S.A.H Nursing Homes Limited

Rosalyn House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Rosalyn House provides accommodation and nursing care for up to 46 people with a wide range of care needs. At the time of our inspection there were 44 people living at the service, many of whom were living with dementia and other associated conditions.

This inspection took place on 8 and 9 November 2016, and was unannounced. At the last inspection in November 2015, we asked the provider to take action to make improvements to the management of medicines and the assessment of risks for people living in the service. We received a provider action plan which stated the service would meet the regulations by 30 September 2016. This action had not been fully completed.

The service has a registered manager. However the registered manager had taken the post of the deputy manager and was no longer responsible for the day to day management of the service. A new manager had been appointed in April 2016. 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.

During this inspection we found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their

registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Potential safeguarding incidents had not been recognised and referrals to the local authority safeguarding team had not been made appropriately. Action was not taken to ensure that people were protected from the risks of abuse and harm. Staff understood their responsibilities with regards to safeguarding people and they had received training.

People were exposed to unnecessary risks. Risks assessments in place were ineffective, had not been reviewed and did not offer robust guidance to staff on how individual risks to people could be minimised.

Incidents and accidents which occurred in the service were not consistently reviewed by management to identify patterns and trends or to ensure action to prevent reoccurrence was identified. Lessons were not learnt from incidents which increased the risk that they would be repeated.

There were consistent numbers of staff on duty to meet people's needs however people experienced delays in responses to their call bells and receiving care and support.

Medicines were not managed safely and audits completed were ineffective in identifying issues and concerns found during our inspection. People were exposed to the risk of harm from unsafe storage of medicines, inaccurate stock levels and poor record keeping.

Staff had not received training identified as being required by the service. There was not an ongoing training programme in place for staff to give them the skills they required for their roles. Staff had not been provided with regular supervision or appraisals to assist in identifying their learning and development needs, raise concerns or seek any additional support they may require in completing their roles

People were not involved in decision making and the requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were not met. However staff sought people's consent before any care was provided.

There were mixed opinions with regards to the activities provided at the service. There were limited activities on the day of our inspection and staff we observed did not have opportunities to engage people in social conversation.

People's needs had been assessed. Care plans took account of individual needs but lacked detail with regards to people's preferences, choices and individuality. Care plans and risk assessments had not been regularly reviewed to ensure that they were reflective of people's current care needs and did not always give clear instructions to staff on how best to support people. The lack of personalised, current information within care plans meant that people were at risk of not having all of their health and social care needs met which could have a negative impact on their health and well-being.

Complaints were not consistently managed, recorded or responded to.

Quality assurance processes were not robust, effective or used to improve the service being provided. Where concerns were identified there was inconsistencies within the responses. Audits completed consistently

failed to identify the concerns found during our inspection. As a result of the failure of these audits risks to people's safety had not been identified and action had not been taken to reduce those risks. This further increased the risk of potential harm to people.

The provider and manager had not acted upon previous inspection feedback with a view to evaluate and improve practice and ensure compliance with the regulations.

The manager was not a visible presence in the service and demonstrated a lack of knowledge with regards to the people living in the service and the systems in place. People and their relatives were unclear as to the management of the service.

There was an open culture amongst staff team members however staff were not sure they would be supported by management. Staff were not always clear on the visions and values of the provider organisation and did not feel involved in the overall development of the service.

Safe recruitment processes were in place and had been followed to ensure that staff were suitable for the role they had been appointed to prior to commencing work.

People were supported to make choices in relation to their food and drink and a varied menu was offered. People received support from health and medical professionals when required.

Staff were kind and caring. People's privacy and dignity was promoted throughout their care. People were provided with information regarding the services available.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were at risk of not receiving their medicines as prescribed. Medicines were exposed to unsafe storage and temperatures. Medicines were not managed safely and stock levels were not accurate.

People were at risk of harm and injury. Risk assessments had not been reviewed, were inconsistent and failed to identify the actions to be taken to reduce the risk of harm to people.

People were not safeguarded from harm. Systems in place to safeguard people were not followed and potential safeguarding incidents had not been reported.

Incidents and accidents were not reviewed or analysed in order to take action to prevent reoccurrence and reduce the risk of harm or injury to people.

Staffing levels were consistent; however people experienced delays in receiving their care.

Safe recruitment processes were followed.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always involved in decision making in relation to their care

Staff did not receive regular supervision and appraisals to assist in identifying their learning and development needs. Staff had not undertaken all training that had been identified as required by the service.

People were asked to give consent to the care and support they received.

People were supported to meet their health needs and had access to a range of health and medical professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

Care plans were not personalised and did not provide staff with information regarding people's backgrounds, interests and social needs.

People were supported by staff that were kind and caring.

People's privacy and dignity were promoted by staff.

People were provided with a range of information regarding the services available to them.

Is the service responsive?

Inadequate

The service was not responsive.

People were at risk of not having their needs met. Care plans did not reflect people's needs and preferences and did not always include clear instructions for staff on how best to support people. Care plans had not been consistently reviewed.

We received mixed views on the activities provided at the service.

The procedure to manage complaints was not consistently followed.

Is the service well-led?

Inadequate

The service was not well-led.

People were at risk of harm or injury. Quality assurance processes were not robust, effective or used to improve the service being provided or mitigate the risks to people. Audits completed failed to identify the areas of concern found during our inspection.

The provider and manager had not acted upon previous inspection feedback with a view to evaluate and improve practice and ensure compliance with the regulations.

The manager was not a visible presence in the service and demonstrated a lack of knowledge with regards to the people living in the service and the systems in place.

There was an open culture amongst staff team members

however staff were not sure they would be supported by management.

Rosalyn House

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 8 and 9 November 2016 and was unannounced. The inspection was undertaken by a team of two inspectors, an expert by experience and a specialist advisor on the first day and two inspectors on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert used for this inspection had experience of a family member using this type of service. The specialist advisor was a registered nurse who had experience in providing and managing the care of people living with dementia.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information available to us about the service such as information from the local authority, information received about the service and notifications. A notification is information about important events which the provider is required to send us by law.

During our inspection, we observed how the staff interacted with the people who used the service and how people were supported during meal times, individual tasks and activities. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 10 people who lived at the service and five relatives to find out their views about the care provided. We also spoke to three care workers, three team leaders, one nurse, and one clinical lead, two members of housekeeping staff, the chef, one activity coordinator, the deputy manager and the manager of the service. The director from the provider organisation was also present on the second day of our inspection.

We reviewed the care records and risk assessments of five people who lived at the service, and also checked

medicines administration records to ensure these were reflective of people's current needs. We also looked at five staff records and the training records for all the staff employed at the service to ensure that staff training was up to date. We reviewed additional information on how the quality of the service was monitored and managed to drive future improvement.

Inadequate

Is the service safe?

Our findings

When we inspected the service in November 2015, we found that risk assessments were inconsistent with people's care plans. We asked the provider to take action to ensure that risk assessments were reflective of people's care needs and consistent with the information within care records.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We received a provider action plan which stated the service would meet the regulations by 30 September 2016. The action required to meet this breach had not been completed.

During this inspection we found that risk assessments and management plans were in place for each person who lived in the service however they were ineffective. We found assessments had not always been updated or reviewed and lacked information to guide staff in reducing levels of risks to people.

Risk assessments lacked detailed information and were not personalised. We saw that generic guidance for staff recorded within risk assessments was not specific to the person for whom it was written for. Assessments contained the same wording and this was repeated in matching risk assessments from person to person. Risk assessments also lacked specific detail and guidance for staff. For example, one person who was assessed as high risk in relation to their nutritional needs, had no information recorded in relation to their daily recommended dietary intake. This meant staff had no guidance to mitigate the risks for that person or a measure against which to assess the person's dietary intake as being adequate.

Risk assessments had not consistently been updated or reviewed following incidents or changes in a person's care needs. We saw that one person who was assessed at being high risk with regards the use of a profiling bed had experienced two falls from the equipment, one resulting in a head injury which required medical treatment. On both occasions there was no evidence that the risk assessment been reviewed or updated in order to identify possible ways of preventing reoccurrence. For another person, there was no evidence of their mobility risk assessment having been reviewed or updated following the person having been diagnosed as having a condition which impacted on their ability to mobilise safely. This meant that risk assessments were not reflective of people's current needs and information was out of date. People and the staff supporting them were exposed to the risk of harm or injury.

The manager told us that the responsibility for the review of all care plans and associated risk assessments for people had been delegated to the deputy manager. This process had been ongoing since April 2016. We reviewed risk assessments for five people and found inaccuracies in information or assessments that required review for three of these people. This showed that action was not being taken by the deputy manager to ensure that reviews of risk had been undertaken. People were exposed to the risk of harm or injury by not having current risks to them assessed and action taken to mitigate those risks.

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

When we inspected the service in November 2015, we found that the service had poor systems in place for the stock control of medicines and found gaps in medicine records. We asked the provider to take action to ensure that sufficient supplies of medicines were maintained and medicines records were completed properly.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We received a provider action plan which stated the service would meet the regulations by 30 September 2016. The action required to meet this breach of regulation had not been fully completed.

During this inspection we found that medicines were not managed safely. We identified issues in this area which exposed people to the risk of harm. The 19 Medicine Administration Record (MAR) charts we looked at, showed that medicines were not always managed or administered safely. The amount of medicines recorded as 'administered' and 'in stock' was not accurate. We were not able to check that some medicine had been given as prescribed for six people living in the service because the total amount of medicine available did not match the records of receipt or administration. We could not identify whether all of the people living in the service had received their medicines as prescribed. We found inaccuracies in the stock records relating to pain relief, medicines prescribed for people during periods of anxiety or distress and within medicines prescribed in relation to medical conditions. This meant that people may not have received prescribed analgesia leading to experiences of pain and discomfort, periods of anxiety or distress and symptoms of medical conditions not controlled.

Medicine records were not accurate with regards to the medicines found in stock. For one person we found that the medicine recorded on the MAR chart was not the medicine in stock and being administered by staff. There was no evidence to show that this difference in medicines had been checked with the prescriber or that the MAR chart had been changed to reflect the substitute medicine. This meant that staff members were following unsafe practice by administering medicine which did not match what was recorded as being prescribed. People may have been exposed to the risk of harm by receiving medicines that were incorrectly prescribed which could have a negative impact on their health and well-being.

Medicines were not stored safely. During our checks of the two medication rooms we found loose medication within two separate medicine trolleys. Members of staff had not identified the presence of these tablets and they could not be accounted for within the recording systems. We highlighted this to a member of staff who was unable to explain the medicines we had found as they "normally worked downstairs."

We found that the bottom of the medicines fridge within the ground floor storage room was dirty and a spillage of an unknown liquid had not been cleaned up. We spoke with the deputy manager who told us that the medicine fridge was cleaned each week and that the task should have completed two days prior to our inspection. It was clear from the deterioration of the spillage found that this had not been completed. The deputy manager told us they were "embarrassed" about the condition we found the fridge to be in.

We also found that, for a period of four consecutive days, room temperature charts showed that the temperature recorded in the ground floor storage room ranged from 26 degrees Celsius to 28 degrees Celsius. Medicines in their original packaging in this area were clearly labelled to be 'store below 25°C.' There was no evidence to show what action had been taken to reduce the temperature or that advice had been sought as to how the medicines stored in this area may have been adversely affected by the high temperature. We spoke to the deputy manager who was unable to confirm that the issue had been highlighted with senior staff or that any action had been taken.

Medicines audits were not accurate and failed to identify the concerns we found on inspection. The internal

audit completed by the manager recorded that there were no concerns in relation to medicines and only minor actions were identified as being required as a result of the audit. No stock control or storage issues were identified in the four audits we reviewed. This demonstrated that the audit system had been not conducted in an effective manner and failed to identify concerns and where action was required to be taken. The manager, when asked, was unable to explain the reason why the audit they completed had failed to identify the concerns we found or answer questions that were asked of them.

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

There were ineffective systems in place to protect people from harm. Potential safeguarding incidents had not been reported to the local authority or the Care Quality Commission (CQC) by the manager of the service. We reviewed 18 incident and accident records, completed within a five month period of time, and found that nine had not been reviewed by the manager or a senior member of staff. The incidents we reviewed included unwitnessed falls, unexplained injuries, incidents of physical aggression between people living at the service and an incident of potential financial abuse. With no review of the incident report forms being completed by management, there was no evidence to show that consideration had been given to the incidents as being potential safeguarding incidents. There were also no records to show a rationale behind a decision being made as to whether or not an incident should be referred. Evidence that these incidents had been analysed by the manager to ensure appropriate action had been taken to reduce the risk of recurrence and that care records had been reviewed or updated was also not present. This meant that there was a risk that safeguarding incidents were not identified and reported correctly. A lack of review and analysis by a senior member of staff showed that incidents were not assessed and actions to be taken to keep people safe and reduce the level of risks of harm to people were not identified or taken.

We saw that four safeguarding referrals had been made to the local authority since our last inspection however, with the exception of one referral and the subsequent investigation, there was no record held of the outcome of the referrals or if any action had been taken by the service. The CQC had not been notified of three of these safeguarding referrals by the service. The manager did not maintain a log of the referrals that had been made and could not confirm the outcomes or any guidance that they had received from the local authority when asked.

Members of staff we spoke with told us they had received training on safeguarding procedures and demonstrated an understanding of the internal reporting processes. They were able to explain to us the types of concerns they would raise but lacked an awareness of reporting to the local authority or other agencies. One member of staff said, "There are lots of forms of abuse. We've done the training and know to report." Another member of staff told us, "Abuse can be anything really; you need to do the care properly to stop abuse." The conversations we had showed that staff were aware of their reporting responsibilities; however incidents or concerns were not always reported on to the local authority or other agencies, once staff had completed an incident report. Training records for staff confirmed that they had undergone training in safeguarding people from the possible risk of harm. There was a current safeguarding policy and information about safeguarding including the details of the local safeguarding team was displayed in the entrance hallway.

Systems in place to protect people from harm were ineffective. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt living at the service. One person said, "Yes, I am safe here. It's being with so many people that makes me feel safe." Another person told us, "I am safe here. I feel very relaxed in this

place." A third person told us, "Very much so. I do feel safe, always someone here you see." Relatives we spoke to confirmed they had no concerns about the service, the conduct of staff or their ability to provide care safely to their relative.

We received mixed views from people and the relatives we spoke with regarding staffing levels in the service. One person told us, "There are enough staff I am sure." Another person told us, "It doesn't take them quite so long to come to me as it used to. There is more staff about." However other people expressed concern about how long it took staff to answer their call bells which suggested to them that there was not enough staff on duty. Comments included, "It varies how long it takes them. Sometimes it's five or six minutes others it can be fifteen minutes or more" and "They come after a few minutes most days, not always though." One relative we spoke to told us, "Very often when we come on Sundays there are no staff around downstairs in the lounge. I've never seen so many staff as there are here today." Another relative said, "Not always no. I know they have to see to a lot of people with a lot of needs but there just doesn't seem to be enough people checking on [Name of person]."

We observed a high number of staff on duty during our inspection and that staff were available to meet the needs of people living in the service when required or requested but there were some delays in the answering of call bells. When asked about the staffing levels in the service a member of staff told us, "I would like to see the staffing levels increase. Lots of people come and think it is an easy job, find it isn't and go again." We also observed some delays during the lunchtime meal when a number of people had to wait for their meal to be served and have a member of staff available to assist them with their meal. For four people in the dining area on the ground floor this was a delay of 55 minutes. Following our inspection, the provider informed us that the delays we observed were a system of planned sittings in place to ensure that people living in the service received the level of assistance that they required with their meals.

A formal staffing level assessment which considered the needs of people whilst taking into account the layout of the building was not in place. The manager explained to us that they used a dependency tool to assess the level of need of all the people living in the service and the support they required. Members of staff were then deployed staff across the three floors of the building accordingly. We reviewed past rotas and found there was consistently the required number of staff on duty that the manager told us had been determined by the dependency tool.

Robust recruitment and selection procedures were in place and were followed consistently. We looked at five recruitment files for staff and found that relevant pre-employment checks including obtaining references from previous employers, checking the applicants previous experience, and Disclosure and Barring Service (DBS) reports had been completed. DBS helps employers make safer recruitment decisions and prevents unsuitable people from being employed. This meant that steps had been taken ensure that the applicant was suitable for the role to which they had been appointed before they had started work.

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 homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's capacity to make and understand the implication of decisions about their care was not consistently recorded as having been assessed and documented within their care records. We saw care records that showed a lack of involvement of people in the decision making process and decisions having been referred to relatives prior to the assessment of the person's capacity to make the decision for themselves. This meant people were at risk of having decisions made on their behalf which they had not been consulted about.

People, and their relatives, were unable to tell us the extent of their involvement with capacity assessments. Pre-admission assessments of people's capacity contained blanket statements such as, 'Lacks capacity – diagnosis of dementia' in many areas of their day-to-day living. The assessments were a pre-typed tick sheet to record whether or not people were able to make any day-to-day decisions for themselves. For one person we saw this assessment had been completed with a relative. For another person there was no evidence as to who was involved in the assessment. We saw references within people's daily records for paperwork to be given to relatives for their signature and one invitation to a relative to come to the service to sign documentation. Records showed that the documentation was in relation to capacity assessments, a DoLs authorisations application and covert medication but there was no evidence of invitations to meetings or discussions in relation to the decisions being made. The PIR completed by the provider prior to our inspection told us that two assessments were used within the service, one for day-to-day living and one for specific decisions. We did not see any specific decision making assessments completed for people or any evidence that best interests meetings had been held with people, relatives or any other health professionals.

Authorisations of deprivation of liberty were in place, or had been applied for, for each person living at the service as they could not leave unaccompanied and were under continuous supervision. Where authorisations were not in place we saw the manager or deputy manager had made applications and was awaiting the outcome of these applications from the relevant supervisory bodies. The service maintained an accurate log of the authorisations that had been granted including the expiry date and recorded when applications had been made to the local authority.

Not all staff had received training on the requirements of the MCA and the associated DoLs and staff who we

spoke with were unable to explain their understanding of how the Act should be followed in the delivery of care. However, staff were able to explain how they supported people with decision making and confirm that they sought consent from people prior to providing any care.

People told us that staff sought their consent before they provided them with care or support. One person told us, "Yes, yes, they always ask." Members of staff told us that they always asked for people's permission before providing them with care. One member of staff told us, "I always knock their doors and ask them if they are ready to get up yet or would they like a cup of tea first." Our observations confirmed that staff obtained people's consent before assisting them with personal care or supporting them to transfer. Where people refused, we saw that their decisions were respected. Records showed a lack of people's involvement in decision making in relation to their care needs and no record of written consent to care was seen.

People were not involved in decision making in relation to their care and support. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they thought that staff were well trained and had the skills required to care for them. One person said, "Staff are well trained, I think so, I don't have any problems." Another person told us, "From what I see of them they are alright." Our observations of staff interacting with people confirmed that they knew and understood people's care needs and used their knowledge to deliver care appropriately.

There was an induction period for new members of staff which consisted of a two day training programme followed by a period of shadowing more experienced members of staff on duty. Staff told us that they received good training. One member of staff told us, "I am nearly finished my NVQ level two qualifications now and would like to do my level three." Another member of staff told us, "We have just finished doing the Care Certificate in July which covered a lot of topics." Staff told us they completed a variety of training courses and explained how this supported them to carry out their role and responsibilities. However, we checked the training records for all staff employed at the service and found numerous gaps within the training matrix. A number of staff had not received training in the Mental Capacity Act, physical intervention training and first aid. The manager explained to us that they were aware of the gaps in training records but had not secured additional training to address this. This meant that there was not an ongoing training programme in place for all staff to give them the skills they required for their roles.

Staff told us that they felt supported in their roles, as they were able to approach senior staff, but did not receive frequent supervision. One member of staff told us, "I do get supervised. [Deputy Manager] does it. It's been a while. Most are group supervisions; I'd like more one to one to be honest." Another member of staff told us, "I've had one supervision since starting here." The manager explained to us that supervisions had been temporarily stopped and that they had the intention of providing supervision to every member of staff but this had not happened. The responsibility for supervision had since been shared between the senior members of staff. No members of staff we spoke with could confirm that they had received an appraisal. Records showed that members of staff received infrequent formal supervision and that no annual appraisals had taken place in 2016. This meant staff were not provided with regular meetings to assist in identifying their learning and development needs, raise concerns or seek any additional support they may require in completing their roles.

Staff did not receive frequent supervision and no appraisals had been conducted in 2016. This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulation 2014.

People told us that they had a good variety of food at mealtimes and were complimentary about the meals that were provided at the service. One person told us, "The food is good, we have nice dinners. I like that."

Another person told us, "Food is good and I can eat between meals." Another person told us, "If we don't like anything we can get something else." A relative told us, "[Name of person] has put on weight since he came here from hospital." Another relative told us, "The food is good and always served hot." There was a four week menu programme in place which had been completed in consultation with the dietitian who supported the service and which considered the likes and dislikes of people. The menu in place offered people a variety of meals, in line with their dietary preferences with regular alternative meals available.

We observed the lunchtime meal in the three dining areas and found that the meal time was generally relaxed. Where people required specific equipment or assistance to eat their meals we saw that this was provided. We observed staff encouraging people to eat at their own pace and chatting with people in a friendly manner. We observed that people were provided with regular drinks of their choice.

People had been asked for their likes and dislikes in respect of food and drink and a 'food preferences record' had been completed for each person. One person told us, "There are no problems. I can choose something from the menu or ask for an omelette or something." We spoke with the chef who told us that all food was prepared at the service and people were given at least two choices for each of the meals, with snacks available throughout the day. Members of kitchen staff were notified of people's dietary requirements and were informed of any changes via a report which was completed by the dietitian who provided support to the service. There was no-one living at the service at the time of our inspection that required a special diet for cultural or religious reasons but the chef confirmed that diet choices could be catered for. Some people had been assessed at risk of poor nutrition and hydration and the chef was able to explain how changes were made to meals for these people to increase the calorie content and ensure that the food provided met people's specific needs. Members of care staff told us they were aware of people's dietary needs and that information was documented in the care plans and risk assessments. Records held in the kitchen detailed people's preferences and specific dietary needs such as allergies or consistency requirements for example, a soft or pureed diet.

People told us they were assisted to access healthcare services, if needed. One person told us, "The GP does come in to the home but I'm not sure how often." Another person told us, "They will get the GP for me if I don't feel well. I've had my eyes tested not so long ago and I'm going to the dentist again in a few weeks." Care plans and daily records confirmed that people had been seen by a variety of healthcare professionals including the GP, dentist and optician. Referrals had also been made to other professionals, such as dietitians and speech and language therapists where required. Daily records that we reviewed confirmed that the advice from healthcare professionals was recorded however care plans had not always been reviewed and updated with the most current information.

Requires Improvement

Is the service caring?

Our findings

Staff told us that they knew people and understood their preferences. One member of staff told us, "You just get to know people after a while. We speak to families too." Information in the care plans enabled staff to understand how to care for people and to ensure their needs were met; however they lacked personal detail about people's preference and their individuality such as past occupations, social and leisure interests and people that mattered to them. This meant that staff were provided with limited information about people's backgrounds.

People we observed appeared comfortable and relaxed in the company of staff and staff engaged people in polite, respectful conversation. However these interactions were mainly task focused and based on enabling people to make day-to-day choices. Staff spent little time engaged with people in conversation or in social activities and appeared consistently busy in meeting people's care needs.

People's bedrooms had been furnished and arranged in the way they like and many had brought their own personal items with them when they came to live at the service. We saw that each bedroom door had a personalised sign for the person which was reflective of a favourite pastime or sport they enjoyed. With the exception of their bedrooms, there were however limited areas in the service where people could go to spend time quietly or have privacy to meet with their family members if they wished as the communal lounges on each floor were popular and in constant use by many people. We saw that there was an outdoor area in the garden with seating for people and their relatives to spend time together outdoors if they wished.

People and their relatives were positive about the staff and the care they received. One person told us, "I have no problems with the attitudes of the carers. They are all nice and kind to me." Another person told us, "They are good girls. All of them are caring and kind." A relative we spoke to said, "The staff all care, you can tell that the service users really matter to them. They really care."

The promotion of people's privacy and dignity was observed throughout the day. We saw staff attending to people and meeting their needs in a respectful, discreet manner. Staff members were able to describe ways in which people's dignity was preserved such as knocking on doors before entering, making sure they offered assistance with personal care to people in a discreet manner and ensuring that doors were closed when providing personal care in bathrooms or in people's bedrooms. Staff all clearly explained that information held about the people who lived at the service was confidential and would not be discussed outside of the service.

There were a number of information posters displayed within the entrance hallway which included information about the service and the provider organisation, safeguarding, the complaints procedure, fire evacuation procedure and the aims and objectives of the service. We also saw contact details available for the local authority and the Care Quality Commission (CQC). This meant that people and their relatives received information regarding the services available to them.

We were told information on how to access the services of an advocate should this be required and support

from charitable organisations who provide services to older people and people living with dementia was available on request.

Inadequate

Is the service responsive?

Our findings

People were unable to tell us the extent of their involvement within their care planning. They were unsure if they had been involved in deciding what care they were to receive, how this was to be given or if any review of their needs that had taken place. When asked a question about their care plan one person told us, "I'm not sure I've seen one." Another person told us, "I've not been asked about what I'm interested in." A relative told us, "I have been asked [Name of person's] preferences but I have not seen any plan or signed a care plan that I have agreed to."

Care plans were in place for each person and records showed that pre-admission assessment visits were undertaken to establish whether the home could provide the care people needed. There were a combination of computer generated care plans and handwritten documents within each file which followed the same format and index for each person. The care plans we reviewed included information on care needs and the support people required but lacked detail on people's background, their individual preferences or their interests. The plans were not reflective of people's needs and did not always include clear instructions for staff on how best to support people. We found that care plans had been not been updated or reviewed regularly and changes were not recorded as they had occurred. For example, for one person their care plan stated that they required 'full support with personal care' however, the plan did not detail what the person's preferences were with regards to the type of personal care or their preferences as to the gender of the member of staff they received care from. The care plan also stated that the person was 'unable to reliably communicate'. There was no further information as what communication difficulties the person experienced or guidance as to how staff should engage in communication of any sort with the person. The lack of personalised, current information within care plans meant that people were at risk of not having all of their health and social care needs met which could have a negative impact on their health and well-being.

We also found one person had numerous sections of their care plan that had not been completed. This was information in relation to their personal background, medical history and known conditions, pain management and the support they required with medicines. The person had a number of medical conditions and was assessed as requiring support with their medicines, with regular analgesia prescribed for them. The lack of this information within their care plan meant that staff were not provided with guidance on how to best to support the person or the information they required to ensure the person's needs were met. This meant that the person was at risk of not receiving the support they required in managing their health conditions and not receiving their medicines as required and in their preferred way.

Care plans did not accurately reflect people's current needs and lacked personalisation. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed opinions from people regarding the activities provided at the service. One person told us, "They give us something to do most afternoons." Another person told us, "I'm bored stiff, it's terrible." A third person told us, "I don't see any purpose to it." Activities were provided by an activities coordinators and an assistant who shared the responsibility of providing activities during the week. Members of staff we spoke with were unable to describe individual activities that people enjoyed but told us that visiting singing groups

and the therapy rabbits that visited the service were well received. Staff explained the difficulties the service had in providing meaningful activities for everyone due to the complexity and variety of needs people living in the service were experiencing. They also shared with us a difficulty in motivating and encouraging people to participate in activities.

There was an activity schedule available so people and their relatives knew the activities that were on offer or any future events that were planned. However the activity co-ordinator explained that the schedule frequently changed based on the health and well-being of people and their level of motivation to participate. During our inspection we saw limited activities being completed by people with the support of staff on duty. The activity room was open and available to people whenever they wished to use the room however limited resources were left out and access to some equipment was restricted as it was locked away. Following our inspection the provider told us this was because items left out were frequently damaged or taken. We saw people sitting with colouring books and crayons but were not completing the activity; many people we observed were watching television for the majority of the time. People who chose to remain in their rooms did not tell us that they had completed any activities.

People and relatives we spoke with were aware of the complaints procedure and who they could raise concerns with but confirmed that they had no reason for complaint. One person told us, "I'd tell them, the staff. They'd need to put it right but I'm ok." A relative told us, "I'm here most days and have never had cause to complain." Members of staff told us that they knew how to respond if a complaint was made to them. A member of staff told us, "The complaint post box has been moved to the nurses' room. We have been asked to put all complaints in there so they are not opened and kept confidential."

We saw in the complaints file that one formal complaint was recorded as having been received in the past year. There was an investigation into the concern and the actions to be taken in response included. The complainant had received a written response to their concern and the manager had recorded the outcome. However during inspection activity we found that a further two complaints had been received in the service. The manager was able to show us the documentation in relation to one of these complaints which appeared to have been investigated and responded to as required by the provider policy. The manager explained that they, "Just hadn't filed it yet" into the complaints file. However, for the other complaint, we saw that action had been taken in response to the concern but there had been no follow up action completed. The complainant had received a response however the member of staff who had received the complaint had received no further support and there was no record to indicate that they were satisfied with the outcome or the complaint had been drawn to a conclusion.

Inadequate

Is the service well-led?

Our findings

The registered manager was no longer responsible for the day to day running of the service and had commenced the role of deputy manager. A new manager had been appointed. These changes in senior management had been in place since April 2016.

When we inspected the service in November 2015 we found the provider was not meeting all the legal requirements in the areas that we looked at. We received a provider action plan which stated the service would meet the regulations by 30 September 2016. During this inspection there were still improvements required in these areas. The provider had not taken sufficient action to fully rectify the earlier inspection findings and had failed to act upon the feedback provided.

The systems and processes for governance and quality assurance at the service were not robust. Processes had not been effectively implemented by the manager so they did not enable them or the provider to assess, monitor and improve the quality of care being provided at the service and they failed to mitigate the risk of harm to people living in the service. The audits completed had consistently failed to identify the concerns we found on inspection.

We found that there were a range of audits and systems in place by the provider organisation to monitor the quality of the service provided. The monthly home audit was an internal auditing tool completed by the manager in relation to specific areas of the service. This included an environmental check, incident and accident review, complaints review, personnel file check, training, maintenance and domestic and a review of meetings. The audit tool also included a final page for recording any actions as a result of the findings of the audit that had been completed.

We found concerns in relation to the safety and management of medicines in the service however the medicines audit completed by the service manager indicated that there were no concerns in this area with only minor actions identified as being required to be taken. The audits completed failed to identify the errors found in stock levels, the inconsistencies within records and the concerns identified with regards to the safe storage of medicines. The provider audits completed in September 2016 and October 2016 also failed to identify the concerns found as it was recorded on both occasions 'This area was not examined during the visit'. This meant that the audits in place failed to mitigate the risk of harm to people from the poor management of medicines and failed to ensure that remedial action was identified and taken.

We also found that risk assessments in people's care plans were not effective or reflective of the current levels of risk. We found that information in relation to people's nutritional needs had not been reviewed or updated following advice from the dietitian and there were inconsistencies in the records. Care plans had not been fully completed regarding people's assessed needs. The care plan audit process had been discontinued at the service since April 2016 and the responsibility of care plan reviews had been delegated to the deputy manager. With no audit process in place for service users care plans the concerns that we found on inspection surrounding the risks to service users had not been identified. This meant appropriate action was not taken to remedy the short fallings within risk assessments which increased the risk that

people may come to harm at the service.

We found concerns in relation to incidents and accidents and that potential safeguarding incidents had not been identified, assessed or referred to external agencies. There was no record within the audits completed to suggest any concerns had been found in this area. The provider audits completed in September 2016 and October 2016 also failed to identify the concerns found as it was recorded on both occasions for incidents, accidents and safeguarding 'area was not examined during the visit'. This meant that the audits completed failed to ensure that appropriate action had been taken following incidents or accidents that had occurred at the service. This included a failure to ensure that potential safeguarding incidents had been recognised and referred the local authority and that people's care plans and risk assessments had been reviewed and updated. As a result of the failure of these audits potential risks to people's safety had not been identified and action had not been taken to reduce those risks. This further increased the risk of potential harm to people.

We also found there were inconsistencies in the response to areas of concern identified by the manager, as well as a lack of remedial action when concerns were noted. The home audits that we reviewed showed that a number of concerns were recorded and put into the action plan at the end of the document to be addressed. However other areas of concern which had been identified had not been recorded on the action plan. We saw that several concerns were repeated following subsequent audits, demonstrating that no action had been taken to rectify the concern. There was no evidence that actions had been recorded as required or that remedial action had been taken to address these concerns following these audits. This meant that the checks and audits in place were not effective as there was no clear process for taking action when concerns were identified.

Systems and processes for governance and quality assurance were ineffective and failed to assess, monitor and improve the quality of care being provided or mitigate the risk of harm to people living at the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives did not always know who the manager was. One person told us, "I'm not sure who it is these days, there's a few of them." Another person said, "I don't think I do know who it is." A relative told us, "I know who [they] are but I have not really had anything to do with [them] really." Another relative told us, "I don't know that I do know management. I met someone before [Name or relative] came in but no communication since."

During our inspection we did not see the manager as a visible presence in the service. They demonstrated a lack of knowledge about the people living in the service and the systems in place. We did not observe the manager interacting with people living at the home and found they predominantly spent their time in the manager's office. We did not observe the manager being actively involved in the running of the service. We did, however, see that the deputy manager responded to staff regarding the support and well-being of the people living in the service and the experiences of the staff on duty.

Staff on duty told us that there was an open culture amongst team members but were unsure they would be supported by the management team. One member of staff told us, "Management? It's early days yet. [They] haven't had a chance to get into it yet." Another member of staff commented, "[The service] lacks a bit of management structure." Staff were aware of their roles and responsibilities and were clear on the lines of accountability within the staff structure.

Staff were not always clear on the visions and values of the provider organisation and the direction of the

overall service development. One member of staff told us, "Provide high quality care to all the residents in here. Privacy, dignity and respect them." Another member of staff told us, "Central to all we do is care. We need to ensure we meet the needs of all residents." Members of staff we spoke with said that there had been a lack of general staff meetings and they did not feel involved in the development or plans for the service in the future.

We spoke to relatives about their involvement in the development of the service and whether they were asked for their feedback and opinion of the care provided. Relatives could not recall completing a satisfaction survey, although we saw one had been conducted, however they described relatives meetings that happened in the past but not since the manager had commenced their role.

We noted that records were stored securely within the computerised system or within the nurse's office, manager's office or administrator's office. Each office door was fitted with a key pad and we were told only those people with authorisation knew the access code. This meant that confidential records about people and members of staff could only be accessed by those authorised to do so.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans did not accurately reflect people's current needs and lack personalisation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not involved in decision making in relation to their care and support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive frequent supervision. No appraisals had been conducted in 2016.