Roseberry Care Centres GB Limited

Swiss Cottage Care Home

Inspection report

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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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We carried out an unannounced inspection at Swiss Cottage Care Home on 28 June 2016 and 6 July 2016. Because we received information of concern in the following these visits we carried out further visits on 2 August 2016 and 15 August 2016.

The home provides accommodation, support and treatment for up to 84 people who require nursing and personal care; some of whom may be living with dementia. At the start of our inspection there were 62 people living at the home but this had increased to 65 during the latter part of our inspection. People lived in three units at the home, dependant on their care needs. The first was a residential unit for people who required personal care in which 20 people lived. The second was a unit for people who required nursing care and the third unit accommodated people who required nursing care but were also living with a dementia.

The home had a registered manager in place at the start of our inspection but they left the service after the initial two days of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Following the registered manager's departure management of the home was overseen by the provider's Home Support Manager and their Regional Operations Manager. In their absence the home was managed by the recently appointed Agency and Recruitment Co-Ordinator, who had worked at the home for a number of years previously as the deputy manager. They had left the post in February 2016.

People told us that they felt safe at the home because there were people around. However, there were insufficient trained, experienced staff to always provide the care and support people needed at the time they required it. As a result people had to wait for assistance to be provided, be this with personal care or assistance to eat their meals. There were discrepancies with the stocks of medicines held and we were not assured that people had received their medicines as they had been prescribed.

People's needs had been assessed prior to their admission but there were not always care plans in place to show how all the identified needs were to be addressed. Where they were in place, care plans did not always give staff sufficient information to ensure that the planned care addressed the identified needs of the individual. Similarly the assessments of risks identified as arising from people's care and treatment had not always been completed. People were not always supported to maintain their interests and hobbies and people who were living with severe dementia were unable to participate in the activities arranged. People who were nursed in their rooms were at high risk of experiencing social isolation.

There was no evidence that people had consented to the care provided or, where they lacked capacity to make or understand decisions, that those made on their behalf had been in accordance with the requirements of the Mental Capacity Act 2005 (MCA).

The recruitment procedures in place gave the provider assurance that the staff recruited were suitable for the posts they applied for. Staff were provided with appropriate induction and on-going training. They were supported by regular supervision and appraisal meetings at which they were able to discuss their performance and training needs. They were encouraged to make suggestions for improvements to the service.

People found the staff to be caring and kind. Staff promoted their dignity and independence and treated them with respect. People and their relatives were aware of the complaints system and complaints had been dealt with in accordance with the provider's policy.

Although there was an apparently robust quality monitoring system in place this had not always been effective. Records were not always accurate or complete.

During this inspection we identified that there were a significant number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 safe.

There were insufficient staff to provide for people's needs at all times due to the size and layout of the building.

The assessment of risks arising from the provision of care and treatment had not always been determined.

Incidents were not always recorded to enable an analysis of causes to be undertaken and thus reduce the risk of recurrence.

There were discrepancies between the records and stocks of medicines held which indicated that medicines may not have been administered as they had been prescribed.

Is the service effective?

Requires Improvement

The service was not effective.

There was no evidence that people had consented to the care and treatment provided. Where people had been assessed as lacking the capacity to understand decisions those made on their behalf were not made in accordance with the Mental Capacity Act 2005.

People were supported to have sufficient to eat and drink to maintain their health and well-being.

Other healthcare professionals were involved in the care and treatment of people

Is the service caring?

Good

The service was caring.

There was positive interaction between staff and people throughout our inspection.

Staff respected people's privacy and dignity.

People were encouraged to be as independent as they wished.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care plans in place did not address all the identified needs of people. The care plans did not provide sufficient detail for staff to be able to support people appropriately.

People were not supported to maintain their interests and hobbies and were often bored. The activities provided did not enable people living with severe dementia to take part.

There was an effective complaints policy.

Is the service well-led?

Requires Improvement

The service was not well-led.

The registered manager had left the service during the period of our inspection. The Agency and Recruitment Co-ordinator appeared to be acting as the manager.
Quality audits carried out by the acting manager failed to identify shortcomings with care records.

People and visitors were encouraged to contribute suggestions for improvements to the service by way of comment books and meetings.

Swiss Cottage 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 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.

The first part of this inspection took place on 28 June 2016 and 6 July 2016 and was unannounced. The inspection team was made up of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of caring for people living with dementia and with multi-disciplinary teams in care homes. Following concerning information which was then received, further visits were made on 2 August 2016 and 15 August 2016.

Before the inspection, the provider completed 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 also reviewed the information we held about the home. and the provider's Statement of Purpose. The statement of purpose is an important part of a provider's registration with CQC and a legal requirement. It sets out what services are offered, the quality of care that can be expected and how the services are to be delivered. We also looked at the notifications that the provider had sent us and information that had been received from members of the public, staff and other healthcare professionals. A notification is information about important events which the provider is required to send us by law.

During the inspection we observed the interaction between staff and people and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with six people using the service, four relatives of people who lived at the home and a visiting healthcare professional. We also spoke with the registered manager, the provider's Regional Operations Manager, the chef and five care staff. During the two later visits we also spoke with the provider's Home Support Manager, the recently appointed Agency and Recruitment Co-ordinator, who was subsequently appointed as the Deputy Manager, and the provider's Quality and Compliance Director. During the inspection we reviewed the care records for eight people who lived at the home and the recruitment files for three members of staff. We also reviewed management records on

complaints, premises and quality.

Requires Improvement

Is the service safe?

Our findings

People did not always get their medicines as they had been prescribed. One person, who had been prescribed paracetamol on an 'as required' (PRN) basis, told us, "The other night I had a terrible headache and kept calling out for someone." They said that no member of staff had responded to their cries for help and they were eventually given some paracetamol in the morning.

We carried out checks on five people's medicines. We found there were discrepancies between the stocks held and the amount indicated in people's records in two cases. In both cases the quantity of medicines held exceeded that indicated by the records and there was no explanation available for this. We checked the medication administration records (MAR). These had been appropriately completed and there were no omissions found. However, the discrepancy in the stock levels meant that we could not be assured that people had received their medicines as they had been prescribed.

The registered manager had recently changed how people's medicines were stored. Instead of medicines being stored in a central trolley these had been moved to individual locked cabinets in people's rooms. The registered manager told us that this increased interaction between staff and people. However a nurse told us that the new system greatly increased the time it took to administer people's medicines as they had to take the medicines from a person's cabinet to wherever the person was sitting to administer it. This was not a problem if they were in their room but if they were in a lounge or the dining room it could be a considerable walk. The nurse was not available to support people with other aspects of their care for longer periods because of the time taken to complete the administration of medicines at each round.

There were personalised assessments for identified risks for each person. These identified the risk, the people who may be affected by the risk, the measures already in place to reduce the risk of harm and any additional control measures needed to keep people safe. There were recognised tools in place to assess people's risk of falls, moving around the home and of developing pressure areas. Where people had been identified as at risk of falls the reason why this was so had been identified, such as the person was at risk of falls because they walked with a frame. When a person experienced a fall this was recorded in the falls log and an accident record completed. However, we found that not all falls had an accident form completed. The daily notes for one person showed that the person had suffered an unwitnessed fall and observations had been completed but there was no accident form completed. Similarly risk assessments had not been properly completed. For example, a risk assessment that had been completed with regard to the use of bed-rails had no outcome recorded.

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

People we spoke with during the first day of our inspection told us that there were insufficient staff to provide the care they needed at all times. The home is large and the staff turnover had been high. A relative told us, "There tends to be a lot of agency staff." This was confirmed by looking at the staff rota and speaking with the registered manager. The provider was actively seeking to address this. The registered manager told

us that they had received a directive from the provider that no agency staff should be used after the 8 August 2016; although they did not believe that they would be able to comply with it because they did not have enough permanent staff in post to cover the rotas. One person said, "The home could do with more staff." Another person told us that when they called for assistance to go to the toilet sometimes they had to wait so long they wet themselves. Despite there being insufficient staff to meet people's needs a further 3 people had been admitted to the home by the latter part of our inspection.

During the latter part of the inspection we observed that people were left alone with no contact from staff in both the lounge and the dining areas of the nursing units. A group of seven people were in a circle in one of the lounge areas in the mid afternoon. We observed them for five or six minutes. All of them were asleep and one person had fallen asleep whilst holding a drink, which had tipped onto their lap. The only staff member present was providing one to one care for a person in the corner of the room. A senior care worker told us that they had left the people in the lounge whilst they went to fetch the tea trolley. We had observed a number of people in the dining area on the same unit. There was no staff member in the room and one person had been calling out for at least 10 minutes before a member of staff attended to them. Feedback we received from a healthcare professional also highlighted that there was insufficient staff deployed around the home. They had observed call bells ringing continuously and people calling for help but no staff responded to them when they visited.

Although staff we spoke with told us that there was enough staff, they acknowledged there was a lot of use of agency staff. Although the registered manager told us that they tried to have regular staff from the agency, as they had some knowledge of people's needs, they were not always available. One member of staff told us, "Sometimes there is not enough staff and they get agency staff to bring it up to the right number." Another member of staff told us, "The team is big enough. When we have enough staff it is nicer for us. Things are not being rushed and people get the time and care they need."

We spoke with the registered manager, during our earlier visits, who told us that staffing levels had been determined by using an adaptation of a recognised tool based on the dependency levels of the people who lived at the home. This was reassessed every time there had been a change, such as a new person being admitted to the home. They agreed that there had been a high number of agency staff but stated they had taken steps to recruit more nursing and care staff. These had included increasing the pay to be offered to nursing staff and displaying the advertisement for nurses to fill the vacancies on a banner outside the home. The registered manager and the Regional Operations Manager had also made plans to recruit care staff from overseas. The registered manager showed us the noticeboard in the reception area which displayed the staff rota and highlighted the staff that were from agencies. People, visitors and staff were thus made aware of how many staff supplied by agencies would be covering each shift.

During second part of the inspection we were told that the nursing vacancies had been filled. We were also told that the method of calculation of staffing needs had been amended and was to be based on the standard tool. The Regional Operations Manager provided us with details of the calculations used which determined that there was an appropriate level of staff for the number and dependency levels of the people who lived at the home. This was based on an adaptation of a system devised in 1970 and care practices and expectations have considerably changed. They have moved away from the institutionalised practices, prevalent at that time, to a more person centred approach. However, because of the size and layout of the home, the revised calculation still did not appear to ensure that there was an adequate number of staff deployed in all areas to provide care when people needed it.

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

People we spoke with told us that they felt safe living at the home. One person told us, "I feel very safe. There's usually someone walks past the door." Another person said, "I feel very safe here. They're very attentive. I feel secure." One person told us they felt safer after locks had been put on the corridor doors in the unit. They said, "I was getting people wander in my room in the middle of the night. That frightened me."

The provider had up to date policies designed to protect people from abuse which included safeguarding and whistleblowing. A relative told us that they had been made aware of a safeguarding incident that had involved their loved one and a member of staff. They told us that the registered manager had acted very quickly to resolve the issue. Staff we spoke with were able to demonstrate a good understanding of the types of abuse that may occur and knew how to report this should they need to. One member of staff told us, "I last had safeguarding training about four months ago. If I had concerns I would contact the [local authority] safeguarding team. We have posters in the staff room that have the office numbers we can call." They were also able to demonstrate their awareness of the whistleblowing policy. Another member of staff said, "I know about the whistleblowing policy but I have not experienced it."

We saw that the necessary recruitment and selection processes were in place and the provider had taken steps to ensure that staff were suitable to work with people who lived at the home. We looked at three staff files and found that in two of the three records appropriate checks had been undertaken before the staff began work at the home. These included written references, and satisfactory Disclosure and Barring Service clearance (DBS). DBS is a way for employers to check whether there is any concerning information on file about the applicant to enable them to make safer recruitment decisions. Evidence of their identity had been obtained and checked. In the third record evidence of the applicant's right to work in the UK had not been recorded. Enquiries were made of the relevant authority whilst we continued our inspection and confirmation was received that the member of staff did have the right to work. This was recorded in their recruitment file.

We saw that there were processes in place to manage risk in connection with the operation of the home. Emergency plans and procedures were in place and each person had a personal emergency evacuation plan (PEEP), which had been updated recently.

Requires Improvement

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Decisions that are made in people's best interests should be made in consultation with members of the multi-disciplinary team involved with them, family members and advocates. We found that where best interests decisions had been documented in people's care plans, such as for 'daily living activities', the member of staff who had taken the decision had failed to consult with any other person and had failed to document the reasons why the decision had been made.

Care plans that we looked at during the latter part of our inspection did not contain evidence that people had consented to the care and treatment provided. Two of the plans contained forms that had been completed by staff at the home which purported to give consent for the administering of medication, liaising with the GP and multi-disciplinary team, basic clinical procedures, such as dressings, urine dipstick tests and observations. Consent to these areas was recorded as having been given verbally to the member of staff by the individual's next of kin. Although one of the relatives consulted was understood to have Power of Attorney which would enable them to make decisions on their relative's behalf they had not provided verification of this to the provider. The decisions made therefore did not comply with the requirements of MCA. There was no consent in any of the care plans for basic care and support to be given. The people had been assessed as lacking the mental capacity to make decisions for themselves and no decisions had been made that it was in their best interest to receive the care and support.

We saw that a safety gate had been installed in the doorway of one person's room to prevent another person from entering the room. Consent for this to be in place had been signed by the acting manager and had been annotated that the person's relative should be asked to sign the document. However, although the person did not have capacity to make decisions for themselves and a risk assessment had been completed with regard to the use of the door guard, no best interest decision had been recorded. We saw that applications had been made to the relevant authorities where it had been determined that people had been deprived of their liberty. The acting manager told us that the person for whom the door guard had been fitted was unable to mobilise independently so the use of the door guard did not deprive them of their liberty. This showed a lack of understanding of the requirements of MCA by the acting manager.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff explained ways in which they gained consent from people before they carried out any care. One member of staff said, "I explain what I am going to do and look for signs that they agree, such as nodding. I give them time and talk to them if they don't like what I am trying to do. I don't force them though and try different ways of still helping them." Another member of staff told us, "A lot of residents have dementia. I give them time and if they can't give verbal consent I use non-verbal signs, such as facial expressions, to make sure they are okay with it. You get to know them; you work with the same people and build up a relationship with them."

People told us that they were involved in the way that their care was delivered. One person told us, "I often have a lie in and they bring my breakfast to me." Another person told us, "It's my choice to eat in my room. Staff are happy to bring my food here." One person said they were invited to go to the activity room every day but they chose to stay in their room whilst another person told us that they often went out and, "Staff have no problem with me coming and going."

People had mixed opinions on the food and drink at the home. One person told us, "The food is very good and we get two choices and it's always nice and warm." Another person said, "We have two choices of main and one choice of pudding. There always plenty and it's nice and warm I couldn't ask for more." However another person said, "The food is not up to much" and told us that they didn't eat their pudding as it was chocolate pudding and they did not like that. Another person commented, "I'm not too happy about the food; it could be better." A member of staff told us, "They have choices. At meal times we will give people visual choices. Some residents don't hear well but can read the menu and decide what they want."

We observed the lunchtime meal experience on both floors. On the ground floor people had been sat in the dining area for a long time before the meal service started. Although the food was kept warm in the hot trolley some people had to wait a considerable amount of time before their meal was served and people sat at tables did not all receive their food at the same time. We saw that on one table a person had eaten both their main course and their dessert before another person was given their main course.

Many people required assistance to eat their food and had to wait until staff were available to support them. We saw that one person had their meal put in front of them but had to wait for more than 15 minutes before a member of staff was able to assist them. Their food would therefore have cooled considerably before they ate it.

We spoke with the chef who told us that they had made changes to menus and mealtimes. They said that menus have been devised using information provided on people's diet sheets and their preferences identified during their care assessments. They told us that the menus were seasonal and used tried and tested options. They made gluten free and low sugar options for people who had health conditions requiring these. These meals were plated separately and labelled in the hot trolleys to ensure that they were given to the people who required them.

The chef told us that they fortified food when this was required using whole milk and double cream. Fresh fruit and vegetables were used in preference to frozen and fruit smoothies were provided both mid-morning and mid-afternoon. They said that they attended meetings with the nursing staff to discuss the menus but had been unable to attend and meetings for people or their relatives.

Staff told us that they monitored people's weight and introduced food and fluid charts where there were

concerns about people's nutrition. One member of staff said, "If I am concerned about someone I would tell the nurse and get the dietitian involved. If people need a soft diet the speech and language therapist (SALT) team come to assess what type of diet is most suitable for them."

New members of staff told us that they had received induction training which had included dementia awareness. Staff told us that they had ongoing training in all areas that the provider considered to be mandatory, including safeguarding, moving and handling and fire awareness. One member of staff told us, "When you're training you learn things you didn't know before and get new ideas you can implement in care." Staff underwent training in dementia awareness. A member of the care staff told us that one of the nurses had done a lot of work with people who were living with dementia and had done training with the care staff. One member of staff told us that the dementia awareness training they had completed had enabled them to identify things they could do with people day by day that reminded them of the everyday things they used to do.

Staff told us that they had regular supervision. One member of staff said, "I have supervision about two months ago. We talked about what is good, what is wrong and what we would like to change. I said we need more staff as a lot of residents now need lifting by the hoist." Another member of staff said, "We talk about ways in which I can improve, things I want to work towards, any training I want and any concerns I have about work. It is an opportunity to make suggestions for improvements." We saw that, as well as supervision, staff received annual appraisals.

The Regional Operations Manager told us that the registered manager was supporting nursing staff through the revalidation process and would sign off the revalidation. However the registered manager was no longer in post by the time the inspection had concluded and this was an area that would need to be addressed following their departure.

People were supported to access healthcare services. One person told us that when they needed to see a doctor a little while ago as they had a urine infection the staff were very quick in getting a doctor to visit them at the home. They said, "They're very good like that they got me better." A relative told us, "They're very good like that. [Relative] had a couple of urine infections they got a doctor straight away." We were told that the GP visited the home twice a week and people could see them at these times, but the GP would attend at other times if staff requested it.

A visiting healthcare professional told us that the staff were very responsive to any issues with people that they had noticed and drew their attention to them quickly. Staff were helpful and followed any advice that they had been given.

The registered manager told us that although staff currently accompanied people to attend their healthcare appointments relatives were being encouraged to take on this responsibility.

Good

Is the service caring?

Our findings

People told us that the staff were caring. One person said, "There are far more poorly people in here than me, but on the whole they're good staff." Another person said, "They're jolly kind, especially the younger ones." A third person said, "The staff are very caring. The regular ones are lovely but there's a lot of changing faces." A relative said, "The staff have an incredible amount of understanding and patience."

Our observations confirmed that staff interacted in a very caring and respectful way. When people were reluctant to do something, such as eat their meal, staff encouraged them in a very gentle way.

Staff told us of actions they took when people became anxious or distressed. One member of staff said, "I talk to them in a respectful way. Some can tell you what has upset them. If they swear I tell them that it is not appropriate language and carry on helping them." When staff noticed people behaving in a manner that could have a negative impact on others they spoke with them quietly and distracted them from the behaviour by encouraging them to undertake a different activity, such as to have a cup of tea or talk about their lives.

People told us that the permanent staff understood their care needs and knew them well. One person said, "I think staff know what they're doing. It's the agency one's that don't know us very well." We observed that staff knew what people liked to drink without having to ask them. Staff told us that they used people's care plans and also talked to other members of staff that cared for people to understand their needs. This showed that people were supported by staff who understood them.

Staff respected people's privacy and dignity. One person told us, "I get my hair done every week here and my nails painted. They always knock on my door before entering and always wear gloves when doing personal hygiene." We saw that, if people were in their rooms, staff knocked on the door and waited to be invited in before entering the room. One person told us, "They always knock before coming in my room. They are respectful like that." Staff told us of ways in which they promoted people's dignity, such as ensuring doors and curtains were closed when providing personal care and speaking quietly to people about personal matters in communal areas.

People told us that they were supported to be as independent as they wanted to be. One person told us that they were quite independent and washed and dressed themselves They went on to say that if they needed help that staff always upheld their dignity. Another person said, "I dress and wash myself but carer's always ask if I can manage."

People and visitors were provided with a lot of information around the home. There was a memo board displaying a list of forthcoming dates for residents meetings, staff rota's, the first aid policy and complaints procedure with step by step guidance on how to make a complaint. There was also a leaflet on the safe guarding of vulnerable adults and details of how to make a referral if this was needed.

People told us that their friends and family could visit whenever they wished. One person told us , "My family

are free to come and go as they please. There is no restriction." A relative told us that they came to the home every day.

Requires Improvement

Is the service responsive?

Our findings

The care records showed that before a person was admitted to the home a pre-admission assessment was completed to identify their needs and check that these could be met at the home. A temporary care plan to cover the first 72 hours following admission was also developed. It was from these pre-admission assessments and information gained following admission to the home that the full care plans were devised.

People and their relatives were not sufficiently supported to know what information was in their care plan. None of the people we spoke with remembered having seen their care plans, although some had capacity to make decisions for themselves. Some people thought that their relatives dealt with it. Some of the relative's we spoke with were aware of people's care plans although they had not seen them. One relative told us that they had been waiting for 12 weeks to see their relative's plan. However, another relative told us that they were always contacted by the manager if anything changed within their relative's care and felt very involved in making decisions within their relative's care plan. The care plans that we looked at during our initial visits showed evidence that they had been reviewed on a monthly basis, or earlier if there had been a change in a person's needs. These plans were quite detailed and gave staff enough information to provide care effectively. For example, one care plan for sleeping detailed that the person liked to have two pillows and a quilt on their bed and they did not like to be disturbed at night time. The plan advised staff to check on them very quietly during the night and not to put the light on in the room when carrying out the checks.

During the latter part of the inspection the Agency and Recruitment Co-Ordinator told us that some care records had recently been completely re-written following recent safeguarding concerns having been raised for individuals. Previously care plans had been typed and were clearly legible. The change of recording care plans from typed text to handwritten text meant that this document was not always legible.

We saw that the revised care plans did not always address the stated aim of the care. For example, a care plan in respect of 'Working and playing' stated that the aim of the care was 'to minimise any risk of social isolation and developing low mood.' The planned care failed to address how this aim was to be met and actually enhanced the risk of social isolation as all the activities identified were of a solitary nature. The care plan stated that the individual had one to one time during the day. When we looked at the activity record for the person during the visit on 6 July 2016 there had been no one to one activity recorded. On 2 August 2016 there had been little activity and none had been recorded after 26 July 2016. We brought this to the attention of the Home Support Manager. When we looked at the record again on 15 August 2016 we saw that there had been only three periods of activity with the person in the preceding two weeks. The Regional Operations Manager told us that these periods would usually be for 30 minutes. The person's social isolation was further intensified when a door guard was installed to prevent other people wandering into their room.

Another of the revised care plans concerned a person's sleeping. The aim of the care plan was to ensure that the person had a healthy sleep pattern. The planned care identified that the person 'occasionally wakens and starts shouting.' There was no indication as to the steps staff should take or how they should support the person when this occurred. Our review of the revised care plans identified that the planned care frequently took the form of a statement of the current provision of care and treatment but failed to address

the aims of the plans.

Care Plans had not been developed to cover all of the needs assessed for some people. For example we saw that one person had been assessed as having behaviour that could have a negative impact on others. However there was no plan to advise staff of how this behaviour should be managed.

People told us that they were not always supported to maintain their interests. One person told us that they had read almost all of the books in the bookcase. They liked to do crosswords and puzzles but told us, "There aren't any. I have mentioned it. I get very bored sometimes." We observed the activities co-ordinator as they ran the 'breakfast club' for residents in the dementia unit. Unfortunately we saw that people who were living with advanced dementia could not participate in some of the activities on offer. We observed that at times people were left alone in the lounge or dining areas with nothing to stimulate them; no television on or music playing. Care records we looked at showed that people who were cared for in bed received little attention.

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

However, one person told us that they were invited to attend activities daily but preferred to stay in their room and knit. A relative told us that the activities co-ordinator was good. They said, "She's good. She takes them (residents) out in the garden and they have tea parties." We spoke with the activities co-ordinator who showed us the weekly schedule for activities. This included the breakfast club which 12 people normally attended. They also provided information about the tea party in the garden which had been attended by 15 people and a bingo session attended by 22 people. They told us that they used the 'This is Me' document within people's care records which gave details of their life history, likes and dislikes so that individual activities could be planned around these.

People were invited to make comments about various aspects of the home in books displayed in the reception area and a notice advised visitor's that all comments would be addressed accordingly. There was one book for housekeeping, one for the kitchen and one for maintenance. We saw many comments, suggestions and complaints had been entered in the books. Relevant staff had responded. One comment requested that pictures were hung in their relative's bedroom. This had been done and the visitor acknowledged how quickly the request had been responded to. Similar responses were evident in each of the books.

There was a formal complaints policy and procedure. People and their families were advised of this when they were first admitted to the home and information about the procedure was available in the reception area. We looked at the records for two complaints that had been received. The first one had been investigated and as a result the comments book for the kitchen had been introduced. The complaint was resolved and responded to on the date of receipt. Following receipt of the second complaint the registered manager arranged to meet with the complainant two days later to discuss options available to resolve the issue.

The registered manager had worked at the weekend. During our discussions with staff they informed us that most relatives visited people at the home during the weekends and this meant that they could more easily meet with the registered manager to discuss any concerns that they might have. The presence of the manager enabled these conversations to take place face to face. The registered manager was absent from the service during the latter period of our inspection. The Agency and Recruitment Co-ordinator did not work over the weekends so this facility was no longer available to relatives. However, following the

inspection, the provider's representative informed us that relatives can contact the deputy manager by phone if necessary.

Requires Improvement

Is the service well-led?

Our findings

After an unsettled period following the departure of the previous registered manager a new registered manager had been appointed in December 2015. Their registration with CQC was completed in May 2016. People found the registered manager to be approachable. One person said, "The manager has a nice face and is always ready to talk to me." A relative told us, "The manager is very approachable."

Staff also were positive about the registered manager. One member of staff told us, "I really like [registered manager]. She has got good ideas and a strong personality. I think she's nice. If I come to her with a problem she will do her best to sort it out herself. If she can't she will take it further. She is here on a Sunday which is nice as we get a lot of relatives then." Another member of staff told us, "She is very nice and has got the resident's needs as her priority."

However, the registered manager was absent from the service following the initial two days of our inspection. The deputy manager had left the service and the provider's Home Support Manager temporarily covered their absence and managed the home with the support of the Regional Operations Manager. They were also supported by the newly appointed Agency and Recruitment Co-ordinator, who had previously been a deputy manager at the home for a number of years, until they left in February 2016. During the latter part of our inspection they appeared to be, and staff told us that they were, acting as the manager at the home and shortly after our inspection they were appointed as the Deputy Manager. It was during the registered manager's absence that we received a number of reports of information that caused concern and we carried out the further two visits to the home.

The Agency and Recruitment Co-ordinator told us that they had arranged for some of the care plans that we looked at during the latter part of the inspection to be rewritten and had audited these before we saw them. However, the audit failed to identify that consent for care had not been obtained in accordance with MCA. We also found the care plans were not fit for purpose in that they only described what people's current needs were and did not address the aims of the plan. One care plan stated that DoLS was in place when it had not yet been authorised, the application having been made at the beginning of July. Care plans did not identify the risk of social isolation for people who were cared for in their rooms.

Records we saw had not always been completed accurately. Risk assessments and care plans had been omitted from some care records. We had also noted that accident forms had not always been completed following incidents.

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

There were comments books in the reception area in which people and relatives could make suggestions for improvements in areas such as menus and maintenance which were actioned and signed off by the relevant member of staff. In addition, there were also regular meetings with the registered manager. Dates for these meetings were displayed on the noticeboard in the reception area. However, one person we spoke with said

that they were unaware of the meetings, even though they had lived at the home for over a year. A relative said that because they were at the home every day they did not attend any of the meetings. Minutes of the last meeting showed that people had discussed menus, activities, days out, what they would like to change in their rooms and support to attend healthcare appointments.

Senior staff also had regular meetings at which they discussed areas for improvement. The chef told us that they had discussed menus and people's changing dietary needs at a meeting they had attended.

We saw that, when they were in post, the registered manager and the deputy manager had carried out a programme of quality audits. The audit of medication in May 2016 had identified that an updated book on medicines was required and this had been purchased. A dignity audit had been completed in January 2016 and this had led to the introduction of a sign that was placed on a person's door when personal care was being carried out. This showed that the audits were used to drive improvements to the service provided.

The Regional Operations Manager told us that they attended the home twice a month and carried out audits to monitor quality and compliance with the CQC fundamental standards, they produced a monthly report which was copied to the home manager, the provider's Managing Director and the Chair of the Board. An action plan for improvements was developed following each monthly report and these were followed up during the next monthly visits.

Staff we spoke with were able to describe their roles and responsibilities, although a nurse, who was providing cover through an agency, told us that they would leave anything they were unsure of to the permanent staff to complete.

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 9 HSCA RA Regulations 2014 Person-centred care Care plans did not address the identified needs of people and the planned care did not meet the aims of the plan. People's social and emotional needs were not met. People were isolated and bored.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent There was no evidence that people had given their consent to the care and treatment provided. Where people lacked capacity to make informed decisions there was no evidence that decisions made on their behalf were in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Discrepancies in stocks of medicines meant people may not have been given the medicines as they had been prescribed. The risks to the health and safety of service users of receiving the care or treatment had not always been identified or assessed. Accidents and incidents were not always recorded and the reasons for them analysed which would enable the provider to identify

ways to reduce the occurrence of such risk

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Although there were systems in place to assess the quality of the service these were not always effective and shortcomings in documentation and care provision had not been identified.

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 Although the number of staff needed to meet people's needs had been determined with a systematic approach based on people's needs, there appeared to be insufficient staff to always meet people's needs in a timely way.