Mrs Elizabeth McManus

St Georges Nursing Home

Inspection report

61 St Georges Square
Westminster
London
SW1V 3QR

Tel: 02078219001
Website: www.stgeorgesnursinghome.com

Date of inspection visit:
10 April 2018

Date of publication:
29 May 2018

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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out this unannounced inspection on 10 April 2018.

St George's Nursing Home is a care home with nursing. 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. At the time of our inspection there were 32 people using the service, 20 of whom were living with dementia.

At our last inspection in August 2017, we rated this service 'requires improvement' overall and 'inadequate' in relation to safety. Breaches were found relating to safe care and treatment, safety of premises, medicines, training and supervision of staff, dignity and respect, consent to care, recruitment of staff and notification of significant events.

Following the last inspection, we asked the provider to complete an action to plan to show what they would do and by when to meet regulations. At this inspection we found the provider was meeting regulations relating to premises safety, dignity and respect and consent to care. However, there had not been satisfactory progress in addressing other areas where the provider had breached regulations and practice had declined in some areas. Consequently, we have rated this service 'inadequate'.

This service put people at unacceptable risk of harm by failing to ensure the safe management of medicines. People missed their medicines or received the wrong dose or at the wrong time. There was a fundamental failure to implement a robust governance framework for delivering medicines safely and a failure by the provider to make sure staff had the right training to do this. Tablets were crushed without proper authorisation in a single crusher which was dirty and contaminated. There were some serious medicines errors, including one person who received an ear drop in their eye. The provider's own records had shown 35 incidents, errors or discrepancies had taken place in just 13 weeks prior to this inspection; these had not been investigated or action taken to address the cause of the errors. The service was unable to account for some controlled drugs and had not disposed of these safely, contravening regulations relating to the misuse of drugs.

The provider did not operate safer recruitment processes as appropriate pre-employment checks had not been carried out. Staff continued to lack adequate training and supervision to carry out their roles. At times there were fewer staff than the provider told us would be in place; there had not been any assessments as to whether these staffing levels were adequate. We observed improved infection control measures, as the building was clean, but staff lacked formal training in this area.

Action had been taken to improve the safety of the premises. Risks to people were routinely assessed and management plans were in place to manage risks from choking and pressure sores. When incidents and accidents had occurred the provider failed to follow its policies and did not look into the causes or take action to prevent a recurrence.

The service lacked insight into the needs of people living with dementia. There was no dementia training made available to staff and a lack of meaningful activities suitable for people using the service. The building was not designed and laid out in a way that would enable people living with dementia to orientate themselves and maintain their independence. Consent to care was obtained, but the provider did not always assess people's capacity to make specific decisions. We have made a recommendation about this.

People were monitored for the risk of malnutrition but food choices were not presented in a way which gave people living with dementia any meaningful choice. There were extremely limited systems for seeking people's views on their care and acting on them. Complaints were not recorded or investigated in a way which facilitated a meaningful response.

People told us that staff were caring, but sometimes we observed less positive interactions. People took a long time to receive their food and were frequently left unattended. Care plans were not designed in a person centred fashion and were not set out in a way which meant people could understand their contents.

The management of the service was inadequate as the provider did not carry out the right checks to ensure that care was being delivered safely and effectively. The provider did not take action to address many of the concerns we highlighted in our previous report.

We found breaches of regulations concerning safeguarding adults, the recruitment of staff, management of medicines, training and supervision, person centred care, good governance and the management of complaints.

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.

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.

Staff did not always receive training in safeguarding adults and some incidents had not been reported or investigated in line with safeguarding protocols.

There were not appropriate pre-employment checks carried out on staff.

People were put at unacceptable risk of medicines errors due to poor medicines management procedures.

Risks to people using the service were assessed and action had been taken to address the safety of the premises. The provider did not routinely investigate when incidents and accidents had occurred to prevent recurrence.

Is the service effective?

Requires Improvement

The service was not effective.

Staff did not receive suitable training and supervision to carry out their roles effectively.

People's nutritional needs were assessed and met. The building was not designed or utilised in a way which met the needs of people living with dementia.

Consent to care was obtained, but the provider did not always assess people's capacity to make specific decisions.

Is the service caring?

Requires Improvement

The service was not always caring.

People were positive about the caring nature of staff. Most interactions we observed were positive but in some cases staff did not interact with people when supporting them.

There were limited systems to obtain people's views and act on them. Privacy and dignity were not always promoted.

People were not offered choices over their food in a way which met their needs.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive.

Care was not always planned or delivered in a person centred way.

There were few meaningful activities for people with dementia and many people felt bored.

Complaints were not suitably recorded or investigated.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of effective audits which could have detected breaches of regulations or risks to people's safety.

Managers did not ensure that policies and procedures were implemented and monitored or promote a culture of constant improvement. Attempts to improve the service were not supported by the provider.

There was a lack of clarity of staff roles and limited communication with staff to ensure standards were maintained.

St Georges 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 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.

We carried out this inspection as we rated the safety of the service 'inadequate' six months ago. This inspection took place on 10 April 2018 and was unannounced. The inspection was carried out by three adult social care inspectors, two specialist advisors in pharmacy and nursing 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.

Prior to carrying out this inspection we looked at information we held about the service. This included information about serious events that the provider is required to tell us about.

We looked at records concerning the care and support of six people using the service and staff recruitment records for five staff. We also looked at records relating to staff training, supervision, health and safety checks and audits of the service. We spoke with 13 people using the service and four of their relatives. We also spoke with the registered provider, two administrators, the deputy matron, three nurses, a senior care worker and one care worker.

Inadequate

Is the service safe?

Our findings

People and their families told us they felt safe using the service. However, we found that the provider had failed to establish and operate effectively appropriate systems to ensure people's safety. We found several serious breaches of regulations which meant people were not safe.

People were put at risk as the provider did not carry out the required checks to ensure that staff were safe to work with people.

At our previous inspection we found that the provider was not meeting regulations in this area. This was because they did not always obtain a complete work history or appropriate references for staff when they were recruited. At this inspection we found the provider was still not meeting this regulation.

We looked at the recruitment of five staff, which included a domestic staff member, two nurses and two care workers. The provider had shown us a new recruitment form, which required applicants to provide a complete work history, however this had not been used. Of the files we looked at, three did not contain a complete work history and one contained contradictions which the provider had not explored. Three staff did not have appropriate references from their previous employer when they had a background in health and social care. The provider also did not always carry out appropriate checks with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions.

One staff member had a DBS check from a previous employer, but the provider had not taken appropriate measures to verify whether anything had changed which may make the person unsuitable for their role. One staff member had a note on their file which said a DBS application had been made on 31 January 2018, but no evidence of a satisfactory check was received. One staff member had applied for their role on 30 March 2018 and was on shift for induction on 1 April 2018 with no DBS check or referencing carried out. The provider told us that this person would only be working under supervision, but there was no evidence on the rota that this person was working in a supernumerary capacity. After the inspection, we asked the provider to obtain urgent proof that DBS checks had been carried out, which they provided to us.

This represented a continuing breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were put at unacceptable risk of harm from medicines errors as these were not properly or safely managed.

At our previous inspection, we found the provider was in breach of regulations around medicines management as they were not checking that medicines were stored at a safe temperature in fridges or medicines storage areas. At this inspection we found that fridge temperatures were now being taken, but on one occasion the fridge was turned off for the day and temperatures were higher than the recommended level; there was no evidence that any action had been taken in response to this. The provider was not

checking that medicines trolleys were stored at a safe temperature. Therefore, although medicines were kept securely in locked areas, we could not be certain that they were stored at the right temperature to ensure their effectiveness.

We found staff lacked training in medicines management. There was no evidence of any training being carried out or any checks that staff were competent to administer medicines. One nurse told us they had received training when they joined the service over 20 years ago, but had not had any recent training. One nurse had been in post for a few years, and had not had training in this time. They informed us that they had been observed by the provider to ensure they were competent, but there were no records to support this.

The provider's policy stated that staff should 'retain responsibility for ordering medicines from the GP practice and should not delegate this to supplying pharmacy', however staff told us that in practice the ordering of medicines had been delegated to the pharmacy. Medicines were checked by two staff members, however this took place the day before the next cycle took place, which meant staff may not have time to raise queries about supplied medicines with the pharmacy.

The provider's medicines policy stated in line with NMC guidance, 'Hand written Medicines Administration Recording (MAR) charts should only be produced in exceptional circumstances and created by a member of staff with appropriate medicines administration training for the setting. The hand written record must be checked and verified by a second member of staff with the same training before first use.' However, we found that some MAR charts were handwritten and signed by one person only and some had no signature at all. In one case an evening dose of medicines had been highlighted to be given at 7am, this had been signed for on three consecutive days before being removed with correction fluid. No formal investigation had taken place, so we could not be sure if this medicine had been administered or was a recording error. In another case a person had a topical medicine in their room, but there was no MAR chart in place to record its administration.

Controlled drugs were not managed safely. We saw that one person was prescribed morphine in injectable ampoules. A controlled drug register was in place and this medicine was stored safely. However, we found that on one occasion a person received a second dose from an ampoule which was already opened, which was against the manufacturer's instructions. Records showed that when a 10mg ampoule was opened, on two occasions 7.5mg of this were listed as 'wasted'. The controlled drug register showed that although excess stock was returned to the pharmacy, half of one ampule was not accounted for. The provider did not have kits which would allow for the safe destruction of controlled drugs or maintain records of destruction, nor did they hold an appropriate exemption from the Environment Agency for sorting and denaturing controlled drugs for disposal. This meant the provider was not meeting the Misuse of Drugs Regulations 2001. The Misuse of Drugs Regulations 2001 allow for the lawful possession and supply of controlled (illegal) drugs for legitimate purposes. They cover prescribing, administering, safe custody, dispensing, record keeping, destruction and disposal of controlled drugs to prevent diversion for misuse.

We also found a bottle of liquid morphine which was dispensed in November 2017. This was not labelled with an opening date, even though it was required to be disposed of within 90 days of first opening. Therefore, we could not be assured that the product was in date and safe to use.

The provider told us that more than one person using the service had their medicines crushed due to swallowing difficulties. The clinical lead stated that they had received approval from the GP to carry this out but no pharmacy advice had been sought. The provider's medicines policy stated the provider should seek authorisation from the prescriber to crush medicines, but we were unable to locate this authorisation. We found that a single tablet crusher was used to crush medicines. This was heavily contaminated with powder

residue and put people at high risk of receiving traces of other medicines.

We checked the medicines records for 18 people. In all cases we found errors. These included missed signatures, missed doses, medicines which were signed for but remained in the blister packs, and stock checks that did not agree with what was received by the service and recorded as administered. In three cases people's medicines instructions stated that these were to be taken after food, but there was no evidence that staff had attempted to ensure that this was taking place.

The provider maintained a medicines incident book. This showed that in the 13 weeks prior to the inspection, 35 errors, incidents or discrepancies were recorded by staff, but there was no attempt to investigate these or take further action to ensure that people were safe. An informal audit had taken place in January 2018; this was handwritten and lacked any formal structure and had noted six areas of concern. We found that errors were rectified but no other action had been taken to investigate the cause or mitigate any risk of recurrence.

Medical oxygen was available in the building but was not safely managed. There was no risk assessment in place for its storage or protocol for its use. The provider told us that this was used for emergency use such as resuscitation, but there was no evidence that staff were trained in its usage.

In some cases we saw that surplus prescribed antibiotics were retained as stock after the course was completed. Staff told us that these were retained to be used if an emergency doctor required a person to be treated. However, the provider's medicines policy clearly stated that medicines no longer required by an individual should be disposed of with their consent and that at no time may one person's medicines be used for another person.

We also saw that the medicines fridge contained a flu vaccine, which was not labelled for any particular person. Two nurses informed us that they had at times carried out flu vaccinations, but that this had not taken place recently. The service did not have an anaphylaxis kit in place and nurses confirmed they did not hold current anaphylaxis training. In 'Immunisation against infectious disease' (2013, Department of Health and Public Health England) it states. 'A protocol for the management of anaphylaxis and an anaphylaxis pack must always be available whenever vaccines are given'. Therefore this was not being carried out safely in line with practice guidance.

The above issues constituted a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not safeguarded from abuse or improper treatment. Staff we spoke with showed an understanding of how to recognise the signs of abuse. However, the provider did not maintain suitable training records, which meant they could not show that staff had received training in safeguarding adults.

We found two incidents which could constitute safeguarding concerns which were not reported to the local authority or to the Care Quality Commission. In one case, a person was found with a long cut to their forearm, this person was unable to explain how it occurred. Incident forms showed the person received appropriate treatment, but there was no further investigation into how the injury was sustained. In another situation, staff noted that a person had sustained a grade three pressure sore, which was later revised to grade four. The provider had referred the matter to a tissue viability nurse, who had given clear instructions to the provider to refer this to the local authority's safeguarding team. The Pan-London Safeguarding Policies and Procedures clearly state that pressure sores of grades three and four must be investigated under this process, but the provider did not carry out an investigation or refer these incidents to the local

authority.

In both cases, following the inspection we referred these incidents to the local authority safeguarding team.

This constituted a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from infections. At our last inspection we found that infectious waste bags were sometimes left open in bathrooms; at this inspection we found that the provider had fitted suitable pedal bins for hazardous waste, which meant this was now safely stored. We observed staff taking appropriate infection control measures such as wearing gloves and aprons when carrying out personal care. However, there was no evidence that staff received any formal training in infection control. The building was kept clean and we did not observe any bad odours or infection control hazards. A nurse told us, "Matron is very particular about basic nursing care and control of infection. This is why the place does not have any bad odours."

The provider had taken action to improve the safety of the premises. At our last inspection we had serious concerns about fire safety, including the operation of fire doors and fire escapes being blocked by rubbish. At this inspection we found that there were measures in place to keep the building safe. We found that fire escapes were observed to be clear and regular walkaround checks were taking place to ensure that this continued. There were weekly tests of the fire system and checking of call points, and an up to date fire risk assessment had been carried out along with a satisfactory inspection by the London Fire Brigade. Checks had been carried out of the lifting equipment, gas boilers and the electrical systems, and although the electrical system did not meet present standards an electrician had recorded that the system was not dangerous.

Audits were carried out of the kitchen to ensure food was prepared safely. A recent food safety inspection had highlighted some issues, such as not recording when meat and fish had been defrosted, but these had been noted by an internal audit and recommendations made following the food safety inspection had been carried out.

There were four different books used to record staffing. These were chaotic, used different codes and did not accurately reflect the times and dates people worked. There appeared to be sufficient staff on duty but some staff complained that they were not given enough notice of their shifts. This was corroborated by the rotas that were only organised two weeks ahead. The provider stated that a new electronic rota was going to be developed and that there had been a short trial but no evidence was provided of this. One staff member told us "people don't know their shifts they complain."

There was a risk of understaffing because the provider had not conducted an appropriate analysis into how many staff were needed. The provider stated that there should be two nurses and four care workers on duty, however in March there were 17 days where there were only three care workers on duty and six days where there were only two. The provider stated that this was acceptable as they were not at full capacity but there was no formal analysis of the required staffing levels based on people's needs. Rotas showed that there were always two nurses on duty, however, numbers of care workers varied. When we visited people in their rooms we observed they had a call bell within reach. Comments from people included, "They usually answer promptly and if they can't they come and say", "There are not enough staff. When you ask for something you have to wait a very long time. They are lovely people but there's not too many of them", and "I sometimes feel a bit rushed; it can happen, but it's not an average situation." A relative told us "On the days we are here there have always been enough staff."

Risks to people using the service were routinely assessed. These included identifying when people were at risk of choking and providing a suitable management plan, including clear written instructions on the action to take in the event of the person choking. When people had bedrails, there was a risk assessment system in place. The provider assessed the risks of people developing pressure sores and their own risk management plans were kept up to date and followed by staff. However, in one instance where a person had developed a pressure sore, recommendations from a tissue viability nurse had not been followed.

We noted that some rooms on the first floor opened out to a balcony which was approximately 1.1m in height. This meant there was a risk of people falling from this balcony. We saw that most people were unable to access this balcony due to the placement of furniture across the doorway and limited mobility, however one person with a diagnosis of dementia was able to, and the key was kept in the door. This person was temporarily staying in this room. We raised this with the provider and asked them to carry out an urgent risk assessment of this person's access to the balcony, which was supplied to us. This contained appropriate measures to restrict this person's access to the balcony and prevent them from falling.

There were risk assessments in place where people were at risk of falls. However, the provider did not take appropriate action to address when people had fallen. One person had had six falls in four months; we found that the provider had referred them to the falls team in September but had not received feedback on this; although the risk management plan had been reviewed the provider had not taken additional steps to address or investigate the cause of these falls.

The incident and accident reporting policy stated that incidents and accidents needed to be "recorded and investigated in order to prevent a recurrence…after reviewing the facts will take the actions necessary to minimise occurrences of the same incident in future. These actions should be noted on the form." There was a reporting form and management review form provided in this pack, but these were not in use. Instead, incidents were recorded in an accident book, with no actions taken as a result. When falls were noted, the action taken was to check people's vital signs, but no further action was taken to investigate the incident or to address the risk of a recurrence. A relative told us that in response to their family member falling "[there was] no action taken that I am aware about…[my relative] had falls identified as a risk factor but to my knowledge did not see a physiotherapist or [be] assessed for mobility aids."

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we found that staff did not have suitable training and supervision and records of these did not exist. At this inspection we found that the provider had not taken sufficient action to address the training and supervision needs of staff and was still not meeting this regulation.

A staff supervision folder showed that just three staff had received supervisions since our last inspection. These records contained limited information on identifying staff training needs. We asked three nurses about supervision and two replied they had never had this and one appeared unfamiliar with supervision. One care worker told us they were now receiving supervision.

14 staff had received appraisals since December 2017. These included questions such as "What have you enjoyed?" and "What have you found most frustrating?" and contained some limited reflections of staff performance, but did not explore staff development needs. Comments from staff about this process were negative, including "I was not able to contribute to the discussion…or talk about my personal development" and "My appraisal was a non-event because I did not have the opportunity to say what I wanted to say".

Staff did not receive suitable training to carry out their roles. Staff files did not contain details of training received during employment with the provider. The provider had compiled an individual training matrix for each staff member, but none of the five staff files we saw had this in place. We confirmed with the administrator that these had not yet been done. The administrator gave us a training matrix, with a list of 16 identified training needs for the entire staff team. Six of these had dates that they had taken place, but did not state who had attended these. Areas of training which could not be evidenced as having taken place included safeguarding adults, fire awareness, health and safety, risk assessment and end of life care. There was no evidence of dementia awareness training being planned or delivered. One person using the service told us "On the whole the standard of education has decreased and therefore the standard has decreased."

Staff we spoke with did not appear to have undergone a rigorous training programme. For example, we asked one care worker what training they had received and they told us "in house training manual handling and using a wheelchair... No other training" and another care worker told us they had only received safeguarding and first aid training. We spoke with three nurses about their training. All three told us they had received training in safeguarding and mental capacity and one told us they had also received training in catheterisation, but could not recall any further training they had received. One staff member told us "We need ongoing training; we've only had two or three."

This constituted a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we made a recommendation about the layout and design of the building. This was because the building was not designed to meet the needs of people living with dementia. The provider told us that people liked the building how it was, which was why we recommended the provider took advice from a reputable source on how to promote a dementia friendly environment in a way which met the

preferences of people who use the service.

At this inspection we found that the provider had not acted on our recommendation and there were no significant changes to the design of the building. Although rooms were personalised with people's own furniture and pictures, communal areas of the building were confusing and difficult to navigate. Comments from staff and visitors included "The building is old fashioned" and "it's not a modern building, it is what it is". There was no evidence of best practice design for people living with dementia being followed, for example the use of handrails, colour coding or memory boxes, which could help people to navigate the building independently. Most people we saw were unable to navigate the building without staff support; this was exacerbated by the high number of staircases, self-closing doors and a single lift. Parts of the building actively deterred person-centred practice. For example, to access the dining room, people needed to pass through two fire doors and go through a classroom area in the basement of the building. This meant most people required staff support to do this and meant that it took a long time to support everyone to the dining area, which impacted on how much time people had to wait for their food.

This failure to act on our recommendations constituted a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before people moved into the service, the provider carried out a global assessment. This was a brief assessment of each aspect of the activities of daily living which affected the person. These documented people's hobbies and interests, information on their daily routines and people's likes and dislikes with regards to food. There was also information on people's life stories, family situations and former occupations. However, in one case we found that this was not completed and was undated. It was not also unclear who this assessment was carried out by.

People received good support to eat and drink. Food was served hot and people received prompt support to eat. However, in the dining room we found that frequently people's food was put down in front of them without explanation and that often food was mashed for people without them asking for this. People waited a long time for their food. Some people entered the dining room at noon and did not receive drinks for half an hour and did not receive their first course until 10 minutes after this, with the main course arriving at 1pm. This meant that some people waited an hour before they received their main course.

When people chose to eat lunch in their rooms, they received their food promptly with far more engagement. The provider carried out assessments of people's nutrition in line with the malnutrition universal screening tool (MUST). This identified when people were at risk of malnutrition and outlined clear plans on how staff could manage this. When people were on food or fluid charts these were kept up to date. Staff also checked people's weights monthly in order to identify people at risk of malnutrition, but this information was not always transferred to people's notes, which meant there was a risk that information could be overlooked.

We saw that when plans were reviewed, referrals were routinely made to other healthcare professionals, such as speech and language therapists, falls teams and tissue viability nurses (TVNs). When people required medical attention this was sought promptly, including contacting emergency services when necessary. However, we saw some instances where further input from other professionals such as falls teams were not sought and one instance where recommendations from a TVN were not followed.

The provider was not consistently working in line with the Mental Capacity Act (2005) (MCA). The Act 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. Where people were thought to lack capacity, the provider carried out assessments of people's ability to make decisions, but these were not always specific to the decision being made. In one case consent to use bedrails was signed by a staff member, without evidence of due consideration of what was in the person's best interests. Where people had a representative such as a lasting power of attorney signing on their behalf, there was evidence that the person had the legal power to do so. We recommend that the provider seek advice from a reputable source to ensure that they are fully meeting the requirements of the Act.

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). Where a person was subject to restrictions on their liberty, the provider had assessed this and completed an application to the local authority to do so. The provider had arranged for a new lock to be installed on the front door, and had selected a design that did not restrict people from leaving the building.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were kind and caring, but sometimes people were left unattended and there were limited systems to obtain people's views.

Most people told us that they were happy with the approach of staff. Comments from people included "There's a nice atmosphere.", "The staff are friendly and you can have a conversation with them" and "they listen to me when I talk. The care is as good as it could be. They're kind to you." However, one person told us "They are very strict. To me it's very old fashioned. I feel I'm spoken to as if I were a child" and another said "I'm dumped in my room and just left here".

There continued to be limited systems for obtaining people's views about the service. A communication book had been implemented for this purpose. There were only three documented conversations with people recorded in April 2018 and a further three conversations in January 2018. People did not have allocated key workers or named nurses. The provider had a questionnaire for people using the service; four of these were done in total; some requested more activities in the afternoon but there was no evidence of action being taken in response to this.

People were not able to make an informed choice about what they ate for lunch. At lunchtime we observed that most people had the same thing to eat and there was no evidence of choices being given. One person told us "We don't get choices. I eat whatever is put in front of me….if you have experienced rationing during the war, you tend not to be fussy. So I eat whatever I am given. Having said that I would love to be asked what I would like to eat." Only one person told us they felt they were given choices about their food. We observed one person asking for wine with their meal, which they were given. The provider told us that people were given a menu at the start of the week, which did not show an insight into the needs of people living with dementia as some people may not be able to retain this information. There was no evidence of people being asked what they wanted to eat at mealtimes and no use of menus or sample plates, which would enable people living with dementia to make choices.

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

When people were supported in their rooms, we observed friendly interactions. However, in communal settings this was less positive. For example, at lunchtimes we observed that people were supported to the main dining room, and then left unattended for long periods of time. Most of the time there was friendly and positive communication between people and staff when they were being supported through, but in some cases we observed people being ignored by care workers, and in some cases people had bibs placed on them without explanation. We observed some staff speaking about people in the third person in front of them.

We observed one person constantly asking where they were and what was happening. When staff were around they answered simply and kindly, but as the person was unable to retain information they continued

to appear distressed. Staff did not try to address this in any systematic way which would show awareness of how to reassure a person living with dementia.

The provider told us that lunchtime on the day of the inspection had been "disastrous", which they attributed to events in the service. However, the provider could not explain why the events in the service had contributed to the high waiting times, particularly since this also happened at our previous inspection.

People's privacy and dignity were not always respected. At our last inspection, we served a warning notice against the provider concerning their use of CCTV in people's rooms during personal care. At this inspection the provider told us they were only using CCTV in some rooms where they had permission, and that cameras were only turned on after 11am. We did not see CCTV being used in the course of the day, and suitable permission had been obtained for its use in most cases, however in one instance surveillance had been put in place with a consent form signed by the provider.

In some cases, staff did not knock on people's doors before entering their rooms, and we saw that most toilets in the building did not lock, which could impact on people's privacy.

Requires Improvement

Is the service responsive?

Our findings

We found there were limited meaningful activities for people living with dementia.

The local authority had invited the provider to participate in home care improvement programmes including My Home Life and Ladder to the Moon. These are programmes designed to listen to older people, gain insights into individual needs and provide meaningful activities. However, representatives from the local authority told us that the provider had shown limited commitment to these programmes and that senior members of staff had blocked participation in these programmes.

The provider maintained a record of activity sessions, however this was frequently not completed and was limited to puzzles, music, colouring and crafts. The provider did not record whether people had engaged with or enjoyed the activity and did not monitor people's involvement or assess what was suitable for them. On one occasion people were read the news, and on another occasion a quiz had taken place, but it was not clear how this was carried out. Pictures that people had coloured in were displayed in the day room. We observed an afternoon activity session. There were eight people sat at tables where they had been at lunch. Some people made attempts at colouring in, but the majority of people sat inactively whilst being observed by two members of staff. At one point, a person tried standing up, and was told by a care worker ""What are you doing? If you want something you ask."

Half the people we spoke with complained of boredom or lack of activities. One person told us "I have 2 newspapers a day, I read, listen to the radio. I'm perfectly happy." However, comments from other people included "Do I get bored? We all do. You don't always have something to interest you." and "We get bored very quickly. You do the best and you hope for the best. You get used to all this."
Care was not recorded in a person centred way. We noted that staff usually referred to people using the service as "patients" and frequently people were referred to by their room number. It was not clear that people's choices were respected around their daily routines. For example, we saw a note to night staff from a senior member of staff which stated "As agreed, four patients to be done when three carers on duty, only three patients done today…please ensure four patients done." There was no discussion as to whether this was in line with people's wishes or which activity was being referred to.

People's care was planned and reviewed using a Standex system for nursing care documentation. This included support plans for daily living and long term outcomes, and covered domains such as cognition, psychological, physical health and social. In most cases these plans were reviewed monthly, but in some cases they had not been reviewed at all during the month of March. Daily recording notes were detailed about the care that people had received and showed that care was delivered in line with care plans. We found that in one case a person had recently been discharged from hospital, but their care plan had not been reviewed to reflect changes in their needs. A senior staff member told us "The care plans definitely need to improve."
Care plans were designed for professionals to follow; there was no attempt to design these in a way that meant people using the service would be able to understand and comment on their contents. This meant that the provider was not meeting the Accessible Information Standard. The Accessible Information

Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with the AIS.

This constituted a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At our last inspection, we noted that complaints were not effectively recorded and investigated. We found this remained the case. Complaints were recorded in a book free hand without a clear structure for what should be gathered and what follow up should take place There had been three recent complaints recorded in the book and space had been left for follow up actions to be written but there were none recorded at this stage. Staff had recorded that a relative had stated they would make a complaint as their relative's call bell had been found on the floor for a third time, but there was no follow up to this. We were aware of another complaint made to the service, but this was not recorded or investigated.

This constituted a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were able to make complaints, and knew who to speak with if they had concerns.

At the time of our inspection, nobody was receiving end of life care. Care plans did not contain information about people's wishes for the end of their lives. Where Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPA) orders were in place, these were signed by a doctor and reviewed, with evidence of involvement of the person, wherever possible and their relatives.

Inadequate

Is the service well-led?

Our findings

At our last inspection we highlighted several areas where the provider was not meeting regulations. At this inspection we found that the management of the service had not taken action to effectively address these serious breaches. The provider had failed to effectively operate systems to ensure that the quality and safety of the care and support provided was assessed and monitored to drive improvement. There was a lack of understanding of the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and current best practice guidance.

Following our last inspection report, managers in the service completed an action plan, which had recently been updated. This highlighted what had and what had not been done. In some areas it had been effective, for example in responding to our concerns about infection control and the safety of premises. Action had been taken to ensure that the provider was notifying the Care Quality Commission (CQC) of significant events which had taken place in the service. However, the provider had failed to notify CQC of two safeguarding concerns. In addition in some areas the provider's action plan had failed to address our findings. For example, action had not been taken to address our concerns about temperature checks of medicines stored in trolleys, and action had not been taken to address serious deficiencies in staff training or recruitment, even though six months had passed since the publication of the previous report.

Systems of audit were limited in their scope. A medicines audit carried out in January 2018 identified six issues of concern which were recorded in the medicines incident book. This was written as free text and there was no established framework for internal audits. Although immediate issues were rectified there was no evidence that this triggered any management action; there were no records of medicines supervision or additional training. A further audit in February had identified a further 11 issues, despite the worsening findings no further audits had taken place. This meant that managers were not carrying out the right checks to ensure the proper and safe management of medicines.

Monthly audits were carried out of the kitchen, which had effectively highlighted some issues of concern. However, elsewhere a single quality assurance audit had been carried out by the deputy manager on 13 December 2017; the sole finding of this was in relation to people who had frequently fallen being referred to the falls assessment team, although it did not state who these people were. Similarly, four people's care files were audited in January 2018, this appeared to be the only audit of care files that had taken place. Overall, this meant that there was a lack of quality assurance measures which may have detected the issues found during our inspection.

At our last inspection we found that policies and procedures were out of date and were not written in line with current legislation. The provider had purchased a set of policies and procedures, and an administrator told us "We've altered [the policies] to meet our needs, so if there's an update we're notified." However, we found that there was limited action to actually implement these policies. For example, a staff meeting was held in January where minutes stated "When policies have been printed we will hold a second meeting to provide further information and to receive feedback". There was no evidence further discussions had taken place. We found that staff appeared unfamiliar with the contents of the medicines policy and several

instances of this not being applied. Similarly, an incident and accident policy was in place which required the provider to investigate incidents and record actions which had been taken as a result, but this was not taking place, and the supplied incident forms which would support this process were not in place. In many areas, there were not clear frameworks for staff to follow which would promote improvements.

There was also limited evidence of communication with staff to ensure consistent processes. This included a lack of formal supervision being carried out. Team meetings had taken place on three occasions in four months, but we only saw one example of a team meeting used to promote good practice. This included ensuring that people had access to call bells, and that changes in people's conditions were reported. Minutes stated that staff needed to "work in accordance with person centred care", but there was no evidence of what the provider understood by this and what was expected of staff.

The management team had failed to provide effective leadership that ensured staff were aware of individual responsibilities and team expectations. Staff we spoke with told us that the team did not always work well together. For example, only two staff were able to complete notes and care plans, meaning that this work was not evenly shared amongst the team. There was no system of allocation such as named nurses or keyworkers, which meant that staff members lacked responsibility for any particular person. One staff member told us "There are two teams here, the night staff and the day staff. They work separately and do their own thing" and another said "Everyone does everything and everyone does nothing."

The provider told us they had engaged with the local care home improvement programme at the invitation of the local authority. However the local authority told us that the provider had shown limited engagement with this and at times had actively blocked staff from participating in it.

The above evidence constitutes a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.