Bondcare (London) Limited

Coniston Lodge Nursing 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 25 and 26 September 2018 and was unannounced.

The last inspection of the service was on 23 January 2018 when we rated the service requires improvement. We identified breaches of four Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to person centred care, dignity and respect, safe care and treatment and good governance. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the service to at least ''good.''

At the inspection of 25 and 26 September 2018, we found that the service continued to be rated requires improvement. None of the previous breaches had been met and we identified breaches of a further three Regulations, relating to the needs for consent, meeting nutritional and hydration needs and staffing. We have rated the key question of, 'Is the service well-led?' as inadequate because we have found the service did not have effective systems to make and sustain improvements.

Coniston Lodge Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service provided both nursing and personal care and is registered to care for up to 92 people. At the time of our inspection, 52 people were living at the service. The majority of people were over the age of 65 years and some people were living with the experience of dementia.

The service is owned and managed by Bondcare (London) Limited, a private organisation.

The registered manager left their post shortly before the inspection. The provider's representatives told us they had successfully recruited a new manager who was due to take up post in November 2018 and who would apply to be registered with the Care Quality Commission. 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 and associated Regulations about how the service is run.

The provider did not ensure the safe and proper management of medicines. In addition, they had not always mitigated the risk of people acquiring pressure sores because they had not helped people, who were at this risk, to change position as often as they needed.

People's needs were not always being met. People did not always have enough to drink to keep them hydrated. The staff had not responded appropriately when people had lost weight to make sure their care was reviewed, and they had the support they needed. Care plans did not always include guidance about how people's individual care needs should be met.

The provider had not always assessed people's mental capacity and ability to consent to their care and treatment. Information about people's mental capacity was not consistently recorded and the provider had not always sought consent in accordance with legislation.

The staff did not always respect people's privacy or treat them in a respectful way.

The provider's systems for mitigating risks, and monitoring and improving the quality of the service were not always effective. Records were not always accurately maintained and this presented a risk of people receiving care and treatment which was inappropriate and did not meet their needs.
People sometimes had to wait for their care because sufficient numbers of staff were not deployed to meet people's needs.

We identified breaches of seven Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to safe care and treatment, consent to care and treatment, nutrition and hydration, dignity and respect, person centred care, good governance and staffing.

We are taking action against the provider for failing to meet Regulations. Full information about CQC's regulatory responses to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

People living at the service told us they were happy and felt well cared for. They said they were involved in planning their care and they were given choices about their everyday lives. People told us the staff treated them with kindness and that they had good relationships with them.

The staff felt well supported. They said that they had good communication with the management team and had access to the training they needed. The provider was organising for additional training for the staff in response to identified areas of need.

The environment was clean and appropriately maintained. There were regular environmental checks. The provider made sure equipment was safe to use. The staff followed procedures to minimise the risks of infection.

There were procedures designed to safeguard people from abuse and for people to make complaints. People felt safe and were happy to raise concerns. The provider had learnt from accidents, incidents and complaints to improve the quality of the service.

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

Some aspects of the service were not safe.

Medicines were not always being safely managed.

Individual risks had been assessed; and whilst there had been improvements in staff practice to mitigate some risks, there were also other risks which had not been mitigated.

There were enough staff deployed to keep people safe, but people sometimes had to wait for care and support.

The environment and equipment were safely maintained and kept clean.

The provider's recruitment processes were designed and followed to ensure that staff were suitable.

There were systems to learn and make improvements when things went wrong.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Consent to care and treatment was not always sought in line with legislation and guidance.

People were not always supported to have enough to drink to stay safely hydrated.

People's needs and choices were assessed before they moved to the service and these assessments were used to develop a care plan.

People were supported by staff who had the skills, knowledge and experience to deliver effective care.

People were supported to access healthcare services.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

The staff did not always treat people with respect, respond to situations in a caring way or consider their privacy and dignity.

Although, some of the time, the staff were kind and caring.

People were able to make choices about their care and support and were encouraged to be independent if they wanted this.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People did not always receive personalised care which was responsive to their needs.

People's concerns and complaints were listened to and responded to.

People were supported at the end of their lives to have a comfortable, dignified and pain-free death.

Is the service well-led?

Inadequate

The service was not well-led.

The provider's systems for assessing, monitoring and mitigating risk were not always effective.

The provider's systems for assessing, monitoring and improving the quality of the service were not always effective.

The provider did not always maintain complete and contemporaneous records of the care provided to service users.

However, people liked living at the service and the staff were happy working there and felt well supported.

Coniston Lodge Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider 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 comprehensive inspection took place on 25 and 26 September 2018. Both days were unannounced. The inspection team on the 25 September 2018 consisted of three inspectors, a nurse specialist advisor 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 visit on the 26 September 2018 was undertaken by a member of the Care Quality Commission's medicines team. This visit was to inspect how the provider was managing people's medicines.

Before the inspection visit we looked at all the information we held about the service. This included contact from commissioners, the local authority, members of the public and notifications from the provider. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also looked at public information about the service, including their own website, other websites providing information about care services and the Food Standards Agency report.

We contacted the local Clinical Commissioning Group and local authority and asked them for updates about the service. They sent us details of a meeting they had held with the provider and information about safeguarding investigations.

During the inspection we spoke with seven people who lived at the service, five visiting family and friends and a visiting GP. We spoke with staff on duty, who included the deputy manager, nurses, care workers, activity coordinators, kitchen and domestic staff. The deputy manager from another home was working with

the service providing clinical leadership, we spoke with this person and the provider's quality and regional support manager.

We observed how people were being cared for and supported. Our observations included using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us.

We looked at records used by the provider for managing the service. These included the whole care plans and records for eight people and part of the care plans for a further 14 people, five staff recruitment records, records of staff training and support, quality audits and checks on the service, meeting minutes, complaints and records of incidents and accidents. We looked at how medicines were managed, which included the storage, recording and administration of these. We also looked at the environment and equipment being used.

At the end of the inspection, we gave feedback about our findings to the quality and regional support manager and the deputy manager. The provider's regional manager contacted us by telephone following our visit to explain some of the actions the provider planned to take to make improvements.

Requires Improvement

Is the service safe?

Our findings

At the inspection of 23 January 2018, we found that medicines were not always managed in a safe way.

We looked at the way in which medicines were managed on the 26 September 2018 and found that these were still not being managed in a safe way.

During our last inspection we found record keeping of people's medicine was not accurate. At this inspection we found records were still not accurate. We looked at medicines administration records (MARs) and care plans for nine people. We found for two people medicines prescribed to help manage their pain were not recorded in their MAR. For another person a rescue medicine prescribed to be used in an emergency for their seizures was not recorded on their MARs. This meant that staff may be unaware they were prescribed these medicines and people would not be given their medicines which could harm their health.

Some people at the home were prescribed medicines to prevent or treat seizures. We found for three people there was no information for staff in people's care plans or guidance in the form of a protocol on how to give these medicines. This meant there was a risk they could come to harm if they had a seizure.

Some people were prescribed high risk medicines such as anticoagulants and insulin. Anticoagulants are prescribed to prevent blood clots. Insulin is prescribed to help control glucose levels in the body. We found guidance was not always available in people's care plans for staff to identify and manage side effects of high risk medicines.

The provider did not have robust arrangements to demonstrate that risks to people's safety and wellbeing were being managed safely. Some people were at risk of developing pressure sores and needed the support of staff to change position at regular intervals so that this risk was minimised. The care plan for one person stated that they should be supported to change their position every three hours during the day and four hours at night to minimise the risks of them developing pressure sores. The records for 17 – 22 September 2018 showed that they had been supported to change position less frequently, with the maximum amount of times they received this support in any 24-hour period as five times. They were supported only twice during the 24 hours of 19 September 2018 and only four times in the 24 hours for both the 17 and 18 September 2018. There were no records to show the support they had received on the 23, 24 or 25 September 2018.

The above evidence shows a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection of 23 January 2018, we found people were put at risk because the staff did not always follow guidance when supporting people to eat and drink to minimise the risk of choking.

At the inspection of 25 and 26 September 2018, we found that improvements had been made. Where people

were considered at risk of choking, this risk had been assessed with the input of external healthcare professionals. There was guidance for the staff and this was being followed. For example, people were given the correct consistency of food and drink and were positioned correctly when eating and drinking.

At the inspection of 23 January 2018, we found that staff members did not always give people their medicines safely as staff left medicines unsupervised with people to take themselves. During the inspection of 26 September 2018, we observed members of staff giving medicines to people in the morning and afternoon. The staff gained permission, were polite and gave medicines to people in a safe manner. They signed for each medicine on the Medicine Administration Record (MAR) after giving it.

Medicines were stored securely including controlled drugs. Controlled drugs are medicines which are more liable to misuse and therefore need close monitoring. The staff checked and recorded medicines storage room and refrigerator temperatures daily and these were within the required range. Waste medicines were recorded and disposed of appropriately.

The local GP regularly reviewed people's medicines with support from a pharmacist. This provided assurance that people were prescribed medicines appropriate for their health condition.

Staff received training and were competency assessed to ensure they handled medicines safely. There was system in place to report medicine errors and incidents. The staff received medicine alerts and acted on them if necessary.

There were not always enough staff deployed to meet the needs of people living at the service. Some people using the service felt told us they had to wait for care or that the staff always seemed too busy to help them. The majority of staff we spoke with told us they felt they needed more staff. Some of their comments included, ''We cannot rely on the agency [temporary] staff to help us'', ''We are managing because we help each other but we are short staffed'', ''We often have to ask the nurse to help us because there are not enough carers'', ''Sometimes it is hard, you have to run, run, run because there are a lot of people who need help and not enough staff to do it.''

People did not always receive the care and support they needed. For example, people waited a long time to be supported at mealtimes, or when they called for assistance or needed the toilet. Also, some people waited an hour and a quarter for their lunch time meal to be served. Records suggested that some people had not been offered regular baths and showers. We also observed that, with the exception of the two activity coordinators, the staff did not spend time talking with people or providing social and emotional support. The staff were not always available when people needed them, although it was not clear whether this was because staffing levels were insufficient or because of the way the staff time was allocated. The same concerns were identified at the inspection of 23 January 2018. Whilst the provider's representatives told us that staffing levels were based on assessed needs, we found that there had not been improvements since the last inspection.

One care worker explained a practice which suggested the staff were focussing on completing tasks rather than giving people the right support. They told us that when they were supporting people at mealtimes they rushed this so that they could move on to helping other people because there were not enough staff to support everyone. This practice could also present a risk if people were not allocated enough time to eat their meal safely. Although, during the inspection, we found that the staff allowed people to take their time and did not rush them.

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

2014.

People using the service told us they felt safe being cared for by the staff and living at the service. Their family members also told us they felt the service was safe, with one relative commenting, ''I feel quite happy to leave [person] here'', and another relative telling us, ''I can honestly say that [person] is safe from abuse and harm here.''

The provider had systems and processes designed to protect people from the risk of abuse. These included procedures on recognising and reporting abuse and whistle blowing. Information about these was displayed around the service and shared with staff during team and individual meetings. The staff received training about this during their induction and at regular intervals. The provider's representative told us that the local authority safeguarding team was organising additional training specifically for the staff at the service. This was due to take place shortly after the inspection.
The staff we spoke with had a clear understanding about different types of abuse and what they would do if they had any concerns. The provider had responded appropriately to safeguarding alerts, reporting these to the correct authorities, and working with them to investigate concerns and protect people from further harm.

The individual risks to people's safety and wellbeing had been assessed and recorded. There was guidance for the staff on how to mitigate these risks and support people in safe and unrestrictive ways. The assessments were regularly reviewed and updated.

We observed the staff supporting people to move around the home, and from chairs to wheelchairs using hoists and other equipment. The staff did this in a safe and appropriate way, providing support in a gentle way to people. The staff had regular training about how to assist people to move. Equipment was serviced and checked to make sure it was safe to use. There were assessments for each individual about how they should be supported to move and any special requirements they had, as well as whether they were at risk of falling and how to minimise this risk.

The provider carried out checks on the environment to make sure this was safe and clean. There was evidence of checks on electrical, gas and water safety. A fire risk assessment and information about emergency evacuation, including individual evacuation plans, was available in the main foyer. All of the staff were aware of the emergency procedures and took part in regular fire safety training and drills.

The staff were provided with gloves and aprons to help prevent the spread of infection. They had training around infection control and there was information about hand hygiene and preventing infections on display and available for the staff to refer to.

Bedrooms, bathrooms and communal rooms were equipped with call bells. We saw that these were positioned so that they could be reached by people in bed and by people if they fell in the toilet or bathrooms. Not everyone we spoke with was aware they could use their call bell but those who were aware of this told us that usually the staff responded quickly when they alerted them.

The provider had suitable systems for recruiting new members of staff. These included checks on their identity, eligibility to work in the United Kingdom, references from previous employers, checks on any criminal records from the Disclosure and Barring Service (DBS) and formal interviews. New staff took part in training and inductions relevant to their role to make sure they could demonstrate the skills and knowledge to work there.

Accidents and incidents were responded to appropriately. Records of these showed that the staff had taken the right action immediately following the event, such as administering first aid and/or calling for medical assistance when needed. The records of accidents and incidents were checked by a member of the management team to make sure the right action had been taken and to take further action if needed. This was recorded. People's care plans and risk assessments had been reviewed following accidents to make sure these took account of any changes in their needs. The staff had systems for discussing adverse events so they could learn from these as a team. There were daily handovers of information and management meetings where any accidents, incidents or complaints were discussed. In addition, the provider organised regular meetings of the representatives of each service so that they could share learning from incidents which happened elsewhere.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The provider had not always undertaken complete or relevant assessments of people's mental capacity. Information about individual people was sometimes contradictory in different parts of their care plans. For example, of the care records we viewed, three people's care plans stated that they lacked the mental capacity to make decisions about their care, however there was no assessment to indicate how this judgement had been made and no evidence of the best interests process being followed to make sure decisions about their care were appropriate. In two care records, the staff had started to complete assessments of the person's mental capacity but had only written their name and room number with no other details.

People's representatives only have the legal authority to consent to care and treatment if they are the appointed Lasting Power of Attorney. A lasting power of attorney (LPA) is a legal document that lets a person (the 'donor') appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf. The provider could not evidence that these legal authorisations were in place in instances where people's representatives had given their signed consent to care. There was also no evidence of the best interests meetings or the involvement of advocates in making decisions about people's care.

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

The provider's systems did not ensure that the hydration needs of people were being met. We saw that drinks were available in bedrooms and communal rooms. However, records indicated that some people were not given enough fluid to keep them well and hydrated. For example, the fluid balance chart for one person recorded a daily target of 1,450mls of fluid intake. The records showed that this target was met on only one day between 17 – 24 September 2018, with the record on one day showing a total of only 100ml fluid intake. However, there was no evidence that further action had been taken to support this person to reach their fluid intake target or to refer the person to a relevant healthcare professional.

A second person's records stated that they had a daily fluid intake target of 1,800mls. They did not reach this target on any day between 11 – 24 September 2018, with fluid intake of 500ml on 13 September, 650 on 12 September and 745 on 11 September.

Therefore, the staff were not ensuring that people were kept hydrated and were not responding when their own calculations showed that fluid intake was insufficient.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People told us that they were not restricted in their movement around the home and garden. They said they could go out with families, friends or on outings. The provider had made applications for DoLS authorisations when they had assessed these as necessary .

The provider's representatives told us that they had organised for additional training for the staff on how to complete mental capacity assessments and this was due to take place shortly after the inspection.

There were some instances where people who were assessed as having mental capacity had signed consent to their care plans. In one person's file we found an assessment about a specific decision regarding whether they could understand and safely look after their own money, there was clear evidence about this and the assessment process.

People told us they liked the food and had enough to eat. They said that they were able to make choices about what they ate and special diets were catered for. Some of their comments included, ''Sometimes the food is nice'', ''The food is very good, we always have a drink by us and we always have a choice'', ''The food is good, having my meals prepared for me is great'', ''First class food, it is always nicely presented'' and ''Very good food and good helpings.''

The kitchen was appropriately organised and the chef created a menu which was repeated every four weeks. The chef was aware of people's special dietary needs and had information about this.

People had nutrition care plans that identified food preferences and dislikes, and there were descriptions of how meals should be presented for some people. Where this was indicated, a swallowing assessment had been completed by a speech and language therapist and there was specific swallowing guidance regarding fluid thickeners and consistency of food for the person.

The provider carried out pre-admission assessments in order to make a judgement about whether they could meet people's needs. These assessments were incorporated into care plans. People told us they had been involved in the assessment process and they had been asked about their needs and choices regarding care.

People told us they felt the staff were well trained and had the skills they needed to deliver effective care. Some of their comments included, ''I wouldn't doubt for a minute that they are well trained'', ''I think they are well trained and when I have needed them, they are there for me'' and ''They seem to give the staff a lot of training.''

New staff undertook induction training which included all areas required by the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. Staff had training refreshers at regular intervals. The administrator at the service kept records of all staff training and was able to alert the staff when they needed to undertake additional or refresher training. Some of the training was classroom based and some was provided via the internet. The staff we spoke with told us they preferred the classroom based training as they could not always ask questions when undertaking on-line training. We discussed this with the provider's

representatives. They told us they were aware of the staff views on this and had organised for some additional classroom-based training specifically relating to the needs of people living at the service. Some of this was being provided by the local healthcare teams.

The staff were able to give us examples of their knowledge and showed us how they had applied their learning to their work. The care workers explained that nursing staff had provided informal training sessions about specific health conditions and the needs of people who lived at the service. They told us that this was useful.

The staff had access to information about the provider's policies and procedures through computer based portals and files kept at the service. There was information about important issues, such as recognising and reporting abuse, fire safety, keeping people hydrated and how to handle complaints, available on display and we saw that these subjects were discussed in team and individual meetings.

The staff told us they felt supported by the management team and provider. They took part in appraisals of their work and felt able to discuss any concerns they had with senior staff. The records of formal supervision meetings with individual staff indicated that these did not happen as often as the provider's guidance on the frequency of such meetings. Although, the staff told us that they did not feel more regular meetings were needed and that they had effective ways to communicate with each other and the management team.

The staff handed over information to each other, both verbally and written information, at the change over of every shift. The staff told us this information included updates on any one's needs, any accidents or if anyone was unwell. The heads of departments, including nurses, the chef, activities coordinators and the housekeeper met every morning to share information. These meetings were recorded. Some of the staff who attended the meetings told us they were useful and ensured that the different staff teams worked together to deliver care and support.

The building included some features which were designed to create an interactive space for people with sensory needs and living with the experience of dementia. These included tactile objects on the walls and a sensory room. However, the provider recognised that this needed to be improved further to create an environment in line with best practice for people living with dementia. In particular, around supporting orientation and creating further interactive areas.

The majority of the home was decorated in a clean and functional way, with some additional attractive features, such as painted furniture in the garden. The entrance hall included a range of different leaflets and information for visitors. People were able to personalise their rooms with their own possessions and furniture if they wanted.

People had access to the healthcare services they needed. They confirmed this when we asked with them, telling us that they were visited by a range of different healthcare professionals. The GP held regular surgeries at the service. There was evidence of good communication between the staff and GP so that they were aware of changes in people's health. The staff recorded when people had attended appointments and any information from these about changes in people's care needs.

Requires Improvement

Is the service caring?

Our findings

At the inspection of 23 January 2018, we found that staff interactions were task based and the staff did not always respect people who they were caring for.

During our inspection of 25 and 26 September 2018, we found that this was still the case. Whilst we witnessed some kind and caring interactions, we also observed staff behaving in a way which did not show people respect.

For example, throughout the morning of 25 September 2018, one person consistently called out in distress. They shouted for staff attention and these shouts included, ''Please help me'' and ''I can't move.'' For a period of over an hour, we saw at least five different members of staff repeatedly walking past this person's room ignoring them. The person became increasingly distressed. We spoke with the staff and the provider's representatives about this. They explained background information about the person's needs which indicated they felt they were unable to help resolve the person's requests for help. The situation was undoubtedly difficult for the staff to manage effectively, however we saw that the staff ignored opportunities to comfort this person and alleviate their distress by ignoring them and not providing any reassurances.

In another example, a person was being supported by a member of staff to travel along the corridor in a wheelchair. The person called out, ''Help me.'' The staff member continued to move the chair along and commented, ''I am helping you'' without stopping to ask the person what was wrong or in what way they could help the person.

A third incident involved a different person calling for help from their bedroom for several minutes and being ignored by the staff walking along the corridor. A member of the inspection team alerted a staff member who went to see the person. They found that the person was in a state of undress, but instead of reassuring or assisting them, they called down the corridor to another member of staff revealing intimidate details about the situation the person was in.

The three examples above were all ones where people were requesting help and being ignored by staff. This indicated a culture where the staff focused on the tasks they were performing rather than recognising people's individual needs and requests. This was further demonstrated in another incident when a person told a member of staff that they needed to use the toilet. The person required the assistance of two members of staff for this and had to wait for a second member of staff to arrive. The care worker who was with the person did not explain this or give any indication of how long they would have to wait. The person became increasing distressed but was not reassured and at one point the care worker walked away leaving the person without any explanation. In another example, two staff were supporting a person who was in a wheelchair. One member of staff was adjusting their foot plates. The staff spoke with each other about the task and did not engage with the person.

Some of the practices at the service did not respect people's privacy or dignity. The notice board in a communal corridor in one unit had two serviettes pinned to it. One serviette listed four people's names and

the word, ''Washed.'' The other serviette listed four people's room numbers. Throughout the day there were times when the staff spoke instructions to each other whilst not engaging with the person who they were supporting. We heard the staff referring to people they were supporting with comments that included, ''[person] goes in that room'' and ''hoist that one.''

The above evidence shows a continuing breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also witnessed some interactions that were kind, caring and thoughtful. We observed a number of times when the staff were supporting people to move using equipment. Notwithstanding the examples above, these were carried out in a caring way with the staff reassuring people and allowing them to take their time. People were not rushed during mealtimes and the staff offered them choices. We also heard the staff speaking with people in a thoughtful and kind manner asking them if they needed help. In particular, the two activity coordinators demonstrated a good rapport with people, speaking about things that interested the person, having a joke with them and checking on their wellbeing.

Despite our observations and findings on the day of the inspection, people using the service and their relatives told us they the staff were kind and friendly. Some of their comments included, ''They are a nice lot of staff'', ''They are kind and caring – the night staff are great'', ''I am happy, I think they do a brilliant job'', ''There are some really nice carers'' and ''All the staff are very kind and caring.''

People were supported to make choices about their care. They had been involved in care planning and were offered choices in their daily lives, for example, what time they wanted to get up and go to bed, where they wanted to spend their time and what they wanted to eat. Care records included a section about people's social history and things which were important to them. These had been completed to varying degrees, with some containing detailed information and others not. The staff could use this information to get to know about the person and understand what choices they would be able to and like to make. People's cultural needs were recorded in their care plans and the provider supported people to meet these. A number of local churches and other religious groups visited to offer people opportunities for individual and group worship.

People were supported to do things for themselves if they were able. They confirmed this telling us the staff encouraged them to take an active role in meeting their own care needs.

Visitors were able to visit whenever they wanted and could be involved in helping to support their relative or friend, for example supporting them at mealtimes or with their worship.

Requires Improvement

Is the service responsive?

Our findings

At the inspection of 23 January 2018, we found people did not always receive personalised care which met their needs and reflected their preferences. In addition, some of the information about people's needs had not been clearly recorded.

At the inspection of 25 and 26 September 2018, we found this was still the case.

There was a care plan for each person but these did not always clearly identify their needs or include information about how these needs should be met.

Some people had a diagnosis of epilepsy (a condition which can cause seizures). We looked at the care plans for two people living with this condition. There was insufficient information about epilepsy in these people's care plans; and they did not contain adequate information to enable staff to know how to care for the person during a seizure . There was no stated seizure type for one person, or a description, warning signs or first aid guidance in their care plan. There was also no chart for recording seizure activity. Another person's care plan stated, that the person will 'Scream loud at first then start to twitch' but did not have any guidance for staff about how they should respond or at what stage the person's health and wellbeing would be at risk.

Another person living at the service was diagnosed with asthma (a condition which affects breathing). The person's care plan section for 'breathing' was blank and did not include any information about how the person should be supported in the event of an asthma attack, or ways to support the person to minimise the risks of this, such as listing irritants or situations which might cause an attack.

During the inspection, we witnessed incidents where two people expressed their needs in a way which challenged the staff. Through our discussions with the staff and provider's representatives we learnt that these types of incidents were not uncommon with both people. However, neither had care plans which included information about ways in which these people communicated their frustration or needs or guidance on how the staff should respond.

Therefore, care was not being planned to reflect people's individual needs, the staff did not have information about how to meet these needs and people were at risk of receiving care and treatment which was inappropriate.

The provider had not always responded to changes in people's needs. The nutritional care plan for one person stated that the person needed prompting and encouragement to eat and drink. They had been weighed monthly, Records showed that the person had lost weight with changes to their body mass index (BMI), a measure of whether the person is under or over weight according to their height. In July 2018 the evaluation of the person's care plan stated they should be weighed weekly because of weight loss. There was no evidence that the person had been weighed weekly since this time. The person lost further weight in September 2018, however the evaluation of their care stated, ''[Person] is eating and drinking well….[their]

weight is stable and to continue with care as planned.''

The records for another person showed that they had lost weight in April, July and September 2018. The staff completed monthly assessments of people's nutritional needs which helped them to determine if people were at nutritional risk. The monthly assessments for April, July and September 2018 had failed to record that the person had lost weight and, therefore, were inaccurate. In addition, the care plan evaluations for this person did not include reference to any weight loss in these months. If applied correctly, the nutritional risk assessment for this person would indicate a very high nutritional risk. However, this was not reflected in the person's care plan.

Therefore, people did not always receive personalised care which was responsive to their needs.

The above evidence shows a continuing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were involved in planning their care. People were dressed in clean clothes, with clean hair and nails. They told us they could have manicures when they needed and that a hairdresser visited the service each week.

The provider employed two activity coordinators who planned and facilitated leisure activities. Both activity coordinators also supported the care staff at busy times of the day, such as mealtimes, when they offered individual support to people who needed this. There was a planned programme of social activities and special events. These included visiting entertainers and regular sessions of games, reading, music, singing and physiotherapy. These activities were advertised on notice boards around the home. The activity coordinators told us that, each morning, they visited people who could not or chose not to leave their bedrooms – they said that they spent this time talking about things which interested the person or providing a hand massage or other individual activity.

We saw that people who joined in the group activities engaged well with these. The activities coordinators made them fun and inclusive. However, people did not have things to do to occupy their time when they were not taking part in these. Some people had visitors and some people were able to pursue individual interests. But most people spent time in the lounges or their own rooms without engaging in any activity. The staff did not provide resources or things to interest people and, except for the activity coordinators, the staff did not initiate many conversations other than those around the care they were providing.

Logs of the social activities which people had taken part in showed that some people did not take part in a variety of different activities. For example, the logs for one person from 10 – 24 September recorded the person as, ''In lounge watching TV'' or ''listening to music'' on 13 occasions and ''[Person] spent the day looking out the window'' on two occasions. The records for a second person also recorded, ''[Person] in lounge watching TV'' for all entries, although there had not been any entries made since the 14 September 2018. The records for a third person were also identical with no recorded information after the 16 September 2018. The records for a fourth person stated that they were in bed most days with three recorded, ''chats with staff'', one in June, one in July and one in August.

People using the service and their relatives told us they knew how to make a complaint and felt these would be responded to. They told us they would be comfortable speaking with a nurse or managerial staff. The complaints procedure was displayed in the main foyer and copies of this were provided to people in their rooms. We looked at the record of complaints and how these had been investigated and responded to. There was evidence that the provider had learnt from complaints and made changes to the service as a

result of these.

Some people were being cared for at the end of their lives. Care plans about the care and treatment people should receive were not always clearly recorded, but people were provided with comfort and care. The staff worked closely with local palliative care teams and the provider told us that the staff would be undertaking additional training provided by the palliative care teams.

Inadequate

Is the service well-led?

Our findings

At the inspection of 23 January 2018, we found that the provider had not always identified or mitigated risks to ensure the safety of people and others.

At the inspection of 25 and 26 September 2018, we found that this was still the case and we found further evidence to suggest a breach of the Regulation relating to good governance.

During the inspection we identified that medicines were not being safely managed and that people were not being supported to change position as often as they needed when they were at risk of developing pressure sores. The provider had not mitigated these risks.

People were placed at risk because care plans did not adequately identify some of their needs and there was no guidance for the staff on how to meet these needs. For example, how to support people with specific healthcare conditions. Furthermore, the staff had not responded to changes in people's needs and therefore they had not planned or provided personalised care to meet these needs. For example, where people's weight had changed they had not identified or responded to this.

People were placed at further risk because they had to wait for care and support, including mealtimes and when they needed to use the toilet.

The provider's systems for monitoring and improving the quality of the service had not always been effective. The breaches identified at the previous inspection had not been met and we identified further breaches relating to the need for consent, meeting hydration needs and staffing.

Whilst some staff interactions were kind and caring, we witnessed instances where this was not the case. The provider had carried out an audit of the service in May 2018, where they had identified one person had lost weight but that the care plan did not reflect this. Despite the provider identifying this as an area for improvement in May 2018, we found the staff were still failing to do this for two other people when we inspected in September 2018.

Records were not always accurately maintained. For example, one person whose care plan we looked at was being cared for at the end of their lives and they and their family had made a decision, that they should not be resuscitated in event that this was needed to sustain their life. However, the care plan had not been updated to reflect this and stated that all attempts should be made to sustain the person's life. Therefore, inaccurate records presented a risk that this person would receive care against their wishes and which caused them and their family distress.

There were not always contemporaneous records of the care provided and people's wellbeing. Food and fluid charts had not been consistently completed. For example, a number of people's records included some days where no information had been recorded. For example, one person's care records included entries for the 24 and 25 September 2018 only and no previous days. Records for the same person included checks on

bed rails. These had been recorded for the 22-25 September 2018 only and not previously. This meant there was no record to show whether the person had received the right support before this time. A second person's records included information about when they were repositioned to minimise the risk of developing pressure sores. These records had only partially been completed with the times of this support but no information to show which position the person had been changed from and to. This meant that the staff did not have the details they needed to provide the right level of care and support.

The care records for each person included a file which was kept in their bedroom. These files contained information about key risks, such as mobility needs and risks of choking. The files also contained records to show when care had been provided. Some of the basic information had not been completed in people's files. For example, the file for one person who used a walking frame did not include any information about their mobility needs. There was not always clear guidance for the staff about how to support people, for example, the chart in one person's bedroom stated that they should be supported to change position to minimise the risk of developing pressure sores. However, the record stated that staff should refer to the person's care plan for information about the frequency of changes.

The above is a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager left the service shortly before the inspection. The provider had recruited a new manager who was due to start in November 2018. The deputy manager was being supported by a clinical lead and the quality and regional support manager in the meantime. They, or one of the other managers, carried out daily audits of the service where they sampled how medicines were being managed, whether call bells were in reach and the service was clean and safe, whether people had access to food and drinks, whilst also asking people for their feedback.

More comprehensive audits of medicines management, infection control and environmental safety took place each month. The provider carried out a quarterly audit of the service. The last one of these took place in May 2018.

People using the service, visitors and staff told us they found the managerial staff helpful and approachable. They told us they were able to take part in regular meetings and share their views of the service.

The staff told us they liked working there with comments which included, ''I am very happy to work here'', ''I feel supported and get a lot of training'' and ''Working here is no problem, sometimes it is interesting.''

The provider's representatives and management team regularly met with the local clinical commissioning group and local authority to discuss the service and any changes that needed to be made. These commissioners felt that there had been improvements at the service and that the provider was open to suggestions and working in the best interests of the people who lived there.

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 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not ensure that service users were treated with dignity, respect or privacy. Regulation 10(1) and (2)(a)

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 The registered person did not ensure that care and treatment if service users was provided with the consent of the relevant person because they had not always acted in accordance with the 2005 Act. Regulation 11(1) and (3)

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 The registered person did not provider care and treatment in a safe way because they had not always: Done all that is reasonably practical to mitigate risks to service users. Ensured the safe and proper management of medicines. Regulation 12(1) and (2)(b) and (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered person did not always ensure that the hydration needs of service users were met. Regulation 14(1)

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 The registered person did not always deploy sufficient numbers of staff. Regulation 18(1)