new role and wanted to help them to make improvements. However staff told us they felt the acting manager was sometimes constrained in some of their ideas for improvement by the registered provider. One staff member said, "[Acting manager] is good, but over many years there has been a theme that certain ideas are blocked by [registered provider]. Another said, "[Registered provider] is lovely, but they don't always see the obvious things that would help. Such as more staff." One person told us, I like [acting manager] he has a similar sense of humour to me, unlike some of the others, he gets my jokes." We asked people if they would recommend the home. One person said, "I wouldn't, but then I couldn't recommend moving into any care home, it's not much fun." And a second told us, "Not if you can find a better one, no."

The deputy manager told us that they felt improvements had been made but they were aware that further improvements were needed. They said that they received good support from the acting manager and they had regular weekly planning meetings.

The acting manager had not received formal supervision since they started in their new post in July 2018. This was particularly important given the current rating of the service, to ensure they were clear on the priorities for improvement and that they had the relevant skills required. For example, we were not assured that the acting manager was aware of safeguarding procedures; there has been a recent allegation of theft

in the service, and they had not reported this to the local authority safeguarding team. Formal supervision would address areas where further training was required.

The registered provider was carrying out health and safety checks of the building and did regular walks around the building to check for any issues. The September 2018 health and safety audit stated that two window restrictors were broken, but these had not been signed off as completed. We asked the registered provider if they had been fixed, they told us they thought they had been, but would have to check with the maintenance person. Given the risks associated with this, such as a fall from height, the expectation would be to make this a priority and check the work had been completed.

Additionally, we found environmental risks which they had not identified via auditing processes or daily walks around the building. Other audits had also not been completed where issues were identified. For example, there was a mattress audit which identified that some matresses might need replacement. It was not clear if any action had been taken to replace these, and the registered provider could not confirm this either way. Medicines audits had also not identified the issues we found. Therefore the quality of auditing was not robust.

There were no care plan audits in place to monitor the quality of the content. Having these in place would help the service to identify errors, such as our findings with the risk assessments and care plans not having been updated to reflect current needs. Staff were completing a review sheet at the back of the care plan, however, this did not specify what should be checked. One entry in August 2018 stated, 'full review', but no other information on what was reviewed and if there were any changes made as a result.

Where accidents and incidents had been logged, details around actions taken and root causes had not been completed. There was no analysis of accidents and near misses so that they could establish how and why they had occurred to prevent recurrence.

A complaint made in July 2018, was not listed on the complaints log. The provider told us that they had spoken to a relative about ther particular complaint, however, they had not documented their response so we could see that this was addressed appropriately.

Surveys were issued to people using the service in 2018. The analysis summary completed by the registered provider said that, 'everything was ok' and actions were; 'Continue good quality care, listen to residents, providing freedom, and more communication and activity'. People's comments included, "More activities", "More communication with staff", and "Some staff are very good, some are ok". The summary did not describe how people's feedback would be addressed, and how their views would be actioned, such as more activity and better communication. The service had not issued surveys to relatives or professionals in 2018, as a means of obtaining their views about the service.

All of the above constitutes a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found that the service had not informed us of a serious injury which had occurred in the service, which resulted in a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. At this October 2018 inspection we found that reporting procedures had improved, and that serious injuries had been reported to us. The service is therefore no longer in breach of this regulation. However, we did advise the acting manager to ensure they were aware of the range of events that needed to be reported to the CQC, such as safeguarding concerns.

The acting manager had been working closely with the local authority quality team to try and drive improvement; they were open to new ideas and systems that would help the service to move forward, and had an improvement plan in place. However, we saw that sometimes their time and the deputy manager's time was not always protected. For example, on the second day of our inspection we were told that a staff member had called in sick. The deputy manager was asked to cover the shift. They had planned to complete the training matrix and check staff training was up to date but this could not be completed. We were told this happened frequently.

The acting manager was part of the 'outstanding managers' forum which is a group that shares good practice and relevant information to support improvements. The acting manager and deputy manager were planning to undertake leadership training to develop their skills.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care plans did not include all their needs, and were not always accurately completed. The provision of activity was not meeting individual and specialist needs. 9 (1) 3 (a) (b)

The enforcement action we took:

NoP to cancel

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health, safety and welfare were not identified and managed so as to ensure people's safety and wellbeing. 12 (1) (2) (a) (b)

The enforcement action we took:

NoP to cancel

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's food and fluid intake was not always accurately recorded. 14 (1) (4) (a)

The enforcement action we took:

NoP to cancel

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care	governance Systems and processes did not enable the provider to identify where quality and/or safety were being compromised 17 (1) (2) (a) (b) (f)

The enforcement action we took:

NoP to cancel

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not receiving sufficient training and supervision to enable them to carry out their duties effectively. Staffing levels were not sufficient to ensure thatpeople's needs were met at all times. 18 (1) (2) (a)

The enforcement action we took:

NoP to cancel