Top Care Homes Limited

Southminster Residential Home

Inspection report

Station Road, Southminster, Essex CM0 7EW
Tel: 01621 773462

Date of inspection visit: 24 and 26 March 2015
Date of publication: 17/07/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

This was an unannounced inspection carried out on 24 and 26 March 2015. Southminster provides care and accommodation for up to 40 people. It does not provide nursing. There were a total of 37 people living in the service at the time of our inspection.

The service has a registered manager. 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.

Arrangements were insufficient for managing risks appropriately in relation to premises and equipment to keep people safe. Staff did not always understand the purpose and type of lifting equipment and how it should

Summary of findings

be used safely and people did not have the appropriate equipment for individual use. At times incorrect techniques were used by staff for assisting people to move.

There was not always enough staff and the delegation and organisation of their duties did not always mean people received the support they needed to meet their individual needs. People were not provided with regular access to meaningful activities and stimulation, appropriate to their needs, to protect them from social isolation, and promote their wellbeing.

People were not always treated with respect and their dignity, privacy, choice and independence were not always promoted. Staff had received some element of training in dementia care but not all staff demonstrated an understanding of dementia and how this affected people in their day to day living. Staff training, development and support was not effective to ensure staff had the right knowledge and skills to carry out their roles and responsibilities.

The provider had suitable arrangements in place to safeguard people against the risk of abuse. As a result the staff could demonstrate they had the knowledge to ensure that concerns were identified and reported in a timely and appropriate manner.

The provider had suitable arrangements in place for the management of medicines and people received their medicines safely.

Deprivation of Liberty safeguards (DoLs) had been appropriately applied. These safeguards protect the rights of adults using services who do not have capacity to make their own decisions and require some element of supervision. Applications had been made for appropriate assessment and authorisation by professionals for a best interest decision on any restriction on their freedom and liberty.

A lack of review of records in some areas including some relevant individual risk assessments and care plans meant that people may not always be supported consistently and in the correct way.

Some areas of the home required redecoration and repair. The environment had not been adapted to suit everyone's needs and did not promote a dementia friendly environment. The service lacked dining facilities and people were not provided with the opportunity to sit at a dining table to eat. This did not promote a social and stimulating mealtime experience and impacted on their health and welfare.

The registered provider and management were unable to demonstrate how they identified where improvements to the quality of the service were needed and quality assurance systems in place were not effective. As a consequence there were no systems in place to drive improvement to the quality of the service being delivered. Improvement was needed to the governance and leadership of the service to ensure the care and support provided to people was appropriate and in keeping with best practice.

We found that there were a number of breaches in the Regulations of the Health and Social Care Act 2008 (Regulated Activities) 2014 and you can see what action we have told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Risks to individuals were not always managed consistently to ensure people's safety.

Arrangements were not sufficient for managing risk appropriately.

Staffing levels were not regularly assessed and monitored to make sure they are flexible and sufficient to meet people's individual needs and keep them safe.

The provider had systems in place to manage safeguarding concerns and people's medicines safely.

Inadequate

Is the service effective?
The service was not consistently effective.

Staff did not have the appropriate skills needed to meet the needs of people living with dementia, effectively.

Requires improvement

Is the service caring?
The service was not consistently caring.

People were not always treated with dignity and respect and their privacy and independence was not always promoted.

Requires improvement

Is the service responsive?
The service was not responsive to people's needs.

People did not receive personalised care that was responsive to their diverse needs.

People did not have regular access to meaningful activities or stimulation to promote their independence, autonomy, choice and wellbeing.

Inadequate

Is the service well-led?
The service was not consistently well-led.

The providers systems for assessing the quality and safety of the service were not effective and had failed to identify the shortfalls identified during this inspection.

Management and staff did not have a clear vision of the service they were providing and the culture was not focused on improving for the benefit of those living there.

Inadequate

Summary of findings

The provider did not have plans in place to demonstrate how they kept up to date, with developments in dementia care, to ensure the care provided was appropriate and keeping up with best practice.	

Southminster Residential 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.

This inspection took place on 24 and 26 March 2015. It was unannounced and the inspection team consisted of two inspectors, two specialist advisors and an Expert-by-Experience. This is a person who has personal experience of caring for older people and people living with dementia.

Prior to our 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 looked at information we held about the service including notifications they had made to us about important events. We also reviewed all other information sent to us from other stakeholders for example the local authority and members of the public.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not express their views and experiences with us. We spoke with 18 people, seven visitors and one professional. We also spoke with 10 care staff, the activity co-ordinators, the registered manager and the provider. We looked at 14 people's care records, nine people's medication records, three staff records, staffing rota's and records relating to how the safety and quality of the service was monitored.

Inadequate

Is the service safe?

Our findings

Risks to individuals were not always managed consistently to ensure people's safety. People's moving and handling risk assessments and care plans did not always specify the control measures in place such as the type of hoist and the type and size of hoisting sling required in relation to their daily activities. Staff told us that people did not have individual slings but used the one available that was kept with each hoist in use; they said that if a different sized sling was required then they would source this from another area of the home. People can experience discomfort or a fall if the wrong size sling is used. A sling was observed hanging on the hoists, some of which were toilet slings. Toilet slings do not provide adequate support for all users or for moving and handling. Additionally because of their purpose they should not be shared as they are a potential source of cross infection. One hoist sling smelt very strongly of urine. Staff told us that the slings were washed on site but this did not happen routinely. We saw other moving equipment in use such as slide sheets but their purpose and guidance for staff on when to use was not included in people's risk assessments and care plans and therefore there was a risk that they would not be used at all where required or that they may be used inappropriately.

Although staff told us that they had received moving and handling training we witnessed incorrect techniques being put into practice for example when supporting a person to transfer from an armchair to a wheelchair using a frame. The person was pulling on the frame to get up which placed them at risk of falling backwards. Staff were not aware that this technique was unsafe and not best practice.

Risk assessments in relation to individual's health, safety and welfare were not regularly reviewed and therefore did not always contain correct or current information which could lead to inconsistent or unsafe care and support being delivered. For example staff told us that a specific hoist was used for one person however this was a different hoist to the one specified in the person's risk assessment. Where people's mobility had deteriorated their risk assessments had not been fully reassessed with a revised plan on how they were to be supported safely.

Floors were uneven in places, some carpet had been patched up, there were free standing heaters in use in some bedrooms, a hoist battery with a long cable was being charged in the corridor and foot rests from wheelchairs were lying in corridors; these all posed a trip or fall hazard. The registered manager told us that they monitored risks by visual checks around the service and the reliance on staff reporting issues. These issues had not been identified and reported. The registered manager said that a risk assessment for each bedroom was carried out annually; the last one recorded was in May 2014. The records were in a tick box format, each tick confirming a check had been carried out to lighting, flooring and loose leads; however the records did not demonstrate what the check was for. The checks were not robust and only identified people's personal belongings as a hazard. A risk assessment undertaken in relation to the overall environment was also not robust. It did not identify all hazards and risks and there was no information detailing the actions to be taken or guidance for staff to minimise risks except for 'staff to be vigilant'.

We found doors propped open and a hoist parked at the end of a corridor blocking a fire escape which posed a risk to people in that area of the home in the event of a fire. Staff were unaware of the risk associated with this.

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

People and relatives told us that there was not sufficient numbers of staff at the weekends to keep people safe. One relative told us that when they visited one week end there was a person very distressed walking around and asking for help, there were no staff visible to help. Another relative said that often there was nobody around to help people. Whilst staff felt there were sufficient numbers of staff to meet people's needs they were not deployed sufficiently to ensure people were adequately monitored, cared for and occupied. For example social isolation was evident for those people who remained in their beds or their bedrooms, particularly those located at each end of the building. Two people in a shared room spent their days in bed; each had dementia needs and were unable to communicate. We did not see staff spending any time with them other than providing personal care and assisting them to eat. Another person was in their room crying alone with no staff member nearby; we alerted a staff member to this person.

Inadequate

Is the service safe?

Staff described how they ensured people at the end of their life were supported to have a dignified pain free and comfortable death, however we found there were not enough staff to provide continued presence to a person at their last stage of life and they died alone.

Two staff members' co-ordinated and facilitated activities for people. They spoke passionately about their work and said they tried to help people feel "trusting, comfortable and confident and liked to give 1-1 care". However they said they did not have enough time to provide the level of individualised support that was needed by people.

Time and resources for people who required full assistance to eat and drink was not sufficient to provide the correct level of support they needed. Whilst staff were attending to people in their rooms other people were seated in the lounge areas up to 50 minutes before staff were available to serve them their lunch. This caused unnecessary anxiety for some people in the delay in expectation of their food.

There was no formal system for calculating the level of staff required that took account of individual needs, time taken to provide the assessed level of care and the layout of the service. The provider and registered manager told us that staffing levels were flexible according to people's needs but this was not evident. One person told us that a staff member sometimes took them out for a walk to the shops and that they really looked forward to and enjoyed these trips. However the staff member did this in their own time when their shift was finished.

Staff told us that the service experienced difficulties in retaining new staff. Vacancies, staff sickness and annual leave were mostly covered by the existing staff team. Some staff worked 14 hour shifts which can impact on the quality and safety of care provision and welfare of staff. We observed that when some care staff took breaks it left the number of staff significantly reduced at times throughout the day.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014: Staffing

People told us that they were treated very well by staff and that they felt safe in their care. Staff were aware of their responsibilities to safeguard and protect people from poor care and identify abuse. They gave a good account of how they would raise an issue or escalate a concern if necessary. They said that they would be happy to raise issues with the registered manager. Staff demonstrated a good understanding of their responsibility to report concerns and stated they would whistle blow if the need arose. They were all confident on what they would do if they were concerned that the registered manager had not responded appropriately. One staff member said, "I would tell head office, the local authority or CQC." There was more than one version of the provider's policy and procedure for safeguarding and whistleblowing which could be confusing to staff if the need arose to use them; they were out of date and required review.

Medicines were not kept securely and were accessible to people and others. Although medicines were kept in a locked trolley, the trolley was not securely fixed to the wall when not in use and the keys to the trolley were kept in an open drawer; the door to the clinical room where the trolley was stored was not locked. Although this was brought to the registered manager's attention we checked several times afterwards and found the situation had not been addressed and this continued to pose a safety risk. Medicines that required cold storage were stored within a refrigerator which was being adequately monitored however this too was not locked. Controlled drugs were stored in a separate locked medication cabinet in the clinical room. Not all liquid medicines and eye drops had dates of opening on them and therefore staff could not be assured that they were still fit for use.

There were instances where it was unclear whether medicines had been administered to people because signatures were missing from the medicines administration record (MAR) and there was no explanation recorded as to why the medication was not given or taken. There were instances where people may be at risk of receiving too much or too little 'as required' medication, usually prescribed to relieve pain. This was because staff had not recorded dose, time given or reason in the administration records. The registered manager carried out an audit each month to check the systems in place and to ensure people received their medications safely. Where errors were identified actions were taken, however we found that the same errors were still occurring and no action had been taken to explore the reasons further.

People were given their medication by suitably trained and competent staff. Those authorised to handle medicines had received appropriate training and had been assessed as competent to do so. We observed a staff member

Inadequate

Is the service safe?

administering medicines to people, they checked medication administration records before they dispensed the medication and they spoke with people about their medication explaining what it was and what it was for, a drink of their choice was provided to take the medication with.

Requires improvement

Is the service effective?

Our findings

Support for staff learning and development was inconsistent. Staff told us that they had either completed or were working towards a nationally recognised qualification in care but they did not have a personalised development plan which reflected professional development or specialisms linked to the needs of people they cared for. For example staff did not consider comfort and safe positioning of a person's arm that they no longer had control over since suffering a stroke. Their arm was very bruised and swollen as a result of continually sliding off the arm of their chair and dangling down beside them. This person told us that their arm was very painful. The registered manager told us that they were looking to deliver further training for staff to enable them to recognise health conditions and associated needs to deliver care more effectively.

The registered manager delivered training to staff in Safeguarding, Mental Capacity Act, Dementia and moving and handling. Staff told us that they had received a basic level of online training in dementia and some from the registered manager. People were at various stages of their dementia condition ranging from early onset to advanced stages. Some staff did not demonstrate an understanding of dementia and how this affected people in their day to day living. They did not know about different types of dementia or how these may show as they progressed. Staff spoke about dementia or advanced dementia but had little understanding of in between and how dementia may, or was affecting a particular person including about what to expect for example mood changes in particular relating to time of day, behaviour, verbal reasoning, and loss of communication skills and how they could respond. They were unable to tell us how they could support people to reduce their anxieties.

Staff said that they would like, and needed, further training to enable them to support people more effectively by understanding how the condition progressed. The registered manager told us that there was a level three dementia textbook available to staff but staff spoken with said they had not seen it. Some staff lacked knowledge about people's backgrounds and past lives which would have enabled them to explore different ways of communicating and understand more about the person they were supporting.

This is a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

Staff sought people's consent before they delivered any care and support. Care records showed that the principles of the Mental Capacity Act (MCA) 2005 Code of Practice had been used when assessing an individual's ability to make a decision on everyday matters such as receiving personal care, nutrition assistance and medication. However records showed that not all assessments were up to date and evaluations did not indicate a thorough reassessment of a person's capacity to ensure there was no change as indicated in some care records. Staff were knowledgeable about how to protect the rights of people who were not always able to make or communicate their own decisions. One member of staff said, "I always ask people for their permission before carrying out personal care and I encourage them to make choices for themselves such as what clothing to wear. I ask them if they want to wear a dress, skirt or trousers."

Applications had been made to appropriate professionals for assessment for people who lacked capacity and needed constant supervision or restrictions to keep them safe. This met the requirements of the Deprivation of Liberty Safeguards (DoLS). In cases where restriction was required urgently emergency processes had been followed and reviewed accordingly. The registered manager demonstrated a good understanding in this area.

People were provided with opportunities to have hot and cold drinks throughout the day. Biscuits were offered with a hot drink mid-morning and mid-afternoon; we noted that people requested the biscuits on offer. The service had no system to support people to independently access food for example there were no finger foods or fresh fruit readily available for people to eat if they were hungry.

We recommend that the service seek advice and guidance from a reputable source about how to support people in meeting their individual nutritional needs, particularly those with specialist needs including dementia.

The level of support given to people to eat and drink varied. One relative expressed concern that their family member was not eating or drinking and that staff were not providing effective support to them to encourage them. Another relative told us that they were concerned that their family

Requires improvement

Is the service effective?

member was getting dehydrated and nobody was checking their fluid intake. They said that since they raised concerns there was now a fluid chart in place and pointed out to us that it didn't have a date or their name on it.

People were positive about the quality of the food provided. One person told us that they found the food was generally good, but when the chef was not working, "Although the quantity of food is the same, the quality is poorer." The chef had worked at the service for many years and knew the people living there very well. They told us that they sourced all the meat and vegetables locally and that they go out personally to inspect it to ensure quality.

People were supported to access other health professionals and services as required. People told us that arrangements were made for them to see a doctor if they needed to. Relatives told us that staff contacted them if they were concerned about their family member and if there had been any changes in their health care needs. Records of visits from GP and other healthcare professionals such as the dietician were evident although care records were not revised to show any change to care and support provision when people's needs had changed. Discussion with the registered manager demonstrated that they advocated for people using the service and requested appropriate health and social care support, particularly in relation to mental health which they said was difficult to access.

Some areas of the service were in urgent need of redecoration. The rear corridor of the extension to the service smelt very strongly of urine. Carpets throughout the service were threadbare, discoloured and in places stained. Two occupied bedrooms were located in a part of the building known as the 'old stable' area, away from the main part of the building. This area also included the kitchen; staff toilet and back door. There was a lot of through traffic and noise to this area and the doors to the kitchen, staff toilet and outside were open; smoke was coming into the corridor from staff smoking outside. The access corridor to these areas did not provide an environment that promoted people's well-being. The walls of the corridor were damaged from damp and required treatment and painting; the flooring was also damaged and in need of replacement.

There were no dining facilities provided to enable people to sit and eat at a dining table if they chose to and therefore people either ate in their bed or in their armchair.

This is a breach of Regulation 15(1) (c) of the Health and Social Care Act 2008 (Regulated Activities) 2014: Premises and equipment

The service did not promote a dementia friendly environment. With the exception of toilet seats that were red there were no other distinguishable features such as different coloured doorframes to enable people to recognise toilets and bathrooms and signage was not consistent around the service. Bedroom doors did not have any form of identification such as a photograph or personal memory to help establish a familiar landmark for individuals to recognise their bedroom. The registered manager told us that people had memory boxes in their bedrooms that contained personal and familiar items but these were not evident or accessible to people.

We recommend that the service seek advice and guidance from a reputable source about the design of dementia specific settings to maximise the safety and suitability of the environment for the benefit of people with dementia using the service.

Requires improvement

Is the service caring?

Our findings

Staff gave good accounts of how they respected and promoted people's privacy and dignity; however we saw times when this was not put into practice. We saw a person, in a state of undress, sitting in their bedroom opposite the doorway; the door was wide open compromising their privacy and dignity. A staff member led us past and did not attempt to protect the person's dignity and privacy. On bringing this to their attention we were told that the person had been "Aggressive" that morning and therefore had not been assisted to dress any further. We asked for immediate attention to be given to this person and later checked and confirmed they had been provided with support.

The leadership in the service had not considered how routines of daily living could be provided in a meaningful and caring way. For example mealtimes were treated by staff as a task and not a social occasion. People remained in their armchairs in the lounge to eat and the cook brought the food into the sitting room in large saucepans, on a trolley. This arrangement did not promote a social and stimulated occasion for people and everybody sat in silence. Staff members working long shifts also ate their dinner in the lounge but they sat separately at a dining table. This did not promote an inclusive environment. Staff did not use alternative methods of engaging with people with dementia to enable them to make choices about their food and drink. We saw they shouted out to ask each person in turn what they would like to eat. In some instances people did not understand what they were being asked. The registered manager said that picture books were available for staff to use to help people living with dementia to make a choice through visual interpretation; we did not see these in use.

One staff member assisted a person to eat with a desert spoon that was overloaded, the assistance was rushed and they cleaned the person's mouth with the side of the spoon. This task led approach was not dignified and showed no respect for the person being assisted to eat. Serviettes or napkins were not provided for people to wipe their mouths and plastic beakers were given to everybody without asking them if they were wanted or consideration given as to whether they may need them or not. Plate guards and assisted cutlery were not available to enable people to eat as independently as possible.

We had feedback relating to two people from their relative and friend respectively. They were concerned that staff did not support people with mobility enough to help maintain or improve their independence. We saw that one person was only moved around in a wheelchair and no encouragement was given to try and support this person to stand or mobilise a little, even though they were able to weight bear. This did not promote people's independence.

Another person told us, "I feel I have lost my independence; I want to do more and go out." Not all care plans evidenced that people or their representatives had been consulted about their needs, wishes and preferences regarding how they would like their care or support to be given.

Staff were inconsistent in their practice as there were occasions when we observed discretion and sensitivity when asking people if they wished to use the toilet and there were other occasions when staff were observed to shout across the room at people when they were asking a question rather than going up to them and responding in a more dignified and respectful manner.

People told us that staff treated them well and praised them for the care they provided. One person told us, "The staff are all terrific; there's no problems here." Other people commented, "The home is ok and staff are very nice" and "Overall, it's all very good here. There are a good bunch of girls and I think they're all overworked and underpaid." There were some good interactions observed between staff and people using the service.

People were supported to maintain contact with family and friends and relatives told us that they were always welcomed and there were no restrictions on visiting times.

Preferred Priorities of Care (PPC) were in place for some people which are end of life directives. They showed that choice of place of care or death had been made but lacked detail in relation to planning and delivery for end of life care. Some people had Do Not Attempt Resuscitation (DNAR) orders in place and these were completed appropriately. In cases where the person did not have capacity best interest decisions had been made by the doctor in discussion with family and staff.

Inadequate

Is the service responsive?

Our findings

Some aspects of the service were not responsive to people's personal needs. Opportunities to support people to maintain independence was not being delivered. The registered manager and staff told us that people using the service lacked motivation however we found that there was not an agreed approach or program in place (either for the service as a whole or for individuals) to encourage activity which supported people's wellbeing including social isolation and independence. For example people sitting in the lounge areas for the duration of the day including mealtimes. They were therefore not provided with the opportunity to have regular short walks even if just for the purpose of eating. A visiting professional shared their concerns about the lack of activity and people not moving. Short walks would help to reduce stiffness and maintain mobility, help circulation and relieve pressure points from sitting for prolonged periods of time, as well as promoting socialisation. Some staff shared their concerns about the impact this had on people's overall health and happiness. On one afternoon of our inspection a church service took place. Three people were taken from one lounge to the other to attend the service. A visiting professional told us that this was the first time they had seen people taken from one lounge to the other to socialise.

People receiving respite care for rehabilitation purposes were not being sufficiently supported to improve their mobility or independence. One person told us how they were looking forward to going home but had been told that this was no longer happening and presumed it was because they were still unsteady. They said they had very little opportunity to improve. Care and support plans did not include any information or guidance for staff to follow on the level and type of support they required in preparation for discharge.

People were not being protected from social isolation and loneliness. There was no system to ensure that people who spent time alone had this explored through individual care planning to ensure their needs were met. When we asked a person in their bed how they were feeling they replied, "I'm alive". They were extremely upset, not covered up and very cold. Staff told us that this person always threw their covers off and was "Always in tears in the afternoon". People living with dementia may experience altering mood levels and although staff were aware that this person was upset each day there was no plan in place in order to try and provide tailored support at this time and /or reduce their isolation.

People did not receive care that was specific or responsive to their needs or interests. A relative told us that their family member had two hearing aids and a pair of glasses when they were admitted to the service. The glasses had gone missing; they were not supported by staff to put their hearing aids in and therefore spent their time unable to hear. A person, in bed, told us that they would be getting up soon; this did not happen and they were in bed for the duration of the day. They were partially sighted and required hearing aids; these were not in place. A document in their care records completed by a family member in 2011 stated that they enjoyed classical music but no arrangements were in place to help them listen to music. Their room was located away from the daily activity and the room was silent. Another person sat alone in their bedroom all morning with a book open in front of them but they were not reading. Staff told us that this person "liked reading" but they had been given an AA book of Britain. The person did not comprehend any of the pictures or the text. We saw another person looking at a knitting pattern book from 9.30am to 3.00pm. There was nothing in their care records to show this was something they used to do or were interested in.

Throughout our inspection we saw some activities taking place however we remained concerned that those provided were relevant to people and in accordance with their wishes, preferences and abilities. We found that a task approach was taken irrespective of the need of the individual and further improvements were needed.

People were not supported with individual interests or hobbies. Two people told us that they liked to knit. One of them told us, "I don't get any support to try to start again; I'd like to knit for charity. I don't receive the motivation I need." The other said, "There is not a lot of support to continue to knit." When we discussed this with the activity co-ordinator we were told that there used to be a knitting circle but people got bored with it. Further attempts or alternatives had not been considered. There was a lack of male orientated activities more suited to the high number of gentlemen using the service. Two people told us they would like to play snooker or darts and said "We don't join in the women's bingo."

Inadequate

Is the service responsive?

None of the care plans we looked at contained a care plan that adequately demonstrated how the service responded to individual's differing needs in terms of interests, social activities, types of dementia and the varying stage of dementia they were at. One person asked if they "could help" with the meal but their request was ignored. This demonstrated a lack of understanding how people with dementia need to be involved in activities of daily living to provide them with a purpose and promote emotional wellbeing.

Care plans and risk assessments had not been updated and therefore staff were not working to the most up to date information. For example, one person was on bed rest to promote healing of an acquired pressure ulcer, the pressure ulcer had healed and they were still being nursed in bed. Further care plans for two people with diabetes did not contain sufficient information to guide staff. A visiting professional told us that people with diabetes had been seen eating biscuits because their breakfast was late. There was no guidance for staff on what diabetic symptoms to look out for and report or information as to what and when people needed to eat particularly in relation to receiving their insulin. As a result people with diabetes were at risk of not receiving appropriate care and treatment, when they needed it.

This is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014: Person-centred care.

Although there was a complaints system, we received mixed views from relatives that concerns may not always be taken on board and managed in a positive way. This did not promote an open culture in which anyone would feel able to raise a concern and, where they feel they need to raise it further as a complaint. The complaints log detailed the nature of complaints received but did not sufficiently detail the actions taken to address them. The registered manager told us that actions in response to concerns or complaints received were taken at the time and not always recorded formally. Therefore they were unable to demonstrate that changes had been made as a result of any failures identified.

We saw that many compliments were received by the service expressing thanks and gratitude for kindness and care delivered to family members and compassion at end of life.

Inadequate

Is the service well-led?

Our findings

The way the service was managed did not demonstrate effective or robust governance, management and leadership. People and relatives had varying views about the leadership of the service. One person told us that the registered manager wasn't aware of "How staff deal with it all in the evenings and at night". They explained that when the manager was not around, "It is all very different" and "Staff do not respond to help you." A relative felt that the home lacked leadership and said, "Nobody is really in charge". Another relative told us that they felt the home wasn't managed very well and that the registered manager was not very responsive. From their experience they found that the response to any issues raised was defensive with a poor attitude to offering any help to resolve them satisfactorily.

The provider, management and staff did not have a clear vision or focus on the service they were providing. The registered manager told us that they believed the culture of the service enabled people to maintain independence and dignity and to feel valued in their home. They said that "Seeing people living with dementia continuing to be responsive and maintaining their mobility" was their biggest achievement. This was not reflected in our findings and there was no system in place to ensure this was what actually happened in the service. The service was part of a UK-wide initiative that supports services to promote quality of life and deliver positive change in care homes for older people. It provides various tools that have been developed to support best practice in care homes. However despite this there was no plan about how the service used this initiative to share learning, keep up to date with developments in dementia care and ensure the care provided was appropriate and kept up with best practice. Observation and discussion with staff showed that they had not had training in this area they needed to give them the skills to support people living in the service.

Staff made positive comments about the registered manager and described them as approachable and supportive. Staff generally felt supported by their team and the registered manager. They said that there was good core team of staff that worked well, they found the registered manager approachable and supportive. One staff member said, "We work as a good team here" and another said that they enjoyed working at the service, "It's a nice team here."

Staff told us that they felt that they were empowered to express their views. They said that they were confident to make suggestions as to how the service could be improved or raise any concerns with the manager. However there was not a consistent approach to supervisions and staff did not receive regular and formalised one to one meetings with senior staff to support them in their day to day practice.

The service did not consistently enable and encourage open communication with people who use the service or their representatives. Meetings took place about three times a year. The minutes showed that people took the opportunity to bring up issues that were concerning them that should have been addressed routinely for example one person raised concerns about their eyesight, another complained they had not received the morning paper and another was concerned about lost clothing. Relative surveys were carried out twice a year. There was no overview of the service formulated from the information to inform an on-going plan to drive improvement and enhance the quality of the service. We were told that any negative comments were addressed immediately but there was no plan to ensure that these experiences were learned from across the service to reduce the likelihood of reoccurrence.

There were limited processes in place to assess and monitor the quality of the service and if it was operating safely and effectively. We found that care records were poorly managed and inconsistent with more than one format or version in use which caused confusion and a lack of review including reassessment of people's needs and risk. Policies and procedures were out of date and needed review to ensure they were current and relevant for staff.

Incidents and accidents in relation to falls were recorded and analysed to identify any trends and themes that could be addressed. The highest level of falls were found to occur between 1.00am and 2.00pm at night. The registered manager changed the times for checking people and offering people awake drinks, food and reassurance. They said that the number of falls had reduced. This was good practice. However there was no system in place that analysed complaints and safeguarding concerns in order to learn from these and improve the service.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18(2)(a) How the regulation was not being met: The registered person did not have suitable arrangements in place in order to ensure that staff received appropriate support, training, professional development and supervision as is necessary to enable them to appropriately perform the duties required of their role. This was in breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15(1) (c) How the regulation was not being met: We found that the registered person had not taken people's needs into account and ensured that the premises are suitable for the purpose for which they are being used This was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 15 (1)(c) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Action we have told the provider to take

Regulation 9 (1) (a)(b)(c), (3)(b)

How the regulation was not being met:

We found that people did not receive care and support that was personalised specifically for them, appropriate to and meeting their needs and reflecting their preferences.

This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (1) How the regulation was not being met: The registered person did not continuously review staffing levels and skill mix to ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to meet people's individual needs at all times. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The registered person had not taken all reasonable steps to ensure the health and safety of people, by doing all that is reasonably practical to mitigate any risks to the individual and within the service.

This section is primarily information for the provider

Action we have told the provider to take

This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The registered person did not have an effective operation of systems or processes designed to enable them to regularly assess and monitor the quality of service provided and to identify, assess and manage risks relating to the health, welfare and safety of people using the service. This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.