Mr Paul Bliss

Leonard Elms Care Home

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

Summary of findings

Overall summary

Leonard Elms Care Home provides accommodation for people who require nursing, personal care and dementia for up to 73 people. The home comprises of two units; the Cherries and the Elms. The Cherries unit specialises in dementia care and the Elms unit is for general nursing care. Prior to this inspection CQC had restricted admissions at the home. On the days of inspection there were 42 people living at the home. The accommodation is arranged in two buildings adjoined by a reception area; one building is for each unit. Most people living with dementia were unable to express their views regarding the support they received. During this inspection the reception area was undergoing some refurbishment.

At the time of this inspection the home was still in special measures. Services in special measures will be kept under review. Adult social care services can remain in special measures for 12 months.

At the last inspection, in June 2016, we found breaches in the home because staff were not receiving all the training they required. Care plans were not always complete for people and still did not reflect their needs. People were unsafe because there were issues with pressure care, risk of choking and medicine administration. We found the home was not well led because there were no auditing systems in place and they had not identified all the shortfalls we found. Following the last inspection the provider sent us an action plan and further regular information about the work they had been doing to meet the regulations. At this inspection we found there had been some minor improvements. Concerns were still found in most of the areas where shortfalls had previously been raised.

Prior to this inspection some further concerns had been received by us. As a result the inspection date was brought forward to follow up these issues. This inspection was unannounced and took place on the 8, 10 and 13 February 2017.

At this inspection the registered manager was present on the first two days of the inspection. A registered manager is a person who has been 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. They were supported by a deputy manager, some nurses and team leaders. The provider was at the home for all three days.

People told us they felt safe and we found some improvements for people who were at risk of choking. However, there continued to be risks to people's safety around pressure care, risk assessments, medicine administration and responses to accidents. Specialist mattresses for pressure care were still not always set correctly. When people were at risk of pressure related wounds care there was sometimes a lack of guidance for staff to follow. There was not guidance for staff to follow for people prescribed creams. Often these were to moisturise skin to prevent pressure wounds.

Before the inspection we had been alerted by the local authority and the provider of an incident where a

person using the service was scalded by a hot drink. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of scalding and the treatment of injuries. This inspection examined those risks.

Most staff received regular supervisions and appraisals. The provider and management supported staff. There had been small improvements with the training staff received. However, staff still did not get all the training they required to carry out their duties to keep people safe and meet their needs.

Staff were aware of their responsibility to protect people from avoidable harm or abuse and most staff had received training in safeguarding. Staff knew what action to take if they were concerned about the safety or welfare of an individual. However, systems put in place since the last inspection to ensure all incidents were correctly reported had not worked. External parties such as the local authority safeguarding team were not being informed of incidents which placed people at risk of harm. The recruitment process still did not always follow good practice. This meant people were being exposed to risk from staff who had not had the correct checks conducted by the provider.

People who lacked capacity did not always have the correct process followed for each decision made on their behalf. When the management and staff had decided to prevent people leaving the home for their safety the correct processes had not always been followed. As a result, people did not have their right to make choices respected.

The registered manager and provider had not followed their legal obligations to notify CQC of incidents such as when accidents had happened which placed people at risk of being hurt. The registered manager and provider regularly met to discuss what improvements needed to be made. Some new clinical audits had been started. However, the systems were not identifying all shortfalls in the home. Where some shortfalls had been identified, actions were not always taken to ensure improvement had been made. People knew how to complain. However, systems in place to manage the complaints were not always being followed to provide people with a timely response.

Most people had updated care plans because a senior member of staff was overseeing this process. Where care plans had been updated there was some evidence of people or relatives being involved. However, not all care plans had a person centred approach or contained information to ensure people's health and care needs were met. They had not always been updated when systems to deliver care or keep people safe had changed. Staff supported people to see a range of health and social care professionals to help with their care.

People had a choice of meals, snacks and drinks. Alternative options were provided if people did not like what was served. Choices were offered in a way people could communicate their preference.

People and their relatives thought staff were kind and caring. We observed mainly positive interactions. However, there were periods of time when people did not receive interactions from staff. The privacy and dignity of people was respected most of the time and people were encouraged to make some choices throughout their day. There were occasions when people's doors were left open by cleaners and choices had not considered people's preferences.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. We are currently considering the action we are taking.

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 always safe.

People were not always kept safe because staff lacked guidance around medicine management and pressure care.

People did not always have risk assessments which were required to help keep themselves and others safe.

People were at risk of abuse because safeguarding incidents had not always been investigated and staff had not received adequate guidance or training in some areas of support.

Staff had not always had the correct checks completed during their recruitment to keep people safe.

Staff were able to tell us how to keep people safe and who to tell if they had concerns about people's safety.

Is the service effective?

Requires Improvement

The service was not always effective.

People who lacked capacity did not always have decisions made following statutory principles. Their liberty was not always taken under best interest arrangements or in line with safeguards.

People were supported by staff who had received a range of training. However, not all training needs had been identified by the provider.

People had their nutritional needs met and most enjoyed the food which was provided.

People had access to other health and social care professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us they were well looked after and we saw most of the time the staff were caring. However, there were times when

the support provided did not consider people's needs.

People were enabled to make choices and benefit from this.

People's privacy and dignity was not valued by staff at all times.

People's cultural and religious needs were respected and staff understood how to do this.

Is the service responsive?

Requires Improvement

The service was not always responsive

People's care plans did not always contain enough detail to make sure staff knew how to deliver their health and care needs.

Some people had care plans that were personal to their needs and wishes.

People had access to a range of activities and staff were continuing to find further opportunities.

People and relatives knew how to make complaints. However, the complaints system was not always followed.

Is the service well-led?

Inadequate

The service was not well-led.

People were at risk of abuse and harm because the provider had not always notified external organisations in line with current guidance and statutory obligations.

People's health and care needs were not always being managed well because the quality assurance systems had not identified all shortfalls. Identified issues had not always been rectified.

People were put at risk because the provider and registered manager had not taken adequate actions to improve safety and reduce the risks to people.

People were involved in the community because staff and the registered manager were building further links.

Leonard Elms Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 8, 10 and 13 February 2017 and was unannounced. It was carried out by three inspectors and one specialist professional advisor nurse who was a specialist in the care of older people.

This was a comprehensive inspection and followed up on concerns from our last inspection in June 2016 when the home remained in special measures.

Before the inspection, we had received a number of concerns from a variety of sources. As a result the inspection was brought forward so the provider had not been asked to complete 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 took this into account during the inspection. We also looked at paperwork from the local authority and other intelligence we held internally about the home.

We spoke with seven people that lived at the home formally and had informal conversations with others. We spoke with the provider, clinical director, registered manager, operations manager and 17 staff members, including registered nurses, chefs, a training coordinator, care workers and agency staff. We spoke with two visitors including a relative and a health worker.

We looked at twelve people's care records and observed care and support in communal areas. We 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 looked at five staff files, the provider's action plans, previous inspection reports, rotas, clinical audits, training records and supervision records, health and safety paperwork, contracts with agencies, minutes from meetings and a selection of the provider's policies.

Following the inspection we asked for some information from the provider including some training records, further documents related to quality assurance systems and information about people's care. The provider

returned most information within the required time frame. If there was a delay a reason was provided.

Inadequate

Is the service safe?

Our findings

People were not always receiving safe care. At the previous inspection, in June 2016, the service was not safe. There was a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk of choking, being placed at risk of harm in the event of a fire and not receiving correct medical treatment when their health deteriorated. There were continued shortfalls, from October 2015, in pressure care, medicine management and incident management. Pressure care means proactive actions to reduce the risk of a person getting pressure sores and if they do appear the correct treatment to heal them.

Following the June 2016 inspection the provider completed an action plan to inform us how they would meet the regulation. This included amending agency staff inductions, seeking advice from the speech and language therapists in relation to people at risk of choking, improving the medicine procedures and continuing to improve pressure care.

At this inspection we found there had been some improvements but not enough action had been taken to meet the regulations. Since the inspection in June 2016 the fire rescue service completed a visit identifying systems were now in place to keep people safe in the event of a fire. People were at less risk of choking because referrals to the speech and language therapist were being made. One person at risk of choking when eating had a clear set of instructions being followed by staff. Several people required thickened fluid to reduce the risks of choking; these were documented and written at the top of the medicine administration records to remind staff. This meant people were now being kept safer if at risk of choking.

Some action had been taken to improve the risks associated with pressure care. For example, care plans contained information about people's needs, skin inspections were completed regularly and most special air mattresses were being monitored. However, Some people required regular repositioning to prevent their skin from becoming sore. Staff told us they recorded times when they did this. However, daily records were not being maintained accurately and this was a concern at the previous inspection. By not completing them it was not clear if the person was being repositioned in line with their care plan to prevent wounds. For example, one person's care plan stated they should be repositioned ever three hours. There were four days recorded when they had been in the same positions for between eight and 12 and a half hours. Another person had pressure related wounds and a repositioning chart in place; their care plan contained no information about how frequently repositioning should occur. There were five days when no repositioning was recorded. A third person should have been repositioned every three hours. There were three days in the last week when they had been in the same position for at least five-hours. This meant staff were not following care plans or provided with enough information to deliver people's repositioning needs. The provider told us they would make sure people's needs were being coordinated by the registered manager and nurses. The auditing systems for pressure care had not identified the gaps in care records.

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

Two people at high risk of pressure related wounds had incorrectly set mattresses; one of them already had a pressure related wound. Another person was at risk of pressure wounds due to contractures in their legs which meant parts of their body were pressed together; they did not always have a pillow placed in the recommended position. This was a concern that had been identified at the previous inspection. We spoke with the provider to share our concerns about this lack of understanding. They told us they would liaise with the registered manager and nurses to pass this information on to all staff in handovers. Following the inspection the provider explained they had previously had a good record with pressure care and shared information to us about this.

Some actions had been taken to improve the risk associated with the management of medicines. People told us, "I get my tablets on time, there are no issues", "The staff issue my meds and I am very happy with that" and "I have no trouble with my tablets". There were now regular medicine audits being completed by the deputy manager. During these audits some medicine errors had been identified and action taken to supervise the staff involved. By doing this they were trying to prevent a repeat of the same mistakes. Each person had a cover sheet in the medication administration records (MAR); these had a recent picture and information about how people liked to take their medicine. Concerns remained from the previous inspection relating to the use of topical creams. Not all people had plans to identify where the creams should be applied. This meant staff did not always have clear guidelines of where to apply creams, how much should be applied and the frequency of the application. Seven people were found with prescribed creams which had no records of application. We spoke with the registered manager who acknowledged there was still a problem because some creams were prescribed and some were not. They said, "We are working with the pharmacist to resolve this". This meant there was a risk people were not receiving their prescribed creams.

Medicines which required additional security were not managed at all times in line with legislation. For example, some medicines required a second person to witness the administration. Members of staff were being asked to do this without training in medicine administration. One member of staff told us they helped to organise the monthly boxes of medicines with the nurse; they had received no medicine administration training to know it was being completed safely. Another member of care staff witnessed the destruction of an unwanted medicine requiring additional security; they had not received any training in medicine management. This meant medicine was being witnessed by staff who lacked training to understand what was happening and ensure it was safe.

Before the inspection we had been alerted by the local authority and the provider of an incident where a person using the service was scalded by a hot drink. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of scalding and the treatment of injuries. This inspection examined those risks.

Risks to people were not always minimised because they had not been identified by the provider. There had recently been a change of staff levels at night so there was one nurse instead of two. The provider told us prior to this change they had completed a trial, introduced portable radios for emergencies and completed a timed medicine round. Additionally, they and the registered manager had been present for the first two nights to provide support. However, some staff raised a concern about this change. Staff told us they thought this could put people at risk. One staff member said, "The nurse does not get back to the Elms unit until after 11pm". A nurse confirmed this was the case and told us the medicine round for both units could take even longer. This meant some people had not received their medicines until late in the evening.

One nurse told us they were informed about someone who may be unwell; they were unable to see them

promptly due to the medicine round. We spoke with the provider who said they did not know of any issues with the new arrangements. They showed us a completed risk assessment for this change. This included staff carrying the portable radios so they could communicate with each other in an emergency. The provider and registered manager had not included arrangements for a person with complex epilepsy who had two recent seizures which could require emergency medicine. This meant the management had not always recognised risks occurring in the home and people were at risk of harm. Following the inspection the provider told us they reviewed this change further and had made further alterations to ensure that the nurse on duty saw people promptly when needed.

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

At the last inspection in June 2016 the provider was in Breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because systems and processes in place to protect people from abuse were not operating effectively. One safeguarding was found not to have been reported to the local authority. Following the inspection the provider completed an action plan to inform us how they would meet the regulation. This included additional training for staff and a new system so the registered manager would see all incidents and safeguarding paperwork.

At this inspection we found the system in place to monitor safeguarding was not working. For example, one person lacking capacity, had left the building and was found on the main road. The local authority safeguarding team were unaware of this incident and CQC had not been notified. By not notifying external parties they were not following current legislation and guidelines designed to monitor the safety of people. We spoke with the registered manager who accepted this was an error they had made. The provider told us they had put an additional key pad on an external door to reduce the risk of the person leaving the building again. Another incident occurred where the person had trapped their legs in bedrails. Neither the registered manager nor deputy manager were aware of the incident. This meant no action had been taken to prevent the person's legs getting trapped again and there had been potential for further harm to the person's health and welfare. During the inspection a special bed was provided to prevent their legs getting trapped. Following the inspection the provider sent us a copy of an investigation they completed for the person trapped in the bed rails. They told us a member of staff had not correctly reported the incident.

Some people who could display behaviours which challenged were at risk of being supported by staff using restrictive practices without guidance in care plans or adequate training. For example, one person with dementia could become resistant to personal care. Their care plan had not provided guidance for staff. Staff described different techniques they used to support this person to have a wash. Some of these involved physical intervention such as holding the persons hands and "Going with them", "Hugging" the person, using what they described as "Soft touch" and placing their hands on the person's upper arms. Staff told us and we saw they had lots of training in working with people with dementia. However, they did not have training in the use of restrictive practice. We spoke with the registered manager, the operations manager, the clinical director and the provider who updated this person's care plan during the inspection so it provided information for staff about how to support the person. They also made contact with their training provider to ensure relevant training was delivered.

This is a breach in Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always being protected by the recruitment process. At the last inspection, in June 2016, we found some discrepancies in staff files; this meant the provider could not guarantee the suitability of staff.

Since June 2016, three new members of staff had been recruited. One member of staff had a file which showed they had two gaps in their employment history, which had not been explained. The operations manager told us the member of staff explained the reason for this gap during their interview; the records did not demonstrate this. Another member of staff had an employment history confirming places they worked; this did not contain any dates. By not having the dates the provider was unable to determine if there were any gaps in the employment history. This staff member had two references on file, both from friends, despite having previously worked in a care home. The provider was not following their own recruitment policy of having two references from previous employers. This meant the recruitment process was not identifying the staff were 'fit and proper' to work with vulnerable people.

This is a breach in Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe at the home. One person said, "I feel alright here, safe and secure." Other comments included; "I am as safe as houses here" and "I feel very safe." Staff told us they were aware of the provider's safeguarding policy; they thought they knew how to recognise and report concerns about people's safety. Staff said, "If I had any concerns I would go to the manager or higher and I am confident they would manage it. I know I could go higher to [name of owner]", "I have never witnessed anything but if I did I would go to [name of registered manager] and I am confident they would definitely manage it. I know I could go to CQC if needed" and "I am aware of the whistle blowing policy and happy to use it."

Most of the time people were supported by enough staff to meet their care needs. People told us, "When I use my bell they come" and "You ring the bell and they come." Other people said, "I sat here yesterday and I didn't see a soul about", "There are just about enough staff" and "There were two of us yesterday and we would have loved a cup of tea, but there was no-one around". During the inspection we saw call bells were answered promptly. Staff told us they thought staff levels had improved in the home recently. One member of staff said, "Staffing levels are ok". Other staff told us, "Staffing is good now, a lot better than it was" and "Staffing levels are safe". Previously, there had been a high level of agency staff. The provider told us this was because of holiday leave and sickness. They showed us a new rota which demonstrated a reduction in the use of agency staff moving forward. This meant there were safe staffing arrangements to meet people's needs.

Requires Improvement

Is the service effective?

Our findings

People were not always receiving effective care. At the previous inspection in June 2016 there was a breach in Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because people who lacked capacity did not always have decisions made following the principles of the Mental Capacity Act 2005. 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.

Following the inspection the provider completed an action plan to inform us how they would meet this regulation. The action plan told us by November 2016, "All care plans are being updated and this will include the best interest decisions and capacity assessments as required". At this inspection we found some decisions for people who lacked capacity were still not following the principles of the MCA. One person who lacked capacity had a stair gate in place to stop people going in. The registered manager agreed no best interest decision was in place for this stating "We missed this unfortunately, it's a work in progress". Other people had best interest decisions recorded with no capacity assessments completed which meant the provider has not considered if people had capacity to make their own decisions.

Often there were blanket statements about capacity rather than decision specific capacity assessments. For example, one care plan said, "[Name of person] does not have mental capacity's to make decisions surrounding her health, welfare for property and financial affairs" and continued "[Name of person] doesn't have capacity to make daily choices". There were no other completed capacity assessments recorded. A number of best interest decisions had been made including personal care, medicine being administered hidden in food or drink and removal of furniture from their bedroom. This meant it was not clear if the provider has considered for each decision if the person was able to make the decision for themselves. By not following the principles of the MCA there was a risk the person's human rights could be breached.

We spoke with the registered manager who agreed the current electronic records did not follow the principles of the MCA. The clinical director and operations manager told us they were in the process of including a more in depth capacity assessment on the electronic system to resolve this issue.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met and they were not always following the principles.

To keep some people safe who lacked capacity they were being monitored closely and unable to leave the home without support. Most of them had the correct application for a DoLS in place or an authorised DoLS. However, one person had an authorised DoLS which expired during the inspection; no application for a renewal had been sent to the local authority. We spoke with the provider and operations manager who found a completed application ready to be sent. A second person did not have the correct application made. The registered manager told us an application had been sent to the local authority; the local authority had no record of the application. This meant there was no an effective system in place to ensure DoLs applications were made in a timely manner and repeat applications weren't being made before they ran out.

At the previous inspection in June 2016 there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff lacked training in certain areas such as pressure care, first aid and managing behaviours which challenge. Agency staff inductions did not contain all the relevant information. The competency of staff was not checked. Following the inspection the provider sent us an action plan to say this would be resolved by the end of December 2016. They had recruited someone to become a trainer internally who would deliver mandatory training. This member of staff would coordinate all the training in the home including the training records.

At this inspection although there were small improvements not enough action had been taken to meet this requirement. One person said, "The staff know what they are doing". Staff said, "There is enough training it's pretty good", "I've done loads of training it's a lot better now. The dementia training was really good, it gave me a better understanding of how to support people" and "There is loads of training, I'm all up to date. It's a lot better". Some staff told us they had challenging behaviour training arranged in February 2017. They had updated the training records to ensure staff received specific training; this included moving and handling, pressure care, safeguarding, MCA and DoLS, dementia, infection control, first aid, fire safety, end of life and epilepsy. Over the period of a year it was planned all staff would attend this training. The training coordinator told us they booked specialist training for the nurses with guidance from the registered manager. We spoke with the provider who explained all training was compulsory. They had arranged for it to be delivered away from the home so staff felt valued.

However, the provider and registered manager had not identified all training staff required to support people at the home and keep them safe. This meant people were being put at risk of harm or not having their human rights considered. For example, staff still had a mixed understanding of MCA which was reflected in the practice at the home. The clinical director told us they were going to move MCA to being the focus for next month. The challenging behaviour training was a three-hour theory session. Although the staff had dementia training at times they were using restrictive techniques to support people. Neither had they received training for how to safely protect themselves when a person became distressed. We spoke with the provider, operations manager and registered manager who told us their training in February 2017 would cover what staff were doing. The clinical director understood the differences and liaised with the external training provider to organise bespoke training for the staff. This meant staff were not always receiving training required to meet people's care needs.

There were only informal systems in place to establish the competency of staff following their training. The training coordinator told us they try to reflect on previous training with staff to identify understanding. The provider told us nurses and senior staff observe staff observe members of staff whilst they are working. One member of staff had completed most of their training whilst working elsewhere. The provider told us they were awaiting certificates to demonstrate they had completed the training. They had no systems to evaluate the quality of the training which had been received and whether it was relevant for this home. For example, they had completed moving and handling training which included using hoists. There was no way of

identifying if they were the same hoists used in the home. This meant the provider could not be sure if staff understood and could apply the training they had received. Following the inspection the provider introduced a system to identify competency levels of staff after receiving training.

When agency staff were used, records showed the training the agency staff had completed, which included manual handling. Agency staff were given an induction when they first worked in the home; this included a tour of the building and location of fire escapes. They were also told about various records they would need to update and had access to emergency contact numbers if necessary. However, if an agency staff had not worked for a period of time there were no systems in place to update their knowledge of the people and provide information about changes. For example, one agency staff had not worked at the home for five months yet had no form of induction or update to people's needs. This meant people were at risk of being supported by people who did not have the most up to date knowledge about their needs.

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

People were supported by staff who had undergone an in-house induction programme. Induction covered the environment and people's needs such as eating and drinking, personal hygiene and mobilizing. Once staff had completed the in-house induction, they completed the Care Certificate. The Care Certificate is a nationally recognised standard which gives staff the basic skills to care for people safely. One new member of staff had recently started the Care Certificate. The training coordinator told us it was planned other staff would top up their existing skills using elements of the Care Certificate.

Staff had a mixed view of how they were being supported. One member of staff said, "We have supervision every month they are pretty good and supportive. It's nice for someone to ask you how you are doing". Supervisions were an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner. Other staff told us, "I have had two supervisions and another pending. Not had an appraisal" and "I used to have supervision every three months, my supervisor has left so I haven't had one in a while. I know I can go to [name of registered manager] and [name of deputy manager] if I have any concerns". Records showed some staff had received an appraisal. The provider told us he had held an appraisal with all staff from the Elms and half of the staff who worked in the Cherries unit. Annual appraisals give both managers and staff the opportunity to reflect on what has gone well during the year and areas for improvement or further training required. The provider also told us they had held supervisions with every member of staff. They said, "There are no records available yet because everything has to be typed." This meant staff had members of management providing them with support and advice.

At the previous inspection, in June 2016, we made a recommendation the provider reviews national guidance on catering and keeping records for people who have specific dietary needs. This was because people on specialist diets did not have moulds used to make their food more visually appealing. There was no information to say whether alternatives were offered if people had refused their food or drink. Fluid charts had not been tallied at the end of each day which prevented staff from monitoring if people had enough to drink. We found there had been some improvements at this inspection.

People told us they had enough to eat and drink. They had mixed opinions on the quality of the food. Some people told us, "We get a choice of two or three meals and puddings. If I don't like something I can ask for something else, simple as that", "We get choices and can have alternatives", "Staff ask me what I like and don't like" and "We get plenty of fruit and vegetables". Whilst other people said, "I think we get plenty to eat. I never know what's going to come next, I just eat it" and "The food is up and down. Sometimes I finish a

meal and think, 'I didn't like that very much'" and "Some of it I like, some I don't".

Staff told us they had information about people's needs, such as whether people needed a soft diet or thickened drinks to help them swallow; the information was available in people's care plans, and was also displayed in serveries. The list in The Cherries showed the drink the person preferred, whether the person liked sugar or sweeteners, if the person needed to use a mug or a beaker and other information such as whether they needed to use a lidded beaker and straw. The information also showed if the person used any thickener to ensure they could swallow easily, if the person needed a fortified diet, if they had a dairy intolerance or required diabetic meals and if they required assistance to eat. Night staff told us people were able to have snacks, sandwiches or drinks anytime they wished.

In the Cherries we observed staff offering people the choice of both meals so they were able to see the meal before deciding. Staff offered people the option to have their meals cut into smaller pieces; staff encouraged people to support themselves and offered support when required. One person in the Elms who required support from staff throughout the meal due to their eating plan was given this. However, there was still no use of moulds to make the food more visually appealing if a softer diet was required.

People were able to access other health and social care professionals to meet their needs. For example, staff told us one person had been referred to a speech and language therapist for assessment of their swallowing difficulties. During the inspection we saw staff following the advice which had been provided. People told us, "The staff get the doctor out if needed and make my family aware of appointments" and "If I am poorly they will get the doctor out." Staff explained people had access to other healthcare professionals according to their needs. The registered manager and staff arranged for people to see health care professionals according to their individual needs. For example, one person had an increased number of falls; an occupational therapist had been contacted to provide a different type of arm chair for them.

Requires Improvement

Is the service caring?

Our findings

People were not always receiving support from staff that respected their privacy and dignity. At the previous inspection in June 2016 there were occasions when people had not received interactions from staff for long periods of time. One person was seen not being supported appropriately at a meal time. Other people were found in their bedroom with the door propped open whilst in bed..

Most people told us they were supported by kind and caring staff and their privacy and dignity was respected. People said, "I like the staff, they're very kind", "I'm happy, I've got everything I need" and "Staff show respect, they always knock on the door and call me by my preferred name", "Staff respect my privacy" and "They always knock on my door before they come in." We observed this in practice during the inspection, through the way staff knocked on doors before entering rooms, spoke with people and assisted them with their care needs. People said, "Staff are very considerate when they help me". One relative told us a core group of staff were "really good" and others who were not so attentive.

At this inspection there were still occasions when staff were not always respecting people's privacy and dignity and people did not receive regular, meaningful interaction. For example, one person's door was found propped open whilst they were lying in bed; staff and other people were walking past in the corridor. By doing this their dignity and privacy had not been respected; the person lacked capacity and was lying in bed with a night dress on. We spoke with a member of staff who said the cleaner had left it open; the staff member closed the door. One person told us, "Staff don't always knock on my door." Five people were observed receiving no interaction from staff for over half an hour during a meal time. The registered manager told us one of the people had a plan set up by the speech and language therapist requiring minimal interaction. Other people were observed sitting in lounges or their bedroom with limited interaction from staff. Following the inspection the provider told us the four other people required a low stimulating environment to have their meals to as to reduce the risk of choking.

We found the service was not always considering people's dignity. For example, people had information on their bedroom doors relating to their past lives and interests. Whilst the majority of this information was relevant and informative, we found on one person's door it stated they were 'prone to over eating'. We discussed with the registered manager whether this information was appropriate because anyone walking past the door would be able to read it. They told us the information was there for staff to be aware of. The provider agreed this information would be better placed inside the people's bedrooms.

People had some opportunities to make choices. Most people chose where they wished to spend their time. Some people preferred not to socialise in the lounge areas and spent time in their rooms. One person told us, "I can get up when I want. I don't want the TV or radio on and I don't want to do any activities." Another person said, "The girls wake me at 7.30am and help me up. I can have a lie-in if I wanted to". Staff described how people made choices of clothes, food, drinks, when to get up, where to spend their time.

However, there were occasions when choices were limited or people's preferences were not respected. For example, One person was in bed watching their television; the remote control was out of their reach. We

asked them how they would change the channel, they told us, "I just watch whatever TV channel staff put it on". Another person had modern pop music playing on the radio through their television in their bedroom. They told us they used to listen to radio stations with talking shows such as Radio Four. They were unaware there were options of listening to alternative stations. This meant people were not always being offered meaningful choice considering their personal preferences. We spoke with the provider about the limited choices being offered at times. Following the inspection they told us this had been discussed with staff at handovers and during shifts. They told us staff were usually thoughtful about this and offered choice.

People's privacy was respected during intimate care and it was all provided in private. Staff described how they ensured people had privacy and how their modesty was protected. For example, closing curtains and ensuring people were covered. One staff member told us, "People can feel embarrassed, we discuss personal care discreetly with them and make sure curtains are closed."

Some people received good interactions from staff to develop positive relationships. For example, whilst the activity coordinator was painting someone's nails they joked about the dog lying down waiting to steal other people's dropped food. Another person told a staff member, "You're lovely", and the staff member responded by saying "You are lovely too." We observed staff reassuring one person who appeared to be anxious by stroking their arm, holding their hand and reassuring them their husband would be in later in the afternoon.

People told us they were able to have visitors at any time. Each person who lived at the home had a single room where they were able to see personal or professional visitors in private. People told us, "My family can come anytime they want" and "My family come in every week, they come whenever they want". We saw people could choose to meet with their visitors in the lounge or their bedroom. Staff welcomed the visitors and provided answers to any questions were asked.

Staff were aware of people who attended the services when the church came into the home. One person told us they used to go to church but they chose not to now; this was respected by staff. One member of staff was able to tell us who used to attend church. Staff we spoke with knew how to respect cultural and religious differences.

The provider had received a range of cards with compliments written in them from relatives. One relative wrote, "My sincere thanks for the loving care you have all given [name of person] throughout the year". Other relative's cards said, "It was a great comfort to know that he was in safe hands being well looked after and being treated with respect and dignity" and "Thank you so much for the wonderful care and understanding you showed my father while he was living at the Cherries".

Requires Improvement

Is the service responsive?

Our findings

People were not always receiving responsive care. At the previous inspection, in June 2016, there was a breach in regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because important information was missing in some people's care plans. People were at risk of care needs not being met because there were no regular updates. Other people with limited communication did not have written records to inform staff of their preferences and needs.

Following the last inspection the provider completed an action plan to inform us how they would meet this regulation. They informed us a nurse had been allocated specific time to work on all care plans. Part of their role was to support other nursing staff in how to use the electronic care plans. The nurse was going to monitor care plans on a regular basis. Further contact was going to be planned with families to gather important information for people unable to communicate it themselves.

At this inspection we found the provider had not taken enough action to meet the requirements of this regulation. People's care plans were more complete. Some people had records about their likes and dislikes. For example, one person had a current interest recorded as "Reading the newspaper". Their care plan continued they would like staff to read the paper to them. There was also information about their end of life wishes; it said, "Would like ashes of her dog to go with [person's name] to her plot at the cemetery". This meant even people who had limited communication could have their needs and wishes respected.

However, care plans were still not being personalised for all people and important information to deliver care was missing. This meant staff were not provided with guidance to meet people's care and medical needs. For example, some people were assisted with transfers using a hoist. One person was seen being hoisted between a wheelchair and armchair. Staff selected certain loops on the sling to attach to the hoist. The care plan contained no information about the correct loops. Staff we spoke with thought they knew which ones to use; there was no way of checking they were correct for the person's height. We spoke with the registered manager and provider who told us this was a nursing task to update the care plans. They would ensure all care plans are reviewed for people who are hoisted.

Two people had catheters in place. There were no records about the management of these for staff to follow. We spoke with a nurse who acknowledged there was no information in people's care plans. Two members of staff were unable to say how the catheter was kept clean. This meant staff had nowhere to refer to if they were new or from an agency and unfamiliar with the piece of equipment. A third person required regular oxygen. To administer the oxygen special tubes were placed in the person's nose. However, there was no guidance for staff to clean the tubes prior to placing them in the person's nose. This meant there was a risk the person's nasal care could be compromised.

Care plans did not contain enough guidance for staff when people exhibited behaviours which challenged. For example, one person had no management plan to guide staff how they should support them. Their risk assessment stated, "[Name's] emotional responses can frequently be inappropriate in some situations. [Name] frequently displays signs of frustration". Another person's care plan had no behaviour management

strategies. Yet staff described how they could bite, pinch, spit and pull hair whilst they were giving personal care. Staff described how they supported them at these times; this was not reflected in the care plan. We spoke with the registered manager who updated one person's care plan during the inspection. However, the new information did not include information about known triggers and ways to reduce the person's anxiety. This meant people were at risk of receiving inconsistent care and becoming agitated unnecessarily.

One person's care plan provided conflicting information for staff to follow. It contained a 'do not resuscitate' (DNR) form which had been signed by the person's husband. There was nothing from a GP to show they had agreed with this. In another part the records for the person's last wishes stated, "Should [name] experience a cardiac arrest, she is for resuscitation". This meant staff could be confused and not follow the correct wishes which had been authorised appropriately.

Care plans were not always updated to reflect changes which had occurred with the person. For example, one person had an increased number of falls. The registered manager told us most falls had occurred from their bed. They had introduced the use of bed rails to reduce the risk of the person falling. The person's care plan contained no information relating to this new way to manage falls. This meant staff had not been provided with updated guidance. Another person who lacked capacity had left the home unaccompanied. Their mobility care plan had not been updated that this was now a risk for the person. The registered manager told us they had never done it before. By not updating their care plan with this new behaviour there was a risk not all staff would be aware of it.

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

People and relatives told us they knew how to complain. People said, "I've complained once and it was resolved, I know who to talk to" and "If I wasn't happy I would talk to the staff, they do listen. I am very happy here." Since the last inspection there had been three formal complaints logged. One complaint received a prompt response by the registered manager with an explanation. No further contact was made by the relative making the complaint. Another complaint was raised with a member of staff. Following no initial response the relative wrote again after a week. The provider's procedure stated all written complaints would be acknowledged within two working days. The complaint received a response from the registered manager after 15 days and was resolved. We spoke with the provider who said they would remind all staff to pass on complaints to the management immediately. A third complaint had been received anonymously. No recorded action had been taken following the concerns raised. The provider said they would review how they document actions taken for this complaint and any raised in the future.

The registered manager and provider sought people's feedback. They had previously sent out resident and relative annual surveys. These provided them with a way to express their views about the care being received. Another annual survey had not been sent because it was not due. There were regular meetings for relatives, staff and activities. Other people were spoken to on a regular basis. One person said, "Sometimes I get asked what I think of the service" so they could give their opinions. The relatives meetings were seen as important because some people had difficulties communicating. At the last relatives meeting the provider was present to speak with them. Concerns were raised about people not always having their glasses on. During the inspection people appeared to have glasses on. This meant when some concerns were raised the provider and registered manager tried to take action.

People were able to take part in a range of activities according to their interests. One person said, "I'll go to the lounge for bingo, and we had a guitarist in". Other people told us, "I like to watch TV and read books", "I keep myself busy, I can listen to music", "We've got bingo this afternoon and we do crafty things, there is

enough going on for me", "There is enough going on. I do some gardening" and "I spend time in my room listening to the radio". During the inspection a music therapist was running a singing session in the lounge of the Elms. An activity coordinator was going round each resident in the Cherries; they were painting people's nails or giving them a manicure. Trips were being planned for people to go on including for cream teas at a nearby town and visiting the zoo.

Inadequate

Is the service well-led?

Our findings

At the previous inspection, in June 2016, the service was not always well led. There was a breach in Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This was because the provider was not notifying external organisations in line with current legislation. Following the inspection the provider completed an action plan to inform us how they would meet this regulation. They told us the deputy manager and registered manager would review all incidents and accidents to ensure the correct notifications have been made.

At this inspection we found improvements had not been made because statutory notifications had not been made to CQC. For example, the local authority safeguarding team had been made aware of two incidents involving medicine errors which put people at risk. One was due to a person consuming someone else's medicine mixed in milk. The other was loose medicine found in a person's bedroom. Although they had been raised with the local authority safeguarding team neither had been notified to CQC. We spoke with the registered manager and provider about this. The registered manager said it was their mistake. During the inspection two further safeguarding incidents were found; neither had been notified to the local authority safeguarding team or CQC. This meant the provider was not notifying external bodies so they could monitor the care and safety of people at the home.

This is a breach in Regulation 18 the Care Quality Commission (Registration) Regulations 2009.

At the previous inspection, in June 2016, there was a breach in regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the management were not identifying shortfalls found during the inspection. Risks were not being assessed appropriately and care plans had not been updated. People were not being informed about the most recent inspection because the website had not been updated.

Following the inspection the provider completed an action plan to inform us how they would meet this regulation. They told us there would be more clinical audits completed. However, the provider had failed to return the action plan within the requested time frame; it arrived five days late with no explanation as to why it was delayed. We spoke with the provider who could not explain the delay. Further updates to the progress against the action plan were received late by the local authority and CQC. This meant external monitoring of the care and safety of people was delayed.

The improvements made since the last inspection were not enough to ensure that the requirements of all the regulations had been met. The provider told us they were now regularly on site alongside the registered manager. They had redesigned the training being received by staff and they told us from the next rota there was a reduction in the use of agency staff. During management meetings progress was evaluated against concerns raised from previous inspections. Care plans now had a senior member of staff overseeing their progress and accuracy. Some clinical audits were being completed by the management team including for pressure care and medicine management.

However, actions taken did not address all concerns identified at previous inspections; the home had been in special measures since February 2016. The provider and registered manager were not taking a proactive approach to improvements. For example, they had organised specialist training around behaviours which could challenge and people's dementia. They had not identified staff required further training to safely manage these situations. Following the inspection the clinical director shared training which had been sourced for staff covering physical intervention training. There were still concerns found with pressure care and medicine management. All risks were not being identified. We spoke with the provider who explained they would have liked longer to resolve some of the concerns even though their action plan had stated that many of the concerns would be dealt with before 2017. Following the inspection the provider told us they would always continue to try to improve the service.

Effective systems had not been put in place by the provider to identify the concerns found during this inspection. At the June 2016 inspection new provider audits were introduced; these were no longer completed or used. Instead the provider held management meetings. There were clinical audits completed by the home's management. However, these systems had not identified concerns found on this inspection. For example, the care plan audits did not identify all gaps in information for staff around behaviours which challenge, pressure care or medical equipment. One incident where a person was at risk of harm was not known about. They had not found shortfalls with statutory notifications; the provider told us they had not had time to check these. This meant quality assurance systems were still failing to identify issues at the home. Following the inspection the provider shared a new auditing tool they were putting in place.

There were failures in ensuring people were fully protected from harm and risks to health and welfare were reduced and responded to. For example, the registered manager had not checked the treatment daily of the person with a scald. Fluid charts were monitored by the provider to ensure they were completed correctly. When low amounts of fluid were recorded actions had not always been taken. The provider had not identified these shortfalls through their quality assurance or monitoring of the service. This meant people were at risk of potential harm because of these failures on the part of the registered manager and provider.

Policy and procedures were not always being followed to ensure people were safe and were consenting to their care, treatment and support. Not all incidents of suspected abuse had been referred to the local authority and some people were not being supported to consent to their care. The recruitment policy and procedures had not been followed to ensure staff being employed had a complete work history and references from previous employers. The principles of the MCA were not being followed to ensure care being delivered was safe and appropriate. This meant people were not always being safeguarded from abuse and being cared for by unsuitable staff.

In June 2016 we found the provider was failing to display the current ratings on their website. At this inspection we found people were still not being informed about the most recent inspection on the provider's website or at the entrance to the home. We spoke with the operations manager who remembered conversations we had in June 2016. They told us they had not updated the website since the previous inspection. The ratings had been taken down in the entrance of the home because there was redecoration of the entrance. During the inspection the website was amended and the ratings were put up in the entrance of the home.

This is a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
People were positive about the registered manager. One person said, "[Name of registered manager] is always about, they are very nice and easy to talk to". Most staff were positive about the registered manager. Members of staff said, "The manager is really good, approachable and they listen", "[Name of registered

manager] is always in the office or a phone call away" and "You can always approach the manager, they are brilliant". One member of staff told us the manager was not around much during their shifts. They were positive the provider had been around instead.

People were supported by staff who had an understanding of the management's vision and values for the home. Members of staff said, "We support people with their independence and make it like their home" and "We make sure people's needs are met to the highest possible standard". We saw staff doing their best to support people and check their needs were being met. The registered manager and provider told us they wanted people to receive good care and have a homely feel.

People were provided with additional opportunities because the provider was trying to build links with the local community. Members of the church came to deliver a service regularly at the home. There were children visiting from a local nursery so people could read stories to them. Other links were being built with schools and parts of the community. The registered manager told us they wanted to "bring the community into the home".