HC-One Oval Limited

Gallions View Care Home

Inspection report

20 Pier Way
London
SE28 0FH

Tel: 02083161079

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 20 November 2018. Gallions View is a care home that provides nursing and personal care and support for up to 60 older people. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection, 47 people were using the service across two units - Squires and Hutton, the majority of whom were living with dementia.

At our previous inspection on 15 and 16 February 2018 we found breaches in our legal requirements in relation to identifying risks to people and detailed guidance not being in place for staff to be able to manage these risks safely. Incidents were not always logged and investigated appropriately. People and their relatives were not involved in planning their care needs and care plans were not always reviewed on a monthly basis to reflect people's current needs. There was a lack of activities on offer throughout the day for people to take part in. Regular staff and resident meetings had not taken place to give people information about the provider, who was new at the time. Audits were not always effective in identifying shortfalls in the safety and quality of the service There was a lack of leadership and staff did not feel listened to and morale was low.

At this inspection we found that whilst the provider had attempted to address some issues, there remained shortfalls, and little improvement had been made. At this inspection we found we found continued breaches of the Health and Social Care Act 2008 (Regulated Activities 2014). Medicines were not safely managed. Staff training was not up to date. People's observation chart which included turning charts and elimination charts were not always completed to ensure people's safety. There were not enough staff deployed to meet people's needs in a timely manner and the provider had not followed safe recruitment practices when recruiting two members of new staff. We found people who communicate were not provided with information in a format that met their needs. Complaints made by relatives were not always logged and investigated in a timely manner. The registered manager had a lack an understanding of their regulatory responsibilities as they had not reported incidents to the local authority safeguarding team or CQC where required.

We found improvements were needed as staff were not always supported through regular supervisions and appraisals. People's diverse needs including, cultural food were not recorded. We found that not all staff were caring. Feedback from residents and relatives had not been analysed and used to drive improvements. We found the ethos of the home was not being delivered which was to provide people with a comfortable life and concentrate on delivering individual support to meet their care needs. People's end of life wishes were not always recorded in their care plans.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspecting 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 act 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 if they do not improve.

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.

At this inspection we that there was a whistle-blowing procedure available to staff and they said they would use it if they needed to. People were protected from the risk of infection and staff were confidently able to describe what they did to prevent the risk of infection.

Staff completed an induction when they started work. People's needs were assessed prior to joining the home to ensure their needs could be met. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff asked for people's consent before offering support. People were supported to have enough to eat and drink and had access to a range of healthcare professionals when required to maintain good health. The service met people's needs by suitable adaptation and design of the premises, with appropriately adapted bathrooms to manage people's needs effectively.

People's privacy and dignity was respected and people were involved in making choices and decisions about their daily care and support needs. People were encouraged and supported to be independent wherever possible. People were provided with information about the service when they moved into the home in the form of a 'service user guide' so they were aware of the services and facilities on offer.

People were involved in planning their care needs. People were aware of the home's complaints procedures and knew how to make a complaint if necessary. The provider worked in partnership with the local authority and other agencies to ensure people's needs were planned and met.

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.

There was a lack of guidance for staff to manage risks, and people did not always receive safe care.

Improvements had not been made as accidents and incidents were not appropriately logged and investigated. Lessons learnt were not disseminated to staff.

Medicines were not managed safely.

There were not enough staff deployed to meet people's needs in a timely manner and the provider had not followed safe recruitment practices when recruiting two members of new staff.

The registered manager had not recognised potential safeguarding incidents and reported them to the local authority as required.

People were protected from risk of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were not supported through regular training, supervisions and appraisals.

People were supported to eat and drink. However, people had to sometimes wait an unreasonable amount of time for their meal. People's dietary needs, likes and preferences were not always recorded in detail.

People's needs were assessed prior to moving into the home to ensure their needs could be met.

Staff understood the principles of the Mental Capacity Act (2005) and supported people to make decisions appropriately. Staff asked for people's consent before assisting them.

People and had access to a GP and other healthcare

professionals when required.

The service met people's

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were not always caring.

People's diverse needs were not always recorded in their care plans.

People were involved in making choices and decisions about their daily care and support needs.

Staff respected people's privacy, dignity and promoted people's independence whenever possible.

People were provided with information about the service when they joined in the form of a 'service user guide' so they were aware of the services and facilities on offer.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Activities were not offered throughout the day for people to take part in.

Complaints made by relatives were not always logged and investigated in a timely manner.

Care plans were not regularly updated.

People did not have advanced care plans to in the care files to document their end of life care wishes, if appropriate.

Is the service well-led?

Inadequate

The service was not well-led.

Quality assurance systems in place to monitor the quality and safety of the service were not effective.

There was a registered manager in place. However, they had a lack an understanding of their regulatory responsibilities as the registered manager had not reported incidents to CQC where required

The philosophy of the home was to provide people with the highest standard of individualised care. However, we found this was not being delivered.

Staff did not feel listened to and morale was low.

Feedback from residents/relatives had not been analysed and used to drive improvements.

The provider worked in partnership with other agencies to meet people needs effectively.

Gallions View Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was 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 site visit took place on 20 November 2018 and was unannounced. The inspection team consisted of two inspectors, one specialist nursing advisor, a dental inspector also attended as part of a thematic review and one 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. Before the inspection we looked at the information we held about the home. This included statutory notifications that the provider had sent CQC. A notification is information about important events which the service is required to send us by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also asked the local authority commissioning the service for their views of the service and used this information to help inform our inspection planning.

We spoke with two people using the service, nine relatives, two nurses, six care staff, two administrative staff, the registered manager, the area quality director, the area director and the operational project manager. We reviewed records, including the care records of the eight-people using the service, recruitment files and training records for eight staff members. We also looked at records related to the management of the service such quality audits, accident and incident records, and policies and procedures.

Inadequate

Is the service safe?

Our findings

At our last inspection in February 2018 we found a breach of regulations as identified risks to people did not always have detailed guidance in place for staff to be able to manage these risks safely. Accidents and incidents were not appropriately logged and investigated. At this inspection we found that no improvements had been made in relation to these issues.

At this inspection we saw that risks to people had been assessed in areas relating to medicines, mobility, skin integrity, nutrition and falls. However, we found there were not always risk management plans were in place, and where there were they did not always provide appropriate guidance for staff in minimising risks or they were not always followed by staff to safely minimise risks. For example, one person had a catheter in place, but did not have detailed guidance in their care plan about how to minimise the risks in relation to management of the catheter, including the frequency of changing the catheter and the steps taken to avoid urinary tract infection. Records also showed that the person's catheter was not changed between 7pm on 10 November 2018 and 11.45pm on 11 November 2018. Daily records clearly showed that the person had been in retention of urine for more than 30 hours. This was evidenced by the signs and symptoms of wet pads; complaints of pain and no urine output was recorded on the fluid balance chart since 09 November 2018. Staff told the nurse that the person's catheter was not working properly, when a nurse diagnosed that the person had a 'catheter blockage' a new catheter could not be found. There was no record that the nurse either sought any advice from any health care professionals to relieve the person or that the person had been referred hospital. Daily notes confirmed that the person's catheter was finally changed at 11.45pm on 11 November 2018.

At our last inspection in February 2018 we found that information regarding people and their current needs were not always adequately shared between each shift in order to ensure they received safe support. This left people at risk of harm.

At this inspection we found no improvements. Care staff we spoke to told us that they were not always told at handover if there was a new resident admitted to the home and that some staff members did not always know what people's risks were. For example, recently a staff member tried to support a person to drink a strawberry smoothie, however they were unaware that the person was allergic to strawberries until care staff informed them and prevented the person from drinking the smoothie. One staff member said, "It was lucky that we saw the staff member about to give the person the strawberry smoothie and we were able to stop them." Another staff member said," After handover, I walked onto the unit and saw there was a new resident that I had not been told about."

We looked at people's monitoring charts and found that these had not always been completed as required. The charts included close observation charts to ensure that the needs of those being nursed in bed were being met. Positioning change charts to ensure that people had been assisted to reposition themselves to avoid any breakdown of their skin at the correct frequency and elimination charts to show people had been assisted with their incontinence needs. We saw one person was being nursed in bed and who was unable to use the call required hourly checks. Their close observation chart recorded that they had last been checked

at 06.12 hours on the morning of our inspection, they were not checked again during our inspection.

One relative told us that "records in people's rooms were often not completed." A staff member said, "We are short-staffed, so charts are not always filled in and get left." This was a risk as it was not possible to establish whether this was an issue of records not being completed or whether care had not been provided.

Medicines were not managed safely. We checked medicines and medicine administration records (MARs) and found that one person's MAR for 03 November 2018 had been signed by an agency nurse to show that their medicine had been administered, however we found that the medicine was still in the blister pack. The nurse in charge told us, "This tends to happen when we have an agency nurse." We checked another person's MAR which showed until the day of the inspection, all medicines had been signed for to indicate they had been administered. However, we found one tablet had been lodged in the blister pack below. The nurse explained, "This must have dropped onto the pack instead of into the medicine cup. This is the only explanation I have and can happen if we do not make sure that the tablet drops in the medicine cup." This meant that the nurse was not always checking that the person was receiving the right dose and that the person had in fact had physically been given the tablet and had swallowed it. We were unable to establish the date that this incident had happened. This also meant that the person had not received their medicine as prescribed.

We also looked at two people's MARs in relation to the application of medicine patches. It was recommended that these patches were to be rotated and not to be applied to the same part of the body for 14 days. The provider had in place a recording chart with body maps for recording the location of the patches when applied, the date of application and the date of removal. Although the MARs showed that the patches were administered to both people, the body maps were not always completed as required and there were no records to show that the patches were rotated regularly. This also meant that if the patch was due to be changed, staff would not know where the patch had been applied or how to ensure that the new patch was not applied to the same part of the body. There was also no detailed guidance in place regarding the application of patches such as how to apply the patches

People did not always receive their medicines in a timely manner. The local pharmacy sent the home receipts when they are unable to supply specific medicines. This was a prompt for the provider to explore alternatives. One person had not received their medicine on 19 or 20 November 2018, because it was not available and staff were aware of this on 15 November 2018. We asked the nurse about this and they told us that, "I returned from leave today (20 November 2018) and was just about to deal with this." They also told us, "We have had problem with the supply of [medicines] before and I am not surprised that it has happened again." We also found that other medicines, such as prescribed creams had not been supplied by the pharmacy. The nurse told us, "I don't know whether somebody has addressed this, I shall check them today. I was off duty on Friday 15 November 2018." This meant that people were not provided with medicines as prescribed because the provider has failed to check in a timely manner that their medicine would be available when the current stock ran out.

We found that there was guidance in place for staff to support people with 'PRN' medicines that had been prescribed to be taken 'as required'. 'PRN' guidance is needed to enable staff to understand when someone may need their 'as required' medicines. Records showed that PRN protocols should have been reviewed on a three-monthly basis, however, we found that this had not been done. For example, nine person had their PRN protocol last reviewed in February 2018. There was a risk that people were being offered PRN medicines they may no longer need.

We reviewed the homes medicine audits for the last five months and found that none of the issues that we

found in relation to medicines had been identified. This meant that the medicines audits carried out were not effective.

We also saw that one person was who was at risk of choking. A choking risk assessment had been completed in 11 September 2018. The person's eating and drinking care plan dated 20 September 2018 recorded that they were at a high risk of choking and needed assistance to eat and drink, the level of support needed was not specified. The person's care plan recorded that they had been seen by a speech and language therapist (SALT), however, there was no documentation to show the SALT'S recommendations. On the day of the inspection, the person was served parsnips for lunch which staff cut up but did not mash with a fork. The staff member also gave the person butter when they asked for it, however, their pre-assessment information from the local authority said to avoid butter. The provider had not carried out further enquiries to establish whether or not the person should be eating butter. There was no risk assessment for the regarding butter or guidance for staff explain any risks.□

At our last inspection in February 2018 we found a breach of regulations because incidents were not always logged and investigated appropriately where they occurred in order to ensure people's safety was maintained. At this inspection we found improvements had not been made as the incidents were not always recorded and investigated. For example, the incident where one person had not received their medicines for two days as they had not been available had not been logged and investigated and no learning from these incidents was disseminated to staff.

This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We brought these issues to the area directors' attention. They acknowledged that improvements needed to be made.

Relatives told us that they did not feel that people were always safe. One relative said, "I come in as often as I can because I do not feel that my [relative] is safe. Some staff are clearly not dementia trained from the way they interact and speak to people." Another relative told us about an incident that occurred a few months ago. They said they had found their [relative's] air mattress was deflated. They asked staff who checked the equipment. They told us that they had been ignored by the staff members on duty.

There were not enough staff to meet people's needs in a timely manner. On the morning of our inspection we saw that the one unit was short by two staff as the staff due in had called in sick. Staff we spoke to told us that this was not unusual. The registered manager had requested an agency care staff member for 2.30pm in the afternoon as a staff member on the unit was due to accompany a person to hospital. We saw people were left longer in bed because there were not enough staff to support people to get up. One person said, "There should be more staff." A relative said, "They are short again on staff, this happens regularly. More often than not they are one short especially at the weekends. Last weekend they were two short." A staff member told us that recently staffing had been cut and it was very difficult. Another staff member said, "We are regularly short-staffed. It doesn't help when staff have to go onto the other unit to help when they don't have enough staff". A third staff member said, "Management do not listen when we say that we cannot cope, we are really struggling."

During the inspection we saw that people regularly needed two staff members to assist them, this meant that at times people were left alone in the lounge or had to wait to have a drink. For example, we saw that the lounge area of one unit was left unattended for 10 minutes as staff were supporting other people in their bedrooms. The inspector had to find a staff member to come and supervise people in the lounge area and

give one person a drink. Therefore, people's health and safety needs were put at risk.

The area director advised staffing levels were based on the dependency assessments carried out at the home. There was no clinical lead or over sight by management, there were also no behavioural care plans were in place to establish the type of support people needed. Therefore, the dependency tool completed may not may not have been filled in accurately. The director agreed with this and told us that they would re-look at the dependency tool.

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

The provider carried out appropriate recruitment checks before staff started work. Staff files we reviewed included completed application forms, details of employment history and qualifications. References had been sought and proof of identity had been reviewed and criminal record checks had been undertaken for each staff member. Checks were also carried out to ensure staff members were entitled to work in the UK. However, improvements were needed as two out the eight staff recruitment files we looked at did not include the member of staffs' full employment histories. One staff member employment history first started in 2002 and another's started in 2006, although they were of an age where their employment histories would have started a large number of years before. The provider had not sought any explanation to determine the large gap in employment for both these staff members.

People were protected from the risk of abuse. There were appropriate safeguarding adult's procedures in place and staff knew the types of abuse that could occur and who to report any concerns to. Staff were aware of the organisation's whistleblowing policy and told us they would not hesitate to use it if required. One staff member said, "I would tell my manager." Another staff member said, "I would report it to my manager but know that I can go to the police or CQC."

People were protected from risk of infection. The provider had an up to date infection control policy in place. We observed staff wearing personal protective clothing (PPE) which included gloves and aprons when supporting people. One staff member said, "I wear gloves and aprons when helping people and I wash my hands."

Requires Improvement

Is the service effective?

Our findings

At our last inspection on February 2018 we found that not all staff had received up to date refresher training. At this inspection we found that no improvements had been made. The overall rate for completed training was 61.9%. Only 55% of staff had completed infection control training. Training completed for safeguarding adults was 52%, nutrition and hydration was 31.9%, dementia was 21%. Staff had not received any fire safety training. Medicines training for nurses was between 40-60%, we were unable to establish an actual figure. We also found that not all staff had completed basic life support training, manual handling, mental capacity act and equality and diversity. The provider was also not able to demonstrate how nurses training and competence was monitored, this included agency nurses. For example, there were six nurses who had not completed medicines competency assessments. New staff were required to complete an induction in line with the Care Certificate. The Care Certificate is the benchmark that has been set for the induction standard for new care workers. However, completed care certificate books were not available to confirm that new staff had completed this training. By not ensuring that all staff members had up to date training the provider could not be assured that staff remained equipped and competent in carrying out their roles properly. Staff we spoke to were unsure if their training was up to date. Some staff were not computer literate so were unable to complete the on-line training. This meant that the provider could not ensure that staff were qualified, competent and skilled to provide the duties they were employed to perform

We found improvements were needed as staff were not always supported through regular supervisions and appraisals. The provider's policy stated that staff were required to have six supervisions a year. However, there was no clear supervision matrix to establish how many staff had received these. We brought this to the area director's attention who said they would look into this.

Staff we spoke to confirmed that they did not regularly have supervisions. One staff member said, "I have been here for a year now and never had a supervision." Another staff member said, "I have not had a supervision for a long while."

We brought these issues to the area director's' attention who confirmed that they had put measures in place such ensuring staff were paid for the time they spent training and training ambassadors to help people who were not computer literate. They acknowledged that improvements were needed and training would be brought up to date as a matter of urgency.

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

People were supported to eat and drink. However, improvements were needed as although there was a monthly menu in place that offered a variety of different meal options there were no pictorial menus in the dining room to help support people to choose their meals. We carried out lunch time observations and saw that on one unit, lunch arrived late. One person who was going to have their lunch in the lounge area waited for 40 minutes before staff supported them to eat. One staff member told us that they were waiting for staff to finish supporting others before they were able to assist the

person in the lounge area.

During the inspection, one lunch time option was whole slices of gammon. Some people were only able to eat with one hand using a fork or a spoon. We saw one person holding the gammon in mid-air above their plate trying to remove the fat with one hand and using a fork. We did not observe staff offering to cut up people's lunch when they were struggling to cut it up. One person said, "The food is not good, not fresh, I eat a bit and leave the rest. I'm always hungry but I leave it. For supper I like celery and cheese. If I want something particular I ask, sometimes, I get it." Another person said, "The food is a better today because you're here. You must come every day." A third person said, "The food is good here." A relative said, that they were a chef and had told the manager that there was a lack of fresh vegetables in people's diets. They said they had noticed a difference in the lunch service overall on the day of the inspection and they though it was because CQC were there. They said, "You don't usually have the unit manager out at lunchtime or the senior managers".

People's care plans did not always include their dietary needs, likes and preferences in detail. For example, we asked a senior staff member if anyone at the home had any dietary needs and preferences and they told us that there wasn't. However, we saw one person only ate curries for lunch and dinner and another person liked to have curries regularly. This meant that the provider could be assured that staff were aware of the food people liked and wanted to eat.

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

Assessments of people's needs were carried out prior to them joining the home. These assessments were necessary to ensure the service would be able to meet people's care and support needs. The assessments were then used to produce individual care plans and so that staff had the appropriate information and guidance to meet people's individual needs effectively. We found improvements were needed because we found that the assessment for the person not able to have put as not been used effectively as a risk assessment had not been carried out and a risk management plan had not been put in place.

We saw that the kitchen was rated five stars from the environmental health inspection on 25 May 2018. The kitchen was clean and well organised and food was covered in the fridge. Fridge temperatures were recorded and checked and monitored. We saw cleaning charts were completed and reviewed. Staff wore gloves, hats and white coats and were also available to visitors. The chef received a copy of people's dietary needs when they were admitted to the home or if there is a change in their needs.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. The registered manager had a good understanding of the MCA and DoLS. They told us if they had any concerns regarding any person's ability to make decisions they would work with the person using the service, their relatives, if appropriate, and any relevant health care

professionals to ensure appropriate capacity assessments were undertaken. If the person did not have the capacity to make decisions about their care, their family members and health and social care professionals would be involved in making decisions for them in their 'best interests' in line with the Mental Capacity Act 2005. At the time of our inspection we noted that two DoLS applications had been authorised by the supervising body (the local authority) to deprive people of their liberty for their protection. The authorisation paperwork was in place and kept under review and the conditions of the authorisations were being followed.

People had access to a variety of healthcare professionals when necessary such as opticians, dentists, GP, and speech and language therapists. We saw that people's healthcare appointments were kept in their care files and monitored. If there were any concerns, we saw that the home referred people to health and social care professionals when required. One person said, "Yes staff will call the doctor for me if I am unwell."
The home met people's needs by suitable adaptation and design of the premises, which included appropriately adapted bathrooms and signage to manage people's needs effectively.

Requires Improvement

Is the service caring?

Our findings

At this inspection we saw that improvements were needed as staff were not always caring. We received mixed comments from people and their relatives about how kind and caring staff were. One relative said, "Although staff pop in and see [my relative], I never seen anyone sitting here and talking with them." Another relative said, "Some of the staff have no smile, no animation in their faces." A third relative said, "My [relative] was wearing clothes that belong to some other residents and other residents were wearing clothes that belong to my [relative]." One person said, "Staff are kind, they are reasonable." Another person said, "Staff are very caring and easy to talk to."

Observations during the inspection showed that there was little interaction between staff and people. Staff were not always attentive and did not verbally communicate with people or make eye contact. For example, during the inspection we saw people were sat in their chairs with nothing to do. Staff members were walking around or standing in the lounge area, only one staff member was observed approaching people to talk to them.

People were involved in decisions about their daily care such as what time they liked to get up and go to bed, or what they liked to do. People's individual needs were identified and respected. One staff member said, "One person likes to get up early and that is their choice."

Staff were knowledgeable about people's individual likes, dislikes and preferences and addressed people by their preferred name. One staff member said, "One person does not like fish or milk." Another staff member said, "One person likes reading the newspaper every day." People were involved in decisions about their daily care such as what time they liked to get up and go to bed. People's individual needs were identified and respected. One staff member said, "One person likes to go to bed late, we respect this."

People's privacy and dignity was respected. We observed staff knocking on people's doors and obtaining permission before entering their rooms. Staff asked for people's consent and explained what they were doing before assisting them. Staff told us they closed doors and curtains if people required personal care. A relative told us, "Staff respect my [relative's] privacy and dignity. When they have a bath, staff shut the door and explain what they are doing, they are patient." A staff member said, "I always close curtains and knock on people's doors and wait for permission to enter." People's information was stored securely in locked cabinets which only authorised staff had access to.

Staff told us that they promoted people's independence whenever possible by encouraging them to remain mobile as possible to carry out aspects of their personal care. One staff member said, "I try and encourage people to walk when they can. It is important that they stay mobile." Another staff member said, "I always ask people to try and do what they can for themselves, like washing their face or eating independently, but I am always there to help."

People were given information in the form of a 'service user guide' prior to moving into the home. This guide detailed the standard of care people could expect and the services provided. The service user guide also

included the complaints policy, so people had access to the complaints procedure should they wish to make a complaint.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in February 2018 we found that there was a lack of meaningful activities on offer to people using the service. There was one full-time activities wellbeing co-ordinator during the week, who split their time between the two units on a daily basis and there was also a co-ordinator who provided activities over the weekend; they also split their days across the two units. At this inspection we found that some improvements were still needed as this was still the case.

Although an activity planner had been introduced, there were still limited activities on offer at the home for people to participate in and to promote their well-being. Activities were not consistently offered on a daily basis as the co-ordinator was at times required to support care staff in serving teas and coffees, assisting at lunch-times and supervising people until care staff were able to do so.

During our last inspection we saw that people were seated in front of the television for entertainment. We found that this was still the case at this inspection during both the morning and the afternoon. The sensory room on one unit had been removed and the room turned into a staff room. One staff member said, "The sensory room has gone, people used to enjoy this room but now it's not available." This meant that people living with dementia were not provided with meaningful activities to stimulate them.

People who were nursed in bed were particularly at risk of social isolation as staff told us that the wellbeing co-ordinator did not have enough time to spend quality one to one time with people. During the inspection we observed two people, one that predominately stayed in their room and the other who was nursed in bed. Records confirmed that they were not visited by the wellbeing co-ordinator for the last week. One person had a language barrier, their care plan showed that they enjoyed watching videos on their spouse's phone. There were details in their care plan that they liked having their legs massaged and their hair oiled and put up. Records showed that although the wellbeing co-ordinator had visited them a week ago, they left as the person was eating their breakfast and did not return. Their activity record did not show that they had been offered to participate in any meaningful activities that met their likes and needs. The activity records showed that they had only had fleeting one to one contact on six occasions from September 2018 to the date of our inspection. The record did not detail how long the wellbeing co-ordinator spent on the six occasions since September 2018. Staff relied on the person's spouse to provide social stimulation. The other person's activity record also showed that they had only had six one to one sessions since September 2018. This included a chat, listening to music and hair brushing on one occasion. There were no records to show that this person had been offered to participate in any meaningful activities. This meant that the provider. This meant that people were risk of isolation and not provided with meaningful activities including people living with dementia.

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

The home had a system in place to log, investigate and learn from complaints. Relatives told us they knew how to make complaints. However, improvements were needed as some relatives told us that they had

made verbal complaints to the registered manager which had been ignored and not investigated. One relative said, at the beginning of November 2018, staff on duty had a heated argument in front them at lunchtime. They said they complained to the registered manger but had heard nothing since. They said with management they found that, "It goes in one ear and out the window. The manager looked disinterested when they made the complaint and did not take any notes to take the matter forward." The complaints log did not show a record of this complaint.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We brought these issues to the area director's attention and they were not able to comment on individual complaints received by the home but acknowledged that improvements needed to be made.

From April 2016 all publicly funded organisations that provide adult social care are legally required to follow the Accessible Information Standard (AIS). The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand, so that they can communicate effectively. We saw that there were a number of people at the home that required support to communicate, however the registered manager was unable to tell us the different formats information had been made available to meet people's needs. There was one person who had a language barrier and could not speak any English, however, information had not been provided to them in the language of their choice. There were no records to show that providing information in the person's language had been explored.

People's end of life wishes were not always recorded in their care files when required. The registered manager had not always recorded what was important to people if they were approaching end of life. This included people they wanted informed and their preferences and choices about their end of life.

People and their relatives were involved in planning their care needs and care files included information about mobility, falls, medicines, communication, personal care and nutrition. However, improvements were needed as care plans were not always regularly reviewed as they did not pick up the issues we found during this inspection in relation to body maps, observation, turning, elimination and food and fluid charts not being completed.

People's cultural, sexual and spiritual needs were documented in their care plans. This also included, for example their preferred choice of language and the dietary cultural needs. We saw that people who wished to practise their faith were supported to do this as a spiritual representative regularly visited the home. One staff member said, "A spiritual representative regularly visits. People who don't practise a faith also enjoy these visits."

Inadequate

Is the service well-led?

Our findings

At our last inspection in February 2018 we found improvements were needed as whilst there were some systems in place to monitor the quality of the service, the provider had either not identified the issues we had found in during this inspection, or had not acted to address the issues they had identified promptly.

At this inspection we found that only some improvements had been made. We found that the quality systems the provider had in place were not effective in relation to activities, staffing, medicines, monitoring charts and that risks to people that were not managed adequately or safely. For example, care plan audits did not identify that monitoring charts had not been completed and that PRN protocols were not reviewed regularly. Medicine audits did not identify issues we found in relation to body maps not being completed and all complaints were not logged in line with the providers complaints policy. Staff training was not up to date, meaningful activities were still not being delivered to people.

Resident feedback surveys had been carried out in May 2018, six people took part. Four people rated the home's complaints process as poor. Two people thought that the home was not well maintained. Two people thought that the standard of meals was poor. Two felt that management of the home was poor and one person said that communication within the home was poor. There was no records to show that an action plan had been put in place or that action had been taken to address these comments or drive improvements.

The provider did not have oversight of the home and staff continued to feel that management did not listen to their concerns. Staff felt that there was a continued lack of leadership at the home and staff morale was low. Staff told us that the registered manager and deputy manager rarely visited the units and the only reason they were on the units was because there was an inspection. One staff member said, "The leadership is not good." Another staff member said, "There is no communication between management and staff, management don't listen when we say we need help and support." A relative said, "The home was better under the old provider."

The philosophy of the home was to provide people with the highest standard of individualised care. Where people's rights, habits, values and cultural background are safeguarded and respected. Staff told us that the home did not deliver its philosophy. Our observations confirmed this as the provider was not always delivering person-centred care, not all staff knew about people's cultural preferences.

Regular resident meetings were held and we saw meetings were minuted. Areas covered included complaints, meals and activities. Regular staff meetings were held. Minutes from the meeting held In October 2018 showed areas discussed included completing accident and incident forms, wearing name badges, communication and the needs of people using the service. However, we did not see that learning was disseminated to staff from incidents, accidents and errors.

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

The service had a registered manager in post. We saw the current inspection rating for the service was clearly displayed. However, the registered manager had a lack an understanding of their regulatory responsibilities. This was because they had failed to report incidents at the home as being potential incidents of abuse amounting to a breach of regulations. For example, the registered manager had not informed the local authority or CQC of the incidents regarding the catheter and medicines not being available to administer to people as prescribed.

This is a breach of Regulation 18 of the Care Quality (Registration) Regulations 2009.

The registered manager told us that they worked with the local authority to meet people's needs. The local authority confirmed this and that they were currently monitoring the home.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager had a lack an understanding of their regulatory responsibilities. This was because they had failed to report incidents at the home as being potential incidents of abuse amounting to a breach of regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care plans did not always include their dietary needs, likes and preferences in detail. People did not have appositive lunch-time experience. People continued not to be provided with regular meaningful activities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Reported complaints were not logged and investigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to meet people's needs.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Medicines were not safely managed. People's observation charts, turn charts, elimination charts and food and fluid charts were not always completed to ensure people's safety. There were not enough staff deployed to meet people's needs in a timely manner and the provider had not followed safe recruitment practices when recruiting two members of new staff.

The enforcement action we took:

Requirement Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Quality systems the provider had in place were not effective in relation to activities, staffing, medicines, monitoring charts and that risks to people that were not managed adequately or safely

The enforcement action we took:

Warning Notice