Greengates Care Home Limited

Greengates

Inspection report

9 Redland Lane
Westbury
Wiltshire
BA13 3QA

Tel: 01373822727
Website: www.greengatescarehome.com

Date of inspection visit:
15 February 2017
16 February 2017

Date of publication:
30 May 2017

Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

The inspection was prompted by the notification of an incident following which a person using the service died. This incident is subject to a police investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of insufficient staffing levels and the monitoring of people's whereabouts. This inspection examined those risks. We carried out this inspection over two days on the 15 and 16 February 2017.

As a result of this incident appropriate disciplinary processes had been followed by the provider and registered manager. Following our inspection we wrote to the provider about what actions they had taken to address the areas of concern. They wrote to us with an action plan of improvements that would be made.

Greengates is registered to provide accommodation which includes personal care for up to 54 older people some of who are living with dementia. At the time of our visit 30 people were using the service. The service has capacity for up to 35 people in single occupancy rooms having changed some rooms which were double occupancy. The bedrooms were arranged over two floors, with only three bedrooms situated on the first floor. These bedrooms had not been in use during our previous inspection. There were communal lounges with a dining area on the ground floor with a central kitchen and laundry.

A registered manager was employed by the service who was present on the first day of our inspection. 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.

Whilst the storage and administering of medicines were managed safely recording when 'as necessary' (PRN) medicines were given was not done in line with the providers policy. Protocols did not always give clear guidance to staff on when these medicines should be administered. Some people who required PRN medicines did not have protocols in place. Medicines were stored and administered safely. People were supported to access appropriate healthcare professionals to ensure they received ongoing healthcare support.

We found that not all people using the service had risk assessments that identified areas of risk and guidance on the steps staff should follow to minimise incidents occurring. Risk assessments included guidance for staff that detailed the preventative actions to be taken to lessen the risks identified to people for areas such as falling, the safe moving and handling of people and supporting people when they showed distressed behaviour. However, there were no assessments in place to guide staff on how to reduce the risk of people choking or to support people to access the outside areas or their community.

During out our inspection we spoke with the registered manager regarding staffing levels and how these were met. They told us they did not use a formal dependency tool but assessed the staffing levels through observation and how care tasks were completed by staff. A lack of a formal dependency tool did not assess if staffing levels remained sufficient if people's needs changed or numbers of people living at the service increased.

The service was not meeting the requirements of the Mental Capacity Act (2005). Not everyone had an assessment to determine their capacity to make decisions and best interest discussions had not always taken place where people were deemed as lacking capacity.

People told us they enjoyed the food. However, we observed that people did not always have drinks available close by and were not always offered a choice of what they wanted to drink. We saw in one person's care plan it was recorded that they had lost weight over several months. This had not been identified in the monthly review and no action had been noted.

Staff were knowledgeable about people's care and support needs. Whilst staff knew how to protect people's privacy their dignity was not always respected. Staff were heard discussing people's personal care needs in front of others. People and their relatives spoke positively about the staff.

We saw some people's care plans lacked important information in order to provide staff with guidance in how to meet people's care and support needs. For those people who were unable to verbally communicate care plans did not always include details of people's preferences, likes or dislikes.

The registered manager told us about the different fundraising events which had been organised throughout the year. Money raised had been used to purchase an I-pad which was used to support people to look up places they had previously visited or listen to their favourite music. The service also had a sensory room for people to access. The service employed an activities co-ordinator who was not available during our inspection. During our two day inspection we observed people were not engaged in any meaningful activities and some people experienced little social interaction. Staff told us they did not have the time to sit and chat with people and we observed this did not happen during our inspection. People did not have access to any day trips out.

People's needs were met by staff who were able to access most of the training needed to meet people's needs. Training records we viewed confirmed staff received training on a range of subjects. However, staff had not received training on how to support people to manage distressed behaviour or how to physically restrain people.

The staff records we looked at showed appropriate recruitment and selection processes had been carried out to make sure suitable staff were employed to care for people. People were supported by staff who received up to date training which was regularly reviewed to ensure they had the skills and knowledge required to meet people's individual needs. New staff received an induction which included a period of time working with experienced colleagues to ensure they had the skills and confidence to support people.

Staff received regular supervision and appraisal which gave them the opportunity to discuss their personal development and training. The service followed clear staff disciplinary procedures when it identified any poor practice in staff. Staff spoke positively about the support they received from both the registered manager and deputy manager.

Whilst the provider had systems in place to monitor the quality of service to ensure improvements were

identified these were not always effective. Audits and checks had been completed but these had not been effective in identifying the shortfalls we found during the inspection.

Staff took appropriate action following accidents and incidents. These were recorded, investigated and reported to the Care Quality Commission when required. Records showed these were regularly audited by the registered manager and action taken to minimise the risk of them occurring again.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. You can see what action we told the provider to take at the back of the full version of the report. We are taking further action in relation to this provider and will report on this when it is completed.

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

This service was not consistently safe.

Recording when 'as necessary' (PRN) medicines were given was not done in line with the providers policy. Protocols did not always give clear guidance to staff on when these medicines should be administered.

Not all people using the service had risk assessments that identified areas of risk and guidance on the steps staff should follow to minimise incidents occurring.

When staffing levels were reduced there was no formal assessment in place to ensure this was safe practice.

People were supported by staff who had received training in safeguarding people and who knew what actions to take should they suspect people were at risk of harm or abuse.

The provider had robust recruitment processes in place to ensure people were protected from the employment of unsuitable staff.

Is the service effective?

Requires Improvement

This service was not consistently effective.

The service was not meeting the requirements of the Mental Capacity Act (2005). Mental capacity assessments were not completed around a person's ability to make decisions.

People told us they enjoyed the food. However, we observed that people did not always have drinks available close by and were not always offered a choice of what they wanted to drink.

People's needs were met by staff who were able to access most of the training needed to meet people's needs. However staff had not received training in supporting people to manage their behaviour.

People were supported to access appropriate healthcare professionals to ensure they received on-going advice and

treatment.

Is the service caring?

Requires Improvement

This service was not consistently caring.

There were positive interactions between staff and people using the service. However, improvements were required to ensure every person was treated in a way that maintained their dignity at all times.

The dining experience on both days of the inspection was poorly managed which resulted in some people having to wait considerable amounts of time before receiving their meal

Staff were able to say how they would promote people's privacy.

People had end of life care plans in place which stated what a person's wishes were at this stage of their life.

Is the service responsive?

Requires Improvement

This service was not consistently responsive.

People were not engaged in any meaningful activities and some people experienced little social interaction. Staff told us they did not have the time to sit and chat with people.

Some people's care plans and risk assessments lacked important information to guide staff on how to care for people in ways they preferred and safely. There were arrangements in place to regularly review care plans each month.

There was a procedure in place to ensure complaints were dealt with in a timely manner.

Is the service well-led?

Requires Improvement

This service was not consistently well-led.

Whilst the provider had systems in place to monitor the quality of service to ensure improvements were identified these were not always effective.

There was a registered manager in post who was supported by a deputy manager.

Staff received regular supervision and appraisal which gave them the opportunity to discuss their personal development and

training. Staff spoke positively about the support they received from both the registered manager and deputy manager.

Relative and resident's views were sought via regular meetings.

Greengates

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.

The inspection was prompted by the notification of an incident. This incident is subject to a police investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of insufficient staffing levels and the monitoring of people's whereabouts. This inspection examined those risks.

We carried out this inspection over two days on the 15 and 16 February 2017. The first day of the inspection was unannounced. Two inspectors attended both days of the inspection. Before we visited, we looked at the previous inspection report.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking with seven people who use the service and three visiting relatives about their views on the quality of the care and support being provided. During the two days of our inspection we observed the interactions between people using the service and staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included ten care and support plans and daily records, staff training records, staff duty rosters, staff personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices.

We spoke with the registered manager, deputy manager, six care staff, and staff from the catering department.

Inadequate

Is the service safe?

Our findings

Risks to people's safety were assessed and regularly reviewed. Risk assessments included some guidance for staff that detailed the preventative actions to be taken to lessen the risks identified to people for areas such as falling, the safe moving and handling of people and supporting people when they showed distressed behaviour. However, not all people using the service had risk assessments that identified areas of risk and guidance on the steps staff should follow to minimise incidents occurring. For example, we were told by staff that there were two people using the service who were at risk of choking and therefore had pureed diets as recommended by the speech and language therapy team. However, when we looked in these people's care plans there were no assessments in place to guide staff on how to reduce the risk of people choking. There were no risk assessments in place to support people to access the outside areas or their community. When we asked the registered manager if people were able to go out on day trips they stated that due to people's levels of dementia it was not possible for people to go out. We could see no assessments that identified if people could or could not go out.

The risk assessments were not always person centred. Some of the terminology in the risk assessments were generic statements which were used in all of the assessments we looked at. For example, mobility and falls assessments noted that people were to 'wear appropriate footwear' as a preventative action. However, it did not include any details of what was appropriate footwear for the person. During our inspection we observed several people walking around with no footwear. One person was seen walking about with only one sock on. We asked a staff member why people were not wearing any footwear and they told us people would not keep their footwear on and they had "tried everything". There was no record on people's care plans to say they would not wear anything on their feet.

Risk assessments were being reviewed regularly, however there was no information recorded about any measures taken or events that had happened in each month. For example, one person had a pressure mat put in place to alert staff when they moved about in their room. However, this change had not been included in the review. Another falls risk assessment stated to 'implement the interventions to reduce risk' but there was no information on what these interventions were or what was in place. One person's fall risk assessment stated there was no history of falls, however the falls care plan recorded a recent history of falls. The falls risk assessment had not been updated to reflect these recent changes.

These concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

For people that had been prescribed medicine to be taken 'when required' (PRN) we saw that staff were not recording the reason it had been given on the Medicine Administration Chart (MAR). This was not in line with the provider's own policy which stated that this should be completed each time PRN medicine was given. Not everyone that was on PRN medicine had guidance in place for this which recorded information on why the person may need it and signs to look for. The PRN guidance that we did see were not always detailed and did not give staff information on other methods they could try before giving medicine to the person.

There was no information on how to establish if a person was in pain if they could not communicate this. For example, one person's care plan stated that the person was 'unable to ask for pain relief' and relied on staff to be vigilant and assess if the person needed pain relief. There was no information recorded on how to assess this and recognise if the person was in pain. There was therefore a risk that some people would not be able to tell staff when they needed PRN medicine and staff would not know the signs to look for to establish this.

We were informed two people were given their medicines covertly (without their knowledge, mixed with food and/or drink). The deputy manager stated they no longer gave one person covert medicine because they now took their medicine. We looked at the care plans for people receiving their medicine covertly and saw it stated 'we have permission from the GP to administer covertly'. The deputy manager told us this was stated on people's MAR's. We checked the MAR's and saw that it was not written on either person's MAR. The deputy told us it may have been archived but was not sure why it was not recorded. The deputy also confirmed there were no documents to show this had been discussed with a GP or a pharmacist. This meant the service was giving people their medicines in a disguised format without having obtained the appropriate guidance to do so. There was no evidence that a mental capacity assessment of the person's ability to make decisions about their medicines had been completed. There were no documents relating to a best interest decision. There was no information recorded on how the service was to administer these medicines to the person. For example in their drink or with a certain food, as the effectiveness of some medicines can be altered when they are crushed or put with certain substances.

On both days of the inspection we observed that the morning medicine round took until lunchtime to complete. On the first day of inspection the staff member told us they were "running behind", but had made a note of the people that were having medicines four times a day. They did this to ensure the next staff doing medicines did not administer them again before the time required in between each dose. The medicine round on the second day did not finish until 11.50am and 13 people were having medicines required to be taken four times a day. There was no guidance in place to direct staff in ensuring there was sufficient time between people's medicines. For example, those people who required their medicines four times a day should receive their morning dose at the start of the round to ensure there was sufficient time before receiving their afternoon dose.

We saw the MAR folder was constantly left open and unattended whilst staff went to administer people's medicine. This meant other people could see what medicines people were taking and access private information they may not want others to see.

These concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Observations of medicine administration followed good practice. The staff member poured each person a drink and took the medicine to them after checking the medicine against the Medicine Administration Record (MAR). The staff member sat with each person and explained about their medicine. The trolley was locked each time and the staff would return and sign the MAR before administering medicines to the next person.

It stated in care plans if people wished to self-medicate. At the time of our inspection no one was self-medicating. A list of signatures was recorded at the front of the MAR to indicate all the staff that were trained and competent to be able to administer medicines. Each person had a record with their photo on and any allergies clearly listed.

During out our inspection we spoke with the registered manager regarding staffing levels and how these were met. They told us they did not use a formal dependency tool but assessed the staffing levels through observation and how care tasks were completed by staff. A lack of a formal dependency tool did not assess if staffing levels remained sufficient if people's needs changed or numbers of people living at the service increased. It also did not take into account the geography of the building when the bedrooms on the first floor were in use. They explained there should be six staff on during the morning and then at 14:00 this would go down to five staff for the evening. Each night there were three staff allocated. Rotas we reviewed showed that at times the numbers of staff identified were not always available. The registered manager and deputy manager explained that as they were running on such high numbers of staff, care and support could still be provided if the staffing levels went down by one staff member. They said during the night shift if one staff member was not available and they could not get cover then they would organise for day staff to stay on until 23:00 and then the staff from the next day would come in early at 6:00 leaving two staff on duty during the night. This was done to ensure everyone received the required care and support. This was the case on the night of incident. However, there was no assessment in place to evidence that this was safe practice. The registered manager explained that where possible cover was sought and they did not use agency. They said themselves and the deputy often provided cover and this was reflected on the rota.

Staff consistently told us there was not enough staff. Their comments included "Sometimes it's hard, we work our way around it but it's difficult. People's needs have got harder, there is not enough time to chat with people as much as I like", "If people call in sick, they ring and try to cover but if there's no one then there would just be two at night. I have never seen any agency. There is not enough staff, the care is met but you lose the one to one and personal touch, been ongoing for a long time", "Not enough staff, been like that for a while. We have a good team to pick up extra but people are getting tired. We don't use agency. It is an issue; it's all rushing, feel like a robot on a conveyor belt, getting people up, in for dinner", "There is not enough staff; we have been struggling for a while. We don't have the time we need. We do work one down if someone is off, you feel rushed" and "One hundred percent the staffing could be improved. We are all exhausted and the residents don't get the care they deserve. We have all asked for more staff and keep getting told the provider won't allow it". One relative commented "There is enough staff but sometimes it goes a bit sparse".

During our inspection staff were not always visible and we did not see staff having the time to sit and chat with people. Some people were left for long periods of time with very little social interaction only received this when they were supported to have a drink or a meal.

These concerns were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of not being able to exit the home safely in the event of a fire. On the first day of our inspection we found that one fire door had been locked. A hoist had also been put in front of the door blocking the exit if people had needed to evacuate. We asked three staff why this had been done and they did not know. One staff member tried to open the door with various keys but was unable to do so. Staff confirmed it was definitely a fire door and one stated "It shouldn't be locked, if there was a fire we couldn't get out". Staff said they would ask the registered manager. We observed that the door was unlocked a short while later and remained unlocked throughout our inspection. When we raised concerns with the registered manager she said "It must have been done by night staff in light of the incident". The deputy went to investigate.

Comments from staff include, "Some of the doors are always locked to the garden and only opened in the summer. We have residents that like to walk around and it's not appropriate if they have no coat on. Night

staff do checks and lock doors. Not sure who unlocks the doors but usually done by 8am" and "There is a checklist in place; we have to turn all door alarms on. Prior to the incident doors to the courtyard and alleys were all unlocked all night, they are now locked. At 8am the door alarms to the courtyard are turned off, some doors are staying locked at the moment".

Smaller courtyard doors were open and people could access the main courtyard through an adjoining alleyway. When we opened the door to the smaller courtyard a door alarm flashed to alert staff that people had exited the people. The alarm sounded but no staff came to check on people's safety and it went off after a short while.

During our inspection we checked three people's sensor mats in their bedrooms with a team leader. The team leader could not get any of the three we checked to work. The team leader had to retrieve two of the sensor mats off the top of the person's wardrobe. One sensor mat had a large rip in it and had tape over the rip. The team leader went to inform the registered manager that the sensor mats were not working. The registered manager then informed us that they were working and had been tested. However, the day staff did not realise that they had to plug them in firmly and wait for them to register in the system for a few seconds. The registered manager explained that the night staff knew how to do this as they didn't use them in the day. Sensor mats were used to alert staff of people being active whilst in their bedrooms. This meant that if people chose to be in their rooms during the day staff would not be alerted to their activity if the sensor mats were not in place.

The four staff records we looked at showed appropriate recruitment and selection processes had been carried out to make sure suitable staff were employed to care for people. Appropriate checks were undertaken before staff commenced work. These records included evidence that pre-employment checks had been made including written references, satisfactory Disclosure and Barring Service clearance (DBS) and evidence of their identity had been obtained. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

People and their relatives we spoke with did not raise any concerns about safety with us. Their comments included "I feel safe. No worries", "I come once a week. She's safe here" and "No concerns about safety. The staff are excellent".

There were policies and procedure in place to inform staff of the action they needed to take if they suspected abuse had taken place or people were not receiving a safe service. Staff informed us they had received training in the safeguarding of people from abuse and records we reviewed confirmed this. The registered manager and deputy were clear about when to report concerns and the processes to be followed to inform the local authority, police and CQC. Comments from staff included "I would tell the manager if I saw something, go higher and whistle-blow", "If an issue that I thought wasn't right I would raise it or if I felt someone was ill-treating a resident I would raise it with senior or manager" and "It's about protection and safety; making sure things are in place to prevent accidents and abuse. I am not shy; if not happy I will say. If something is too big for me I would go to the manager, we are here to help the residents.

Requires Improvement

Is the service effective?

Our findings

We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). 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.

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).

Consent to care was not sought in line with legislation. The majority of care plans did not contain evidence that mental capacity assessments had been undertaken and where necessary best interest decisions had been made in conjunction with people's relatives and the care team. For example, one person's care plan it stated 'staff to make decisions within my best interest. These include what to wear, eat, drink and when I go to bed'. There was no mental capacity assessment in place to evidence the person was unable to make these decisions or how the best interest decision had been made. The person's preferences for food, drinks or when they liked to go to bed were not recorded in their care plan. This meant that there was a risk that choices made by staff were not in keeping with the person's likes, dislikes and preferences.

The provider had started to implement capacity assessments for new people coming into the service. Capacity assessments assess people's ability to make a specific decision such as consenting to care. In some assessments we reviewed it was not clear which decision the person was being asked to make. In one person's assessment it referred to their communication abilities and cognitive impairment but not how this impacted on their decision making. It stated the person did not have capacity but there was no evidence of how they had arrived at that decision.

We saw evidence in some care plans that people or their representatives were involved in planning care. Where decisions were made by someone other than the person there was no appropriate documents held by the provider or registered manager to validate the decision making process was lawful. Where it had been identified that representatives had lasting power of attorney it was not always clear if this was for finances, health and welfare or both. The registered manager told us they had contacted relatives to gain copies of the appropriate documents but had no evidence of this.

A stair lift was in place in the home. There was a gate at the bottom of the stairs and a keypad exit on the door at top of the stairs. People on the first floor did not have the code to enable them to come downstairs independently. They had a call bell in their room to press for staff to come and assist them to be able to come down to the communal areas. Staff told us one person would bang at the door to be assisted. This was observed during the inspection. Staff were unclear regarding the capacity of the people upstairs. They told us they had capacity to use a call bell but not to use the door code. One person's care plan stated they

were independent in their mobility and were able to climb a staircase and we saw this person moving freely around the home. However, staff told us they would not be safe to use the stairs alone. This person was being restricted in their movement by having to wait for staff to assist them from their bedroom despite being independent. During our last inspection in August 2016 there were no people residing on the first floor.

People were restricted from accessing some external areas independently. There was one main paved courtyard and several smaller courtyards and alleys around the building. Doors to the main courtyard were locked so people were unable to access it during the first day of inspection. We asked staff why the doors to the garden courtyard were still locked in the afternoon but staff were not sure why. Staff informed us that these doors were usually locked.

Forms for people to consent to the use of their photographs were in people's care plans. Some of these forms had been signed by people but their consent had not been reviewed. For example some people had signed their forms in 2011but there was no evidence to check if they still consented to their photographs being used.

These concerns were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection, the registered manager explained that where needed they had made applications for DoLS authorisations. Applications had been submitted by the provider to the local authority. More urgent DoLS had been authorised, whilst others were awaiting a response. Where DoLS applications were in place the deputy manager reviewed these to ensure the application was still relevant for the person's needs. Staff had an understanding of the Mental Capacity Act 2005. Records showed staff had received training in this subject. Comments from staff included "If residents don't have capacity we can look into DoLS" and "It allows us to make decisions for them in their best interests".

People were supported by staff who, for the most part, had access to a range of training to develop the skills and knowledge they needed to meet people's needs. The service used an external training company to provide classroom based learning for staff. New staff had been provided with induction training before working independently. During their induction they were expected to complete the Care Certificate. The care certificate covers an identified set of standards which health and social care workers are expected to adhere to. The induction required new members of staff shadow more experienced staff to ensure they were safe and competent to carry out their roles before working alone.

Training records confirmed that staff received training in core subjects as required by the provider. This included the safe moving and handling of people, safeguarding of vulnerable adults, food hygiene, safe management pf medicines and mental capacity. Comments from staff included "Induction was alright, I shadowed someone for a week. I do training every six months; it is face to face training", "We do training regularly; it gets put on the rota" and "I would say the training is not enough, we need refreshers for staff, I have done first aid and manual handling but no dementia training for a long time".

However, staff told us they had not received training in supporting people to manage their behaviour despite raising this with the registered manager. Some people living at Greengates at times, due to living with dementia, showed distressed behaviour verbally and/or physically. Staff told us when supporting some people with their personal care, staff would hold the person's hands whilst another member of staff undertook any personal care needs. Guidance on what staff should do in these instances was not available in people's care plans. This could be seen as restraint. This meant there was a risk that people would not be

supported consistently during these times and that staff may be undertaking unsafe practices. Comments from staff included "[X] can be done on your own if compliant but other days he can be violent so we need two staff. One staff holds his hands and the other gives care; he's hit me a few times", "We can't use restraint but we have a lot of people that we hold hands, I have raised it with manager as had no training", "People's needs have got worse, it's got difficult, you lose patience quicker and you need to keep your patience on this job", "We hold people, we have mentioned to the manager about restraint training but not heard anything back, it would be nice to know we are holding people correctly" and "Some people do have two carers, one will do the talking and reassure and hold their hands. [X] can be aggressive; we take it slow, take our time and are clear on the instructions".

We raised this feedback with the deputy manager who was unaware that staff were restraining people. The deputy stated that if staff held people's hands it was because they were resistive and it was for staff safety when people were aggressive. The deputy said when staff have asked for training she does not know why it's not in place but the registered manager deals with this. The deputy confirmed that there was not capacity or risk assessments in place for staff to be conducting safe holds or guidance for staff to know how to do this safely.

These concerns were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager stated that staff should receive supervision six times per year. These meetings were used to discuss progress in the work of staff members; training and development opportunities and other matters relating to the provision of care for people living in the home. These meetings would also be an opportunity to discuss any difficulties or concerns staff had. Staff received an appraisal on an annual basis which looked at their personal development during the past year and what they would like to achieve in the coming year. Staff told us they received regular supervision and appraisal and records we reviewed confirmed this. Comments from staff included "I have supervisions with the manager every three months and can discuss any issues", "One to one every few months, it's useful" and "We have supervisions, I am confident to raise things". Records we reviewed showed the service followed clear staff disciplinary procedures when it identified any poor practice with staff.

People and their relatives spoke positively about the food. Comments included "Food is alright. Drinks are offered, I make my own drinks at home but not here", "Food up till now has been alright" and "Breakfast was nice". One relative commented "I eat here, brilliant food".

People's food preferences and needs were not always recorded in their care plans. For example, one person was on a pureed diet. This person was not able to communicate their needs verbally. Their care plan documented they were unable to choose what they would like to eat. There were no food or drink preferences recorded in the care plan. When we spoke with staff and asked how they knew the person liked the lunchtime food being offered they said they didn't. They would only know the person did not like the food by them refusing to eat it. They said the cook held information on people's food preferences. We spoke with the cook who confirmed they held a file of people's preferences. However, when we looked at this it did not contain any information on this person's particular preferences. The cook told us they had a list of people who were on pureed diets. We asked what food choices these people were given. They said they tended to puree what would be the "smoothest" meal that day and if people did not like that then they would puree the second option or find them something different. This meant that people's food choices were not always based on their preferences.

On the second day of our inspection people had a choice of chicken pie or beef stew for their mid-day meal.

People were asked to choose what they wanted at lunchtime during morning coffee. There was a choice of carrots or cabbage but we observed that people were not given a choice about which vegetable they wanted to accompany their menu choice. We observed that one person pushed their cabbage to the side of their plate when given their meal and did not eat it. When asked they said they did not like cabbage. Some staff reminded people what they had chosen whilst some meals were placed in front of people with them being told "Here is your lunch".

At the last inspection in August 2016 the registered manager advised us they would be looking into producing some pictorial menu's to support people to visualise their meal choice. This was to support people who were not able to remember what they had chosen earlier in the day. During this inspection we saw that this had not been implemented. A menu was displayed on the entrance to the dining room in small print. There were no menus on the table or pictorial menus in place for people who needed information in this way.

There was a drinks trolley that provided people with drinks in between meals. However, we observed that people sitting in the lounge areas did not have drinks close by at other times. There was a jug of juice and some glasses on a window ledge. A staff member told us "No one makes their own drinks. We have jugs of squash out but no one helps themselves". At the time of our inspection no one was on food and fluid monitoring charts.

Care plans contained assessments which identified the support people needed to stay healthy such as monitoring people's weight. Whilst these assessments were reviewed monthly we saw in one person's care plan it had not been identified they had lost 10.6kg in weight since June 2016 despite being immobile. Daily records did not mention that the person was not eating or drinking well. There were no food and fluid monitoring charts in place for this person. The records showed the person had weighed 54.4kg in June 2016. Their weight had then gone down to 47.9kg by October 2016 and had then dropped to 43.8kg by February 2017. In their nutritional care plan it stated the aim of the plan was to ensure the person maintained their weight. No actions had been taken to explore the reasons for this weight loss with the person's GP. We discussed this with the registered manager who said they would add the person to the list to be seen during the next GP's visit the following week. In another person's care plan it noted they had lost 4kg in the month of December 2016. On the weight monitoring form it stated what action had been taken if there was a weight loss of 3kg and above. The weight loss had not been identified as something to monitor. Daily records stated the person was 'eating well'. Whilst these assessments were reviewed each monthly change in people's weight were not noted as requiring monitoring.

These concerns were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to health and social care professionals as required. Records showed people had access to a range of healthcare professionals including doctors, district nurses and opticians which ensured they received effective healthcare and treatment. When people needed to be admitted to hospital the service had a form which would be completed. This contained detailed information to inform hospital staff of people's medical history and care and support needs. There was also a section to be completed when the person was discharged from hospital which included information for the service of the person's skin condition, weight and level of understanding. Comments from staff included "When a person is discharged from hospital, nurses come in for a couple of days to do checks and we keep them in the lounge for a bit to keep an eye on them" and "We have a GP round weekly and they can see them or ring GP if urgent. The district nurse comes in for wound care".

Requires Improvement

Is the service caring?

Our findings

We observed some positive interactions between staff and people using the service. However, we found improvements were required to ensure every person was treated in a way that maintained their dignity. For example, we noted occasions where staff did not speak to people in a respectful manner that maintained their dignity. One member of staff was heard in the main lounge saying to a person they were supporting to move "We will take you to the toilet now". This was done in front of everyone who was in the lounge. We heard another staff member shout out to another staff member "I'm doing her now" when referring to supporting the person with their meal. Another staff member went over to a person who was moving around in their recliner chair and leant down in front of the person's face and said loudly "What now [X]". The staff took the remote control for the recliner away from the person and put it to the side. As the person began to talk to the staff member they ignored the person and walked away. They then proceeded to tell another person to "Sit there, you're fine".

One person was quite vocal throughout both days of inspection regarding wanting to go out. They commented "I could walk up to the town but they worry and don't like it in case you escape. They are not encouraging". We did not see any assessments on this person's care plan clarifying if they were able to go out independently or with support. On the second day of our inspection we heard the person discussing going out driving with a staff member. The staff member then said "I'll take you somewhere later X (person's name)". To which the person said "That would be nice". The staff member then said "Yeah I'll take you tomorrow we can go to Canada". This was insensitive to the person as they were expressing a wish to go out and the staff member had promised to take them out and was obviously unable to take the person to Canada. We heard this person talking to their lunchtime companion about the time they had spent in Canada and how much they had enjoyed it.

We were told by the registered manager that people with dementia like to "Walk with purpose" and were able to walk freely around the home and courtyard. During our inspection we noted people moved freely around the home. However, on the second day of the inspection one person, who was in the small lounge, got up to walk about and was asked by staff "Where are you off to". The person did not respond and was then asked to sit down without any explanation as to why they needed to. The person sat down and then instantly got up and walked off. The same staff member then supported them into the larger lounge area and again without any explanation asked them to sit down. We observed this person walking around the home which they appeared to enjoy but was frequently asked to sit down by staff.

The dining experience on both days of the inspection was poorly managed which resulted in some people having to wait considerable amounts of time before receiving their meal whilst other people in close proximity had their meals. Although we observed some positive interactions from specific staff, such as asking people if they required assistance, which drink they preferred or sharing some banter during support, this was not consistent across all staff. For example, some staff fetched people their drinks without asking which they preferred. Some people received their meal with no explanation as to what it was. Protective covers were placed on some people without staff seeking permission or asking if they required a cover. Conversation between some staff and people they were supporting was minimal and consisted of staff

saying "You alright" or "Is that OK".

We observed one member of staff talking to people about the weather. One person who had waited 25 minutes to receive their meal experienced some positive interaction during their support. We observed the staff approach the person and say "X (person's name) I have you dinner, its beef stew". There were lots of smiles from the person towards the staff member and they were supported to eat at a pace appropriate to them. However, when the staff member went to get the person a drink they did not offer them a choice.

One staff member was observed comforting one person who became anxious during the day. The staff member went over to the person and was heard saying "Of course I worry about you because I care". We observed another member of staff supporting a person who was quite vocal and was calling out. The staff member asked the person what was wrong and the person responded that they were hungry. The staff member then walked away and had not brought the person anything to eat after 20 minutes. The person continued to call out. Other staff walked through the lounge and did not engage with this person.

Approaching lunchtime which, we were told was served at 12:00, some people were assisted into the dining room at 11.30 and had a clothes protector put around them. They then had to wait a further 45 minutes before lunch was served. People were not always asked or informed before staff put a clothes protector around them.

During the lunchtime we observed some people were not asked what choice of drink they would like with their meal. For example, we observed one staff member say to one person "I'll go and get you a drink" and returned with a glass of blackcurrant squash which they put in front of the person. Staff refilled people's drinks during the lunchtime meal but did not always offer a choice before pouring a drink into their glass. At the evening meal people were being asked if they would like coffee or tea. The chef went around giving people soup and another staff asked if people preferred white or brown bread.

When staff supported people to eat their meal this was not done in a consistent or dignified manner. For example, one staff member sat down and began to support the person without explaining what the meal was or what they were about to do. Another person was being supported with their meal but was not in an appropriate position to be able to safely eat. The person had their head bent over onto their chest whilst the staff was putting food into their mouth. Another member of staff told them to fetch an adapted spoon with a long handle. The staff did not explain to the person where they were going and walked off. During this time we watched the person searching for their meal and trying to put their clothes protector in their mouth. When the staff member returned they resumed assisting the person without alerting them to this. The staff member put the person's plate of food on the floor each time they stopped to give the person a drink instead of on the table.

These concerns were a breach of Regulation10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoke positively about their experience of living at Greengates. Their comments included "It's alright here, staff couldn't be better. If you want help, you can get masses of help", "They do try their best, they really do" and "It's alright living here". Relative's comments included "My husband has been here five years, lovely place. If any mess they clean it up straight away" and "It seems nice, I have nothing else to compare it to but I have no complaints. Staff are friendly, I know most of them".

During our inspection one person was celebrating their birthday and staff had put up banners and balloons. The person sat in the lounge and had a birthday hat on which one staff later asked if they wanted removing

which the person did. The person's birthday cards had been put on a table bedside them and one staff said they would have a cake later that day.

Staff were positive about working at Greengates and supporting people with their care needs. Their comments included "it's good here, it's family orientated, I love it here", "It's good, the staff are brilliant, everyone has the best interests at heart of the residents. We all want to be here", "I love the residents and we have got a good team" and "I love it, even on days off I pop in".

In discussions with staff they were able to say how they would promote people's privacy by ensuring intimate care tasks took place behind closed doors and they always knocked before entering a person's room. People who used the service had their own bedroom which afforded them privacy. One staff member commented "We need to improve staff saying things they shouldn't such as[X] is wet". We saw in previous staff meetings it had been discussed that staff were to be mindful of their language when supporting people.

People were supported by staff who knew them well. In discussions with staff they told us how they promoted people's independence. Their comments included "I give people the flannel to wash themselves; I do the bottom half as they struggle to reach down, but they clean their teeth", "I give them the toothbrush, hairbrush, don't take it away from them so they don't lose independence" and "I will ask them to take their own clothes off and offer help. I pass the towel to people so they can dry themselves. I give them the hairbrush to brush their hair". We observed one person being supported to walk with their frame and the staff member was positively encouraging the person with this.

The service understood people's needs with regards to their race, sexual orientation, and gender and supported people with any specific needs they may have. People were supported to maintain relationships with people that mattered to them.

For people that had a Do Not Attempt to Resuscitate CPR (DNARCPR) in place, this was kept in their care plan. We saw that people had end of life care plans in place which stated what a person's wishes were at this stage of their life. This also recorded if the person had a will in place. The registered manager explained that end of life care plans would be put together in conjunction with medical professionals such as GPs and district nurses when required.

Requires Improvement

Is the service responsive?

Our findings

Some people's care plans, assessments and risk assessments lacked important information to guide staff on how to care for people safely and in ways they preferred. This meant people were at risk of not receiving care that was responsive to their individual needs.

The assessment information was important as it helped determine the care and support needs of people using the service. For example, assessments were in place for people at risk of falling, pressure ulceration and malnutrition and hydration. Each assessment was awarded a score and from this people would be rated as low, medium or high risk. This score would then determine the level of care and support people required. These assessments were then reviewed each month to determine if there were any changes to people's levels of support. In one person's care plan a short term care plan had been written in July 2016 due to the person breaking their leg. This included the person needing four hourly repositioning to protect them from the risk of developing a pressure ulcer. However, their pressure ulceration assessment had not been updated to reflect these changes. The assessment still stated the person could make major and frequent changes in position without assistance and moved independently. This had been reviewed each month since the person had broken their leg and no changes had been documented on the assessment. This meant it was unclear from the assessment what level of risk there was of this person developing a pressure ulcer. Assessments completed did not refer to any care plans put in place which detailed the level of care and support people required.

When people were at risk of malnutrition a Malnutrition Universal screening Tool (MUST) was used to assess the persons level of risk. If the person scored 20 and above with their BMI they were at low risk and if they scored 18-20 they were at medium risk and the assessment advised the person should have their food intake monitored. The same person who had broken their leg had lost 10.6kg during the period of 14 June 2016 and 09 February 2017. The universal tool still had this person scored as their BMI being 20 and in the 20 and above category which scored that as being at 'no risk'. Their weight loss had not been identified nor monitored at each monthly review. If they had been scored 18-20 the person would then have had their food intake monitored. We looked at daily records which said the person had eaten well but did not detail what the person had eaten or the quantity. We spoke with the registered manager and deputy who confirmed the person was eating well. We asked if there could then be another reason for this person losing weight. The registered manager advised they would add this person to the list for the next GP visit the following week.

Care plans often lacked detail around people's needs. For example, one care plan stated a person needed assistance during personal care. There was no information on what this assistance was or what the person could manage themselves. Another person's communication care plan stated they were unable to communicate their needs, wishes, likes or dislikes. There was no information recorded about what other methods, if any, had been used to support the person to make choices or how they supported them in ensuring they received care and support in their preferred way. There was very little information in the initial assessment recorded about this person's historical preferences. Another care plan stated the person walked with purpose but did not say what this was or if the person needed support to do this.

In one person's nutritional care plan it stated they were unable to choose what they would like to eat. This person was unable to verbally communicate. The care plan did not contain any information for staff on the person's preferences, likes or dislikes. This information was also not available in the information folder held by the cook. This person also experienced epileptic seizures. Their care plan stated if the seizure lasted longer than five minutes then staff were to call an ambulance. However, there was no information detailing what this person's seizures looked like and how to support the person during this time. We observed this person was left unobserved for significant periods of time without staff checking on them. Whilst they were in the lounge area, staff often passed this person without any interaction.

Care plans contained a photo of the person on the front and recorded admission date, birth date and important information about them such as any allergies the person had and their next of kin. A one page resident life history was in place which captured information about a person including how many children they had, grandchildren and any hobbies. For some people there was very little or no information recorded. One person's care plan recorded they had four grandchildren but contained no information on their names or if they visited that would enable staff to talk to the person about this.

A handover took place between staff from one shift to another. During these handovers staff explained information was passed on about how people had been during the day or night and if there were any concerns to be followed up. Comments from staff included "There is a care lead on every shift, we don't have a routine we prioritise people. There is a walk around in the morning and we have a handover from night staff", "We have a handover from night to day. The senior lets you know your role that day; all staff are in the handover" and "We have a handover sheet; we all have a handover in morning and a night handover"

We looked at the handover sheets in place and saw that one was dated 14 February and the other had no date. The sheets recorded that people were mostly fine and if they had been sleepy or received a visit or spent time walking a lot. It was recorded in the daily log that one person had a 'scab' on their leg that was very red and looked infected. We asked staff about this person during the inspection and they did not know about this information commenting "I didn't know anything was wrong with her leg". We looked in the handover notes and saw that this had not been recorded for the next shift. We raised this with the registered manager who was unaware and thought the recording may have been exaggerated. The registered manager informed us she would have the district nurse look at this person's leg later this evening when they visited the home.

At the time of our inspection people had monitoring charts in place for regular repositioning to reduce the risk of pressure ulceration. We looked at three people's monitoring charts and found that two people's charts had no recording for 24 hours on the 15.02.2017 and one person had no recording for 24 hours on the 14.02.2017. There was nothing in the handover information that highlighted these records had not been completed and if people had been assisted to be repositioned as required.

These concerns were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection the inspector had spoken with the activities co-ordinator regarding the activities available to people. The activities co-ordinator was not available during this inspection. We spoke with the registered manager who told us about the different fundraising events they had organised throughout the year. They said the funds had been used to provide the installation of a sensory room and an electronic tablet which people could use to look up places of interest, experience virtual tours of gardens and listen to their favourite music.

An activity board was displayed in the lounge showing the week's events. This had not been completed for the week and staff explained the activity co-ordinator filled this out when she was in. as the activity co-ordinator was off this week no activities had been identified for staff to carry out.

During our two days of inspection we observed people were sat in the lounges with no activities available. We observed an activity initiated by a staff member which included giving people a flag to wave or a musical instrument to use in time to music. We saw that people did not appear engaged in this activity. One relative was joining in but most people sat with the flag or instrument in their lap. The home had a sensory room which was keypad entry so people could only use this room without a staff member present. On the second day some people were supported to go to the sensory room by staff during a half an hour period before lunch. One person they asked to go to the sensory room said "What's the point" and staff replied "To do something different". The person further said "There must be a reason why" before agreeing to go with staff. Another person returned five minutes after being taken down to the sensory room. On the second day of inspection we observed four people asleep in the small lounge at 10:00. A staff member entered the lounge and without asking people switched on the television. They then left the lounge without asking what programme people wanted on or even if they wanted the television on.

Some people moved between the lounge areas and the dining room during meal times. Some people remained in the same chair to eat their meals which meant for the two days of inspection they did not move other than to receive personal care and to go to bed. They also had very little if any engagement or interaction from staff. The main interaction was when they were assisted to have a drink or eat their meal. People were observed mostly sitting and looking around, wandering or asleep in the lounges.

The activity log for people showed that people were not engaged in meaningful activities. For example, one person's log listed three activities offered during January 2017 which included 'declined shortbread for Burns night', 'visited our armchair fitness, declined to join in' and 'declined to meet PAT dog'. This showed the person had not participated in any activities during this month. Records did not show if anything else had been offered. Another person's activity log recorded they had participated in three activities in December 2016. Two of these activities were nail care and one was joining a mulled wine event. This person at times showed distressed behaviours and their care plan stated to support them with this they enjoyed one to one time. There was no evidence this person had been offered or joined in any other activities during this month. Another activity logged for people included 'choosing a sweet from our sweet shop' or 'declined to choose a sweet from our sweet shop' and opening a Christmas card.

Daily records recorded people as spending their days walking around the home. For example, we noted seven entries that stated the person had spent the day walking around, sometimes with purpose and sometimes just walking. There were no recorded attempts of staff supporting this person to go outside for a walk or engaging the person during these times. Throughout our inspection we observed people in the corridors walking about continuously talking to themselves or looking withdrawn. We observed one person access the courtyard on the second day but despite it being sunny and dry, they were immediately brought back in.

There were no records that evidenced activities had been evaluated to see if people had enjoyed them or their level of participation. We spoke to the registered manager who said that doing this would take the activity co-ordinator away from spending time with people. This meant it was difficult to ascertain if the activities were meeting people's needs.

People and staff told us they never left the home to participate in activities outside of the service. One person's care plan stated 'I love the outdoors' however this was not represented in the activities the person

had access to and this person was not encouraged to go outside. We asked the registered manager if people had access to day trips. They said that due to people's levels of dementia they were unable to support people to access outside opportunities. There were no records of assessments in place to determine if people could or could not access external outings.

When asked about activities people's comments included "I don't know what I'm doing today, I don't go anywhere", "Goodness knows what I doing today. I have always done a lot of knitting but been off it for a long time, it's something to do but not done it for a while. It's better than doing nothing. I haven't been outside since being here, I would like to", "I don't get to go out, I feel stupid as don't know what I am meant to be doing. I have nothing planned today", "There is not a lot to join in with, there's nothing to do" and "I'm ok; I have been chatting to people today". We heard one person say to staff "I have got nothing to do" and was told to go to the lounge. Relative's comment included "I have never been here when activities have happened but I see the board has bits on it" and "I don't see activities, I see things put on the board but not here at that time".

Staff comments included "People don't have enough to do. Because people have dementia it's not safe to go out. The activities are for children, not appropriate; it's what you'd expect to see in a nursery. It's down to the carers to do activities and we don't have time", "We haven't done trips out with people, haven't the staffing to go out with the level of dementia needs", "People go out of the home with family but not on their own. They have not got the ability to stay safe and will get lost",
"Not since I have been here over two years have people gone out, maybe for a quick walk but not really out", "There isn't enough, only one lady for activities and not sure how many resources she is given. People don't get to go out; I don't remember them ever getting to go out on trips".
"The activity sheets say 'keeping kids busy' and aren't right for adults. Needs to be person centred and to their interests", "Activities lady usually does colouring and sticking, some staff think it's childish but they like it. We have had a fete, mulled wine evening, choir has been in. Some people are going to the sensory room today. We have flags and sing along CDs" and We have an activity co-ordinator four days a week but not in today. She does singing, have pantomime in, do baking. Carers do it on days she is not here. Around 3pm till 4.30pm we will do something with them, singing or quiz".

A SOFI was conducted on the second day of our inspection to observe the engagement and interaction opportunities available for people. We observed that some people had very little interaction at all and were only engaged to offer a drink. People were often sat for long periods watching or withdrawn in their surroundings.

These concerns were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a procedure in place which outlined how the provider would respond to complaints. We looked at the complaints file and saw there had not been any recent complaints. Previous complaints had been dealt with in line with the provider's procedure. One staff member told us "If a resident makes a complaint we would take it to the care leader". A relative we spoke with commented "I have just complained about the state of this cup, I come in every other day. It's very good overall but now and again things crop up. I can speak my mind if I want here and raise anything".

Requires Improvement

Is the service well-led?

Our findings

We found some audits and checks had been carried out by the registered manager and provider but these had not been effective in identifying the shortfalls we highlighted during our inspection. For example, in relation to risk assessments and management, medicines management, protocols for managing shortfalls in staffing, mental capacity and care files. As mentioned in other areas of the report, some people who use the service did not have risk assessments for accessing the community or who were at risk of choking. Audits had not identified that one person had lost 10.6kg and an appropriate plan of action had been implemented as detailed in the registered manager's 'Key point audit' which was completed each month. Although care plans were reviewed each month the assessments had not always been updated to reflect changes in people's care needs. Medication audits had not identified that some people who required PRN medicines did not have protocols in place to guide staff about the administering of these medicines.

Staff members' training was monitored by the registered manager to ensure their knowledge and skills were up to date. There was a training record of when staff had received training and when they should receive refresher training. Staff told us they had not received all the correct training to assist them to carry out their roles. As mentioned in other areas of the report staff told us they had spoken with the registered manager with regards to receiving training on how to support people who may display distressed behaviour. The provider's policy stated that 'Training will be provided to help staff understand arrangements in place for their protection and for staff to deal with conflict to avoid verbal and physical aggression'. Staff said they had not received training on how to support people with this.

The registered manager told us they regularly undertook unannounced spot checks at night. During these visits they did a check of the building and ensured monitoring records had been completed. The registered manager told us there had never been any issues raised during their night time checks. However, these checks had not been recorded to evidence they had taken place and any outcomes.

These concerns were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff took appropriate action following accidents and incidents. These were recorded, investigated and reported to the Care Quality Commission when required. Records showed these were regularly audited by the registered manager and action taken to minimise the risk of them occurring again.

Maintenance, electrical and property checks were undertaken to ensure they were safe for people that used the service. Servicing of equipment was carried out to ensure it remained fit for purpose.

The registered manager told us the provider undertook monthly unannounced visits where they spoke with people and their relatives about their satisfaction with the service they received. They would monitor any complaints raised and complete a general observation of the condition of the building. These visits were recorded and any actions required passed on to the registered manager.

There was a registered manager and deputy manager in post who were responsible for the day to day running of the service. We found the manager and deputy manager were familiar with people's care and support needs. When we discussed people's needs, they showed good knowledge of the people using the service.

We saw staff meetings took place where staff were able to express their views about the service. Staff were complimentary about the registered manager and stated they received support from them. Their comments included "Couldn't get any more support than her, door always open", "My manager has been very good, can go to her. The manager is visible on the floor and talks to resident, she will help us. It feels like a big family", "I feel supported, I can go to the manager, she is under pressure to keep everyone happy, her door is always open. There are team meetings every month with all the staff", "We all get on, have team meetings. The manager is available, door always open", "Manger is approachable and comes on the floor a bit" and "If I ever have a problem I don't feel like I'm on my own the manager is great, we support each other".

People and those important to them had opportunities to feedback their views about the home and quality of service they received. We reviewed the minutes of resident meetings and saw that these were held regularly. There were no recorded areas of improvement raised by people in the home from these meeting. One person we spoke with commented "Manager is ok; she's got a job that I don't envy. She does her best". A relative commented "If I want to see her, I can go and knock on her door".

During our previous inspection the registered manager had informed the inspector that they were seeking to recruit another activities co-ordinator to be able to support with larger group events. During this inspection the registered manager informed us they had not been able to successfully recruit to the post.

The service had appropriate arrangements in place for managing emergencies which included fire procedures. There was a contingency plan which contained information about what staff should do if an unexpected event occurred, such as loss of utilities or fire. There were arrangements in place for staff to be able to seek out of hours management support should they require it.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always have drinks available close by and were not always offered a choice of what they wanted to drink. We saw in one person's care plan it was recorded that they had lost weight over several months. This had not been identified in the monthly review and no action had been noted. People were not engaged in any meaningful activities and some people experienced little social interaction. Staff told us they did not have the time to sit and chat with people. Some people's care plans and risk assessments lacked important information to guide staff on how to care for people in ways they preferred and safely. There were arrangements in place to regularly review care plans each month.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect There were some positive interactions between staff and people using the service. However, improvements were required to ensure every person was treated in a way that maintained their dignity at all times. The dining experience on both days of the inspection was poorly managed which resulted in some people having to wait considerable amounts of time before receiving their meal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Training records we viewed confirmed staff received training on a range of subjects. However, staff had not received training on how to support people to manage distressed behaviour or how to physically restrain people.

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 11 HSCA RA Regulations 2014 Need for consent The service was not meeting the requirements of the Mental Capacity Act (2005). Not everyone had an assessment to determine their capacity to make decisions and best interest discussions had not always taken place where people were deemed as lacking capacity.

The enforcement action we took:

We imposed a positive condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Recording when 'as necessary' (PRN) medicines were given was not done in line with the providers policy. Protocols did not always give clear guidance to staff on when these medicines should be administered. Not all people using the service had risk assessments that identified areas of risk and guidance on the steps staff should follow to minimise incidents occurring.

The enforcement action we took:

We imposed a positive condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Whilst the provider had systems in place to monitor the quality of service to ensure improvements were identified these were not always effective.

The enforcement action we took:

We imposed a positive condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered manager did not use a formal dependency tool to identify staffing levels but assessed the staffing levels through observation and how care tasks were completed by staff. A lack of a formal dependency tool did not assess if staffing levels remained sufficient if people's needs changed or numbers of people living at the service increased.

The enforcement action we took:

We imposed a positive condition