Longwood Care Home Limited

Longwood Grange

Inspection report

Longwood Gate
Huddersfield
West Yorkshire
HD3 4UP

Tel: 01484647276

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

We inspected Longwood Grange on 15 and 16 October 2018. Our first inspection day was unannounced.

Longwood Grange is a care home for up to 34 people. At the time of this inspection there were 29 people living at the home (30 on second day). People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Longwood Grange consists of one building with two floors; communal areas are located in the first floor and bedrooms on the second floor.

Longwood Grange was last inspected on the 21 and 22 December 2016. At that time it was rated requires improvement overall and was in breach of regulations in relation to consent, safe care and treatment, staff's access to training and supervision, fit and proper people employed and good governance. This was the third time this service was rated required improvement. Following the last inspection, we have served a warning notice on the registered provider and told they had to become compliant with the Regulations by 12 April 2018. At this inspection we found not enough improvements had been made in some of the areas identified and the provider was in continuous breach of regulations related with consent, safe care and treatment, fit and proper people employed and good governance. We also identified two new breaches in relation to person centred care and dignity and respect.

At the time of this inspection the service had a home manager since June 2018 who had not registered to manage the service. The home manager was on annual leave during our inspection visits but the deputy manager and regional support manager were available to provide information. After our visits, we spoke with the home manager to gather more information in relation to some areas of concern. It is a legal requirement that the home has a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

We found widespread failings in the oversight, monitoring and management of the service, which meant people did not always receive safe care.

The provider's compliance with the Mental Capacity Act 2005 was inconsistent. Assessments and best interest decisions for some people living with dementia were in place but we saw relatives giving consent for decisions without having lasting power of attorney. There was no evidence people were being restricted or receiving care that was not in their best interests.

Medicines were not always administered in a safe way. We found medicines were given in a caring way however we could not be certain these were always administered as prescribed and there were no protocols for people who required 'as and when required' medication.

Risks to people were not always managed safely. The provider was not checking the temperature of the water before helping people to take a shower or bath therefore putting them at the risk of being scalded. Not all staff had been involved in a fire drill, in particular night staff, so the provider could not evidence staff would be able to safely evacuate people in an event of a fire. Other risks related with people's care such as their skin integrity, mobility, eating and drinking were being identified, assessed and managed.

The provider was not consistently recording the accidents and incidents that happened at the home or analysing any patterns and trends to prevent them happening again.

We received variable feedback from people, relatives and staff about staffing levels at the home. The home used a dependency tool to assess people's needs and determine staffing levels however our analysis of the rotas did not evidence there were always the required members of staff on shift.

Staff did not always complete relevant training for their roles. Staff had access to regular supervision since new home manager had been appointed but this was not consistently happening before.

People's privacy and confidentiality wasn't always maintained. We saw people's records weren't safely stored and we observed staff talking about people's confidential matters in communal areas.

Recruitment process were not robust. Staff's full employment history and appropriate references were not always sought in line with regulations.

We received variable feedback from people in relation to the quality of the meals and meal experience. Care and catering staff were well-informed about people's dietary needs, food preferences and dislikes. People at risk of losing weight were monitored and when required referred to other healthcare professionals, however records of people's food intake lacked detail and this did not allow the provider to have an accurate picture of what people were eating and what time.

People did not always receive person-centred care. We found one person who displayed behaviour that challenged and others did not a behaviour support plan and advice from mental health professionals was not being followed. Another person at risk of choking did not have an eating and drinking care plan.

There was a regular and varied programme of activities at the home and most people spoke positively about the activities coordinators however we found people were not offered enough social stimulation throughout the day and spend long periods of time sitting in the lounge.

We saw examples of people being treated in a caring way by staff.

Staff told us that they felt supported by the staff team. Where appropriate notifications were sent to the CQC.

There were several systems in place to monitor the quality of care however these were not effective in identifying the issues found at this inspection. The provider had improvement plans in place and told us they had completed these however our findings at this inspection did not evidence this. The governance systems in place were not effective in implementing the necessary changes and improvements already identified at previous inspections.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Where regulations have been breached information regarding these breaches is at the back of this report.

Where we have identified a breach of regulation which is more serious we will make sure action is taken. We will report on this when it is complete. Where providers are not meeting the fundamental standards we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service.

When we propose to take enforcement action our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medication was administered kindly but we could not be certain it was always administered as prescribed.

The provider's approach to risk management was inconsistent.

Recruitment practices in place were not always robust to ensure safe recruitment.

Is the service effective?

Requires Improvement

The service was not always effective.

The home was not fully compliant with the Mental Capacity Act 2005.

Staff did not always complete relevant training for their roles. Staff had access to regular supervision.

We received mixed views about the meal experience at the home.

Is the service caring?

Requires Improvement

The service was not always caring.

People and their relatives described staff as kind and caring. Our observations throughout the inspection supported this.

Care staff did not always promoted people's dignity and respected their privacy. Records were not always stored securely.

We observed people and care staff laughing together.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were regularly reviewed however the information was not always updated to reflect people's current needs.

There was an activities programme in place but we saw people spending long periods of time without social stimulation.

Is the service well-led?

Inadequate

The service was not well led.

Staff told us they felt supported by the management team however we found management's oversight was not robust.

The systems for monitoring and checking the quality of care provided were not effective.

The registered provider had not taken appropriate action to ensure the service was compliant with the regulations.

Longwood Grange

Detailed findings

Background to this inspection

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

This inspection took place on 15 and 16 October 2018; our first inspection day was unannounced.

The inspection was completed by two inspectors and an Expert by Experience on the first day and one inspector on the second day. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience had experience as a family carer of a person living with dementia who used care services.

Before the inspection, we reviewed all the information we had about the service including previous inspection reports and notifications received by CQC. A notification is information about important events which the service is required to tell us about by law. We used this information to help us decide what areas to focus on during our inspection. The provider sent us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We discussed this information during the inspection. We requested and received feedback on the service from the local safeguarding teams and commissioners.

We spoke with seven people using the service and three relatives. We spent time observing care in the communal lounge and dining room and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us.

We spoke with eight staff; this included the regional support manager, deputy manager, senior care staff, catering staff, maintenance and domestic staff and care workers. We looked at support records for three people using the service including support plans and risk assessments. We also looked at specific parts of care plans for four people. We looked at four medicine administration records. We reviewed the home's training and supervision matrix, looked at training, recruitment and supervision records for three staff. We

looked at minutes of team and residents' meetings, various policies and procedures and reviewed the quality assurance and monitoring systems of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 21 and 22 December 2016 the provider was in breach of the regulation related with safe care and treatment. We found; people's person evacuation plans (PEEP's) lacked detail, staff had not completed fire training evacuation and drills, people's risk assessments lacked detail, there was poor recording of prescribed topical creams and issues were found with referring and following up referrals relating with people's nutritional needs. At that time, we issued a requirement notice asking the provider to make improvements. At this inspection we found not enough improvement had been made and the provider was still in breach of regulation.

People told us they felt safe. Comments included, "This is a safe place and "I feel safe, yes, if not I'd look after myself, I'd tell staff." Relatives comments coincided with what people told us, "Yes, it is safe for [relative], we like it" and "Yes it's safe here, no concerns really." However, during this inspection we found concerns about the safety of the service.

Medicines were not always administered in a safe way. People could not be reassured staff would always administer medication as prescribed. One person was prescribed a medicine that needed to be taken once a day before food and on the person's medication administration record (MAR) it was indicated this should be taken in the morning. We observed staff preparing to give this person their medication after they had their breakfast and we asked them to double check the instructions from the prescriber. Staff reviewed instructions on the MAR and spoke with the deputy manager; they administered this medication and told us they would consult with the GP later that day to review the time this medication could be administered. We discussed this with the regional support manager and deputy manager and they told us they were going to identify every person that had been prescribed with time sensitive medication and ask night staff to administer this to ensure this was given before food. We reviewed the records of three other people that were taking time sensitive medication and we saw evidence they had been given their medication as prescribed.

One person who was living with dementia had been prescribed with an 'as and when required' or PRN medication to help with their bowels and manage the risks of constipation. There was no protocol in place to tell staff when to give this medication. We asked a staff member when would they administer this medication and they were unsure of the prescriber's instructions. Records showed this person did not have a bowel movement for eight consecutive days and this medication was not administered. Another person had been prescribed with PRN medication to manage their agitation and pain and there was no protocols to guide staff. We shared our concerns with the regional support manager and deputy manager and they told us they would put in place PRN protocols when required and address this issue with staff in their supervisions.

Staff administered people's medicines in a caring way, giving people the choice of when and how to take it. For instance, we heard a staff member administering medication asking if the person wanted the tablets to be placed on their hands or in their mouth; we also observed staff asking if people wanted to take their medication with water or juice. At this inspection we saw improvements to how people's prescribed creams

were being recorded and how controlled drugs were being managed.

Risks to people were not always managed safely. We saw care records included risk assessments in relation to people's skin integrity, mobility and swallowing difficulties. However, one person who was known to display behaviours that challenged others did not have a specific risk assessment or care plan in relation to this. Another person's moving and handling risk assessment indicated they were able to stand and only required the assistance of one staff member. However during inspection we saw this person was always supported by two staff members and a mechanical hoist was used when they needed to move. This same person was using a pressure mattress to manage the risks of them developing pressure areas but this was not on the correct setting according with their weight. We spoke with the regional support manager and deputy manager about these concerns and they told us they would address them immediately.

The provider was not checking the temperature of the water before helping people to take a shower or bath therefore putting them at the risk of being scalded. The regional support manager told us this had been an oversight and they were going to introduce these checks.
We reviewed how the provider was managing the risks of fire and we found concerns. For example, not all staff had been involved in a fire drill, in particular night staff, so the provider could not evidence staff would be able to safely evacuate people in an event of a fire. The home's fire risk assessment indicated that 15 staff would be available during the day to help with an evacuation in case of fire. However the last three fire drills showed there were only 8 to 9 staff members at the service. One person's PEEP was not updated to reflect their current moving and handling needs. We shared our concerns with the management of the home; they showed us an updated PEEP on our second inspection day and told us they would review their fire risk assessment and complete evacuation drills with night staff soon. After our inspection we shared our findings about how the home was managing the risks of fire with the Fire Service.

These findings constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

The home was not following safe recruitment procedures. We found full employment history and gaps of employment of new staff were not being fully explored in all three staff files we reviewed. This same issue had been identified at our last inspection.

The provider continued in breach of Regulation 19 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 in relation to fit and proper people employed.

We received mixed views about staffing levels at the home. People told us, "Sometimes staff are too busy, I have to wait", "There are enough staff, I can't complain about the number of staff", "At night sometimes they come straight away, sometimes you have to wait", "Sometimes I have to wait a bit, ten minutes or so, it's not so bad at night." Relatives told us, "I think there are enough staff, I've seen the odd agency staff", "If one person takes two staff, it can be a wait [for help]", "They are pretty quick, take [relative] to the toilet straight away, I've never seen people wait" and "Disturbing and saddening is the fact that there aren't enough staff on duty at Longwood Grange Care Home to appropriately cover the needs of the residents." We asked staff's views regarding staffing levels; one said, "Staffing is good", another commented, "There should be more, sometimes we can't take a break, we can't always get to the call straight away."

The provider told us they were using a dependency tool to assess the level of support each person required and to determine staffing levels. The regional support manager and deputy manager told us they were operating with five staff members during the day and two staff members at night. When we reviewed rotas, there were four occasions, one in the morning and three on the afternoon shifts, when there was one staff

member less than what we had been told. When we spoke with the home manager they told us they usually worked with four staff members in the afternoon and that was adequate to meet people's needs; this was not the information initially provided to us.

When we looked at accidents and incidents reports for the last 3 months, records showed a substantial increase in falls in particular during the night. We shared our concerns with the regional support manager and deputy manager and they told us the increase was due to improvements in the recording of accidents and incidents introduced by the new management team and not due to an actual increase in people falling. We asked the regional support manager and deputy manager if they were analysing any trends or patterns in these falls to enable changes to be done to prevent them happening again. They told us and we saw evidence of actions taken in relation to particular people however the regional support manager acknowledged further analysis was needed to identify possible patterns and consider if organisational changes were needed to prevent them happening again.

The home had a safeguarding policy and procedures in place, staff had been trained in these and were able to tell us the signs of abuse that they would look out for and what steps to take if they had concerns. One staff member told us, "I'll go up to my manager." Records at the home showed concerns about people had been raised with the local authority safeguarding team.

The environment was safe for people. We saw safety checks had been regularly completed, there were no obvious trip hazards and communal areas were clean. We saw staff using protective equipment such as aprons and gloves were available throughout the building. We observed housekeeping staff cleaning people's rooms and good practice was followed in separating soiled linen and clothing and keeping cleaning materials locked away when not in use.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 21 and 22 December 2016 the provider was in breach of the regulation related with consent because records for the Mental Capacity Act 2005 (MCA) MCA were not consistent and incomplete. At this inspection, we continued to find inconsistency in the provider's compliance with the MCA.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 a person lacks the mental capacity to make a decision, any made on their behalf must be in their best interests and the least restrictive option available. 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 service 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.
We found good examples of people's mental capacity being assessed for specific decisions and records of best interest decisions made. However, we found relatives signing consent forms without having the legal authority to do so. People can only make a decision on behalf of another person if they hold power of attorney for finances and property or welfare and health, depending what the decision relates to. During this inspection, we also found one person's care plan indicated they were able to make decisions in relation to their care and health, however one senior staff member told us this person could not make an informed decision in relation to their medication. We shared our concerns with the regional support manager and deputy manager. They told us they would address them.

Our findings indicate the provider was in continued breach of Regulation 11 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 as not enough improvements had been sustained in this area.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. At this inspection eleven people were being deprived of their liberty and the appropriate authorisations had been requested.

At our last inspection on 21 and 22 December 2016 the provider was in breach of regulation related with staffing due to several gaps in training and staff not having access to regular supervision. At this inspection we found some improvements had been made, the provider was no longer in breach of this regulation, but further work was still required in relation to training.

We looked at the induction and training that staff received and we saw evidence of this being completed however we reviewed the training matrix and we saw nine staff have not completed fire training and eleven staff members did not have food safety training. We shared this information with the regional support

manager after our visits and they told us the matrix had been further updated and there was no staff with fire training overdue; they also told us staff requiring food safety training had been booked to do it.

There were people that were living with dementia living at Longwood Grange and improvements were required to ensure their needs were being met. We noted that the training matrix did not evidence staff had been offered training in working with people with dementia. We observed one person living with dementia in the communal area. They spent time folding and unfolding a blanket, attempting to get up unsupported and being redirected by staff to sit on the chair because it was safer. People living with dementia sometimes benefit from having available to them sensory objects to help them keep occupied and reassured. Another person who was living with dementia at the home used to display behaviours that challenge. We saw staff were not following the advice from mental health professionals in how to manage this person's behaviours and records of behavioural incidents evidenced staff were not always using a dementia friendly approach. For instance, records showed that after this person displayed aggressive behaviour towards staff, staff "told [person] that [their] behaviour was unacceptable" and "explained to [person] that this behaviour was wrong." People living with dementia have variable levels of cognitive impairment and frequently have difficulty in communicating their needs, likes and dislikes. Their behaviour is a form of communication and staff should try to understand and act as appropriate. This person had been prescribed pain relief medication for which there was no PRN protocol to guide staff and staff were not using appropriate tools to help them assess the level of pain this person might be experiencing, such as the Abbey Pain Scale. We recommend the provider to consult reputable sources of information in relation to dementia care such as the National Institute for Health and Care Excellence (NICE) or the Social Care Institute for Excellence (SCIE). These findings constitute a breach of Regulation 9 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Records showed staff were being offered regular supervision and appraisal since the new management team have started and staff told us their found these useful. Staff comments included, "It is good" and "It is fine, we discuss training and if we have any concerns they [management] will take it on board."

We asked people about their meal experience at Longwood Grange. They told us, "The food's ok, there's enough, it's hot", "Not spectacular, it depends what you have", "The food is very nice", "It is eatable, it's not seasoned enough, not tasty, it's hot or warm most of the time, there is enough choice and you're not hungry." One person had requested improvements in the tea menu twice and this had been recorded in the resident meetings in July and September. People were offered a choice of meal at lunch time which was the main meal and a lighter meal at tea time. Our observations confirmed people were given a choice and meal experience for people choosing to use the dinning area was positive with people interacting with each other. However, we noticed that every person choosing to use the communal area were having lunch at the same time and we saw no evidence of people being offered the choice of having lunch at a different time. We shared these observations with the regional support manager and they told us this was happening for safety reasons, to ensure food was served after being cooked and avoid any risks with storing and reheating cooked food. They also told us people's preferences were discussed at admission but they would raise this theme again at resident meetings. We saw the home manager and deputy manager had conducted audits on the mealtime experience but no actions had been taken or were planned.

We spoke with the cook and staff about people's dietary needs and they were knowledgeable about people's requirements; for example, who required fortified meals due to weight loss or were diabetic. The provider was monitoring people's weights and we saw actions being taken when people lost weight for two consecutive months, as per the provider's policy. For instance, one person was at risk of malnutrition, was having fortified meals and had been prescribed with nutritional supplements but was still losing weight; records showed the dietician and the GP had been contacted for advice. Another person's health was

deteriorating and this was having an impact on their appetite and weight; the provider had been in contact with other healthcare professionals and a referral to the dietician was made on our first inspection day. However, records of the food and fluids consumed by service users at risk of weight loss lacked the detail required to make them meaningful because the amount of food the person was offered and had consumed was not recorded. The regional support manager showed us a matrix they were using to monitor people's weights and this was reviewed every month in the report prepared by the home manager.

Staff said the team worked well together and they communicated with each other about the care people needed or any changes to their health. We saw from records that people had attended appointments with specialists, opticians and dentists. Comments from people and relatives confirmed this. People told us, "Staff would ring the GP for me", "They do it [contact the GP] straight away, they don't mess about." One relative said, "The memory clinic came when [relative] had just started here and the opticians visit every year."

Requires Improvement

Is the service caring?

Our findings

We asked people if staff were kind and caring. One person said, "Yes they're fine, I haven't had a problem". Another person said, "Some are, they vary; they might say you'll have to wait." And another commented, "They're really nice staff, they'll do anything." Relatives told us, "Staff are kind and caring, there is no trouble" and "The staff are caring."

People's dignity and confidentiality was not always respected. During our first inspection day we saw people's records were not safely stored because the door of the office where they were kept was regularly left opened and unlocked. We shared our concerns with the regional support manager and deputy manager on the day but on our second inspection day the same was happening. We heard staff talking about people's confidential information in communal areas while other people living at the home were present. For instance, on our first inspection day we heard two staff members talking about a person's skin integrity in the communal area. We mentioned this to the deputy manager and they immediately asked the staff members to move to another area. We observed one person asking staff to support them with transfers so they could use the bathroom; the staff member acknowledged and shouted to another staff member who was in the communal area saying, "[Person] wants to use the toilet." We shared our concerns with the regional support manager and deputy manager and they told us improvements had been made since new the management team had started and they showed us records of issues with people's confidentiality being discussed during team meetings and in individual staff supervisions.

These findings constitute a breach of Regulation 10 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 in relation to people's dignity and respect.

During this inspection we observed warm and positive interactions between people and staff. We saw several examples of staff showing affection towards people, for example, we saw a person touch a staff members hand and the staff member positively engaged with the person by putting their hand onto their hand. We also heard staff calling people by their name or terms of endearment. We observed staff promptly attending to people if they heard them calling out or observed them in need of attention. For example, we observed one person living with dementia walking in the dining area and appearing to be confused to where they were, the deputy manager noticed this and promptly asked this person if they were ok, they said, "I need to go to the bathroom and I don't know how to get there;" the deputy manager offered to guide the person to where they wanted to go.

People told us they could make choices and that staff listened to them. They told us, "I make my own choices" and "I have to ask [for a bath or shower], I can have when I want one, staff respect my privacy". One relative said, "[Do staff listen?] Definitely, I go to them with problems." The deputy manager was aware of using advocacy services and had helped one person to have an advocate to support them making decisions about their safety and health. By doing this, the provider was supporting people to continue to be involved in decisions about their care even when they showed some difficulty in being involved.

Some people and relatives told us they had been involved in planning and reviewing their care but when we

checked the records these were brief and did not show how people had been involved. Three people told us they knew they had a care plan but had not seen it. Relatives told us "Staff talk to me when things change" and "I was involved in care planning at the beginning."

People's needs in relation to the protected characteristics under the Equalities Act 2010, were taken into account in the planning of their care. For example, people's communication and specific health conditions were assessed. The deputy manager told us and showed us evidence of one person they had been supporting who had recently moved to another home whose main language was not English so the home printed a menu in person's mother tongue to facilitate and support their choice of meal.

Requires Improvement

Is the service responsive?

Our findings

People told us they felt supported by staff that knew them. They also felt able to feedback on the care they received if they had any concerns or complaints. One person said, "I would speak with one of them [carers] or to [home manager], I've not had to. Another person commented, "I have never had any worries concerns or complaints, I would speak to the manager."

The regional support manager and deputy manager told us they assessed people prior to admission to the home. The pre- assessment included gathering information about people's needs and preferences. When we looked at people's care plans, we saw these were organised by sections which included information about people's medical conditions, personal care, mobility, communication, skin integrity, records of professional visits/referrals and end of life care.

There was a risk of people receiving inconsistent support because information in people's care plans was not always consistent with the care people were receiving; some information was not up to date and some people did not have specific care plans for their needs. We checked one person's care file and saw they were at risk of chocking and had been losing weight and staff had been in contact with healthcare professionals regarding this, however this person did not have an eating and drinking care plan. We saw one person's allergies had not been recorded in their care plan or fully in their MAR. This issue had already been identified by the pharmacist during a medication review more than two months ago but no changes had been made. Another person who was known to display behaviour that challenged others did not have a behaviour care plan. This same person liked to be called by another name which staff knew and used, however there was no indication of this in the person's care plan. We shared these concerns with the regional support manager and deputy manager and they told us they would address these concerns.

We saw people's care plans were regularly reviewed however changes in people's needs were not always prompting changes in people's care plans. One person's mobility needs had changed and they now required support by two staff using a mechanical hoist but their mobility care plan and PEEP continued to indicate they only required support from one staff member. We shared our concerns with management and on our second inspection day we saw this information had been updated.
The above evidence constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

We asked people and relatives about the activities happening at the home and we received mixed views about this. People comments included, "There are musical activities, quizzes, stuff like that, it's quite good", "I can go anywhere, I go out with [activities coordinator]", "there's enough for the staff [to do], no not enough for me" and "I've been out with [activities coordinator), sitting in the car and relaxing, watch the world go by, there's it enough to do but I don't know what I would like [to do more], it's boring." Relatives told us, "There's not enough staff for what they should be doing, to occupy them, keep them busy, they try but there is not enough", "There aren't enough activities, [relative] has been out, [relative] didn't like it" and "There is an entertainments man and a girl in the afternoons, they do quizzes and songs."

The provider offered a regular and varied programme of activities at the home. However we found people were not offered enough social stimulation throughout the day and spent long periods of time sitting in the lounge. There were two activities coordinators at the home and they had developed a plan of activities however when we reviewed people's activity records these showed some people were not regularly involved in activities. For instance, records showed one person had been involved in activities on the 19 September and then again on the 9 and 14 of October. NICE guidance 'Older People: independence and mental health' recommends that people living in care homes should be offered meaningful activities during their day to maintain and improve their mental health. We shared our findings with the regional support manager and deputy manager and they told us improvements had been made to the activities on offer since new management had started however some people preferred to watch TV and have quieter moments. They told us they would discuss activities during resident's meetings.

The home was not providing end of life care to anyone at the time of our inspection. However one person was on the palliative care pathway, which meant they may require this in the future. Staff told us they felt confident in providing end of life care if required and knew what actions to take if a person deteriorated. We saw one person had been prescribed with anticipatory medication to manage pain symptoms, this was available at the service but district nurses were in charge of administering this if required.

There was a complaints policy and procedures in place and people and their relatives told us they would feel confident to report any complaints or concerns. We reviewed two complaints the home had received and we saw these were investigated in a timely manner and outcomes communicated to the person making the complaint.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 21 and 22 December 2016 the provider was in breach of the regulation related with good governance because of a lack of effective auditing processes in place and breaches in regulations related with consent, safe care and treatment, staff's access to training and supervision and fit and proper people employed. We have served a warning notice on the registered provider and told they had to become compliant with the Regulations by 12 April 2018. At this inspection we found not enough improvements had been made in some of the areas identified and the provider was in continuous breach of regulations related with consent, safe care and treatment, fit and proper people employed and good governance. We also identified two new breaches in relation to person centred care and dignity and respect. This showed the provider continued fail to implement the necessary improvements to be compliant with the regulations and the fundamental standards which demonstrated a systematic failure of the governance systems in place.

We asked people, relatives and staff about the management of the home. Comments from people included "I don't know who the manager is, I think it's a fella", "Yes, I know [who the manager is]" , "Yes [its well managed] and "It is not a miserable place, sort of in between happy and miserable." Relatives told us, "I know the manager by sight, I would speak to her if I were worried" and "I think it's well managed." Staff told us improvements had been made since new management team took over. Comments included, "They are new, but they are ok, we have got quite a few [managers] these last years" and "Staff and residents and happier, there is a good environment, everyone talks to everyone" and "New management team are more knowledgeable, more positive which than passes onto us." Despite these comments, at this inspection we found the service was not well-led.

The quality assurance systems implemented by the provider were ineffective to ensure the best delivery of care. The service carried out various quality audits of records including audits of medication administration records, residents' files, nutrition and dining experience audits however these had not been effective in recognising or improving the issues identified at previous and at this inspection. For example, monthly audits had been done by the management team but the issues found at this inspection such as no PRN protocols or advice from pharmacist not being followed had not been identified. Two of the care plans reviewed during inspection had been recently audited however the issues we found at this inspection were not identified by these audits. The nutrition and dining experience audits conducted did not reflect the comments shared by people or our observations of peoples' meal experience at the home.

The regional support manager showed us a quality improvement plan had been devised following the warning notice issued in March 2017; they showed us records of meetings where this was discussed and told us most of the action plan had been signed off as completed. However, on this inspection we found that this was not the case and sufficient improvements had not taken place. For instance, the action plan indicated that analysis of trends of accidents and lessons learnt were required and had been completed in March 2018 however we found this was not happening. The same action plan indicated that due to 'residents being in one communal room, this can trigger potential behaviours' therefore 'include in care plans where behaviour may be an issue with methods of how to distract the situation.' However, at this inspection we found one person who was known to display behaviours that challenged others did not have a care plan and advice

from mental health team was not being followed. The action plan indicated other areas for improvement that were identified at this inspection such as privacy and dignity to be respected in the communal lounge or 'memory and fiddle aprons to be sourced' that should have been completed in April 2018 but had not been signed off as completed.

During this inspection we found areas where the management's oversight and governance had failed and this was putting people at risk of not receiving safe care. For instance, no checks were being done on the temperature of the water before supporting people with taking a bath or shower therefore placing people at risk of being scalded. We saw bowel movement charts had several gaps in recording which made them ineffective as a monitoring tool and they were not being used to inform decision about people's care and health. The provider was recording the quantity of fluid people took however no record was being made of the quantity of food offered or taken by people or at what time, which meant the provider could not use this information to monitor how much food people were taking and address any concerns with this. The provider was not keeping a close oversight of staff's training. The reporting of accidents and incidents was inconsistent and no analysis was being done on trends and patterns to enable the implementation of organisational changes to prevent them happening again.

Since our last inspection, the provider had not ensured a robust leadership capable to drive the improvements needed in the areas that had already been identified at last inspection. The home had a manager who was in post since June 2018 but they had not yet registered with the Commission to manage this service. It is a legal requirement of the home's registration that a registered manager is in post. After our inspection visits, the home manager showed us evidence that they had recently submitted their application to manage the service.

During the inspection, the provider was receptive to the areas of concern identified and in most of the cases, responsive in introducing the changes needed. For instance, staff that had food and safety training overdue were book into training; plans were put in place to review the home's fire risk assessment. However, the fact that these issues had to be once again highlighted to the provider during an inspection showed a persistent lack of good governance and a continued inability to drive the improvements needed at the home.

These findings constitute a continued breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

The registered provider organised resident meetings to gain feedback from people. One person told us, "There's been one or two but I was in the bath so I missed them." Another person said, "I missed it on Wednesday as I went out with [activities coordinator]." Relatives also confirmed they had been asked for their feedback through meetings and a questionnaire. One relative said, "There are family meetings, I don't go as there are no problems, I've had a questionnaire every year." Another relative commented, "I've not been to any meetings." Staff meetings were also regularly organised. We saw relevant discussions about the management of the home being held. Staff told us they found them useful.

There was evidence that the provider was working with external organisations in relation to the care provision. For example, the provider had regular contact with the GP, dieticians and other community care teams.

Under the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015, registered providers have a legal duty to display the ratings of CQC inspections prominently in both the office and on their websites. On our arrival at the home we saw the ratings from the last inspection were displayed.

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 living with dementia did not always receive person centred care to meet their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect We saw people's records weren't safely stored and we observed staff talking about people's confidential matters in communal areas.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider's compliance with the Mental Capacity Act 2005 was inconsistent. Assessments and best interest decisions for some people living with dementia were in place but we saw relatives giving consent for decisions without having lasting power of attorney.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Breach of Regulation 12 (2) (a) (b) (d) (g). Medicines were not always administered in a safe way. Risks to people were not always managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment process were not robust as staff's full employment history and appropriate references were not always sought in line with regulations.