Delphine Home Care Limited

Annabel House Care Centre

Inspection report

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Ratings

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

Overall summary

We carried out this inspection over two days on the 23 and 29 January 2015. Our last inspection to the service was in May 2013. During the visit in May 2013, we identified that people were not being moved safely and the provider had not undertaken audits in relation to infection control. In September 2013, we followed up the shortfalls, which had previously identified. We did not re-visit the service as the provider supplied us with information to evidence that action had been taken to address the shortfalls. At this inspection, we found that all actions had not been implemented effectively.

Annabel House Care Centre provides accommodation to people who require nursing and personal care. Some people may have dementia or mental health needs. The home is registered to accommodate up to 32 people. On the day of our inspection, there were 26 people living at the home. Annabel House Care Centre has bedrooms on the ground and first floor. A passenger lift is available for people with mobility difficulties. There are four communal lounges of which three have a dining area. There is a shower room on the first floor and a bathroom with an adapted bath on the ground floor.

Summary of findings

The manager has worked at the home for approximately five years but became the registered manager in 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was at a meeting when we arrived for the first day of our inspection. They returned after their meeting and were present for the remainder of the inspection. The provider visited the home on both days but was not involved in the full inspection process.

Whilst the registered manager confirmed staffing levels were satisfactory, there were concerns about the number of staff available to support people effectively. The lunch time meal was chaotic and people had to wait for staff assistance to eat. Some people walked around unsupported, looking anxious as if looking for something. There were incidents between people which impacted on safety but staff were not within the vicinity to intervene. There was no cook after 3pm, which meant this responsibility was transferred to the care staff. This impacted upon their ability to provide support, particularly at a time during the late afternoon when some people became anxious and unsettled.

Some people did not look well supported and had food debris on their clothing. At lunchtime some people used their fingers to eat their meal. This did not promote their dignity as the food was not considered "finger food." Some people remained in the same position for most of the day and were not assisted to use the bathroom. This increased people's risk of pressure ulceration. Staff did not consistently complete care charts to show the support they gave people. Some food charts showed people had refused meals or ate very little. There was no information to show further attempts or alternatives had been tried to encourage eating. One person staying in the home on a temporary basis did not have a plan of care in place, which increased the risk of inappropriate care. Other care plans were not person centred and did not reflect the support each individual required. Records detailing the management of wounds were not clearly organised. The information did not evidence the assessment, treatment and re-evaluation of the wounds.

The lunchtime meal looked colourful although there were some concerns from relatives about the nutritional content of the meals provided. There was a four weekly cycle of menus in place but these were not used. All meals were cooked according to the produce available on the day. People had a choice of two dishes for each meal, which they chose on the day. Staff were aware of people's nutritional requirements although not everyone was supported to eat, in a way which met their needs. There was a large store cupboard, which contained basic food provisions.

There were systems in place to assess and monitor the quality of the service. However, these were not fully effective as shortfalls with the environment, fire safety and cleanliness had not been identified. Risks to people's safety in terms of hot surfaces and hot water from hand wash basins had not been identified or recently reviewed. When discussed, the provider confirmed the potential risks associated with the radiators would be addressed without delay. The registered manager had identified the number of falls, incidents, complaints and safeguarding referrals. However, the control measures in place did not minimise further occurrences. This particularly applied to the high number of falls some people experienced.

Staff told us they felt supported in their role and enjoyed their work. However, supervision and appraisal systems where staff could formally discuss their work, performance and development were not consistently being undertaken. Records did not show that all staff were up to date with their training, to enable them to do their job effectively.

The home was taking part in the Butterfly Project which aimed to enhance the lives of people with dementia. The registered manager was passionate about the project and spoke about it with enthusiasm. They said improvements including more relaxed routines and a less clinical environment had been developed, as a result of the project. A kitchenette had also been installed. Doors to people's bedrooms were being painted bright colours on the day of the inspection.

Staff spoke and interacted with people in a polite, caring and sensitive manner. They responded well when they identified people were anxious or upset. They gave reassurance, showed concern and gave people the time they needed. Staff enabled people to sit with them in the office if this is what they wanted. They used people's

Summary of findings

preferred form of address and encouraged people to be involved in their care. This included informing a person about what was happening when being assisted to move using the hoist. Staff were clear about ways in which to promote people's privacy and dignity. However, this was not always seen in practice.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Not all risks to people's safety had been assessed and appropriately addressed. This included the risks associated with hot surfaces and hot water.

Whilst the registered manager reported that staffing levels were adequate, there were not enough staff particularly at key times of the day to meet people's needs effectively.

There were no written protocols in place to ensure consistency and the maximum effectiveness of medicines to be taken 'as required'. Instructions for the use for topical creams were not always written in full, which increased the risk of error.

Is the service effective?

Requires Improvement

The service was not effective.

Not all staff had received up to date training to do their job effectively. Whilst staff generally felt supported, formal systems of supervision and appraisal to discuss work performance and development, were not consistently taking place.

There were some concerns about the nutritional content of the meals provided. Whilst the food looked appetising on the day of inspection, this was reported not always to be the case. People were not consistently supported to eat their meals in a way which met their needs.

Is the service caring?

Requires Improvement

The service was not caring.

Staff were knowledgeable about the ways in which they promoted people's privacy and dignity but this was not consistently shown in practice.

Staff involved people in their care and responded well when they noted people were anxious or upset. However, staff were not proactive in managing aspects of people's care, resulting for example in some people, using their fingers to eat food not considered "finger foods".

Staff spoke to people in a caring, kind and considerate manner. They were fond of people and told us they liked their job.

Is the service responsive?

Inadequate

The service was not responsive.

Not all people received care that was responsive to their needs. Some people were not assisted to use the bathroom and were not supported to change their position, which increased their risk of pressure ulceration.

Summary of findings

Some people did not look well cared for with staining on their clothing.

One person did not have a care plan to inform staff how they wished their care to be delivered. Other care plans were not person centred and did not reflect the support needed. Care charts had not been consistently completed.

The complaint procedure displayed in people's bedrooms was not in a format to easily understand and was dated 2013. Action plans to address any concerns raised were not in place. This did not demonstrate on-going development in relation to the feedback received.

Is the service well-led?

Requires Improvement

The service was not well led.

The registered manager was passionate about the Butterfly Project, run in conjunction with Dementia Care Matters and its focus regarding person centred dementia care. Improvements to the home had been made as a result of the project.

Systems were in place to monitor the quality of the service. However, not all shortfalls were being identified and action plans were not consistently being developed. Such shortfalls included aspects of the environment, fire safety checks and the reduction of the number of falls people experienced.

Systems to gain feedback about the service were not fully effective. Informal discussions were not documented and action plans were not in place to address any concerning information received.

Annabel House Care Centre

Detailed findings

Background to this inspection

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

This unannounced inspection took place on the 23 and 29 January 2015 and was carried out by one inspector 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.

Due to their dementia, people were not able to tell us in detail about the quality of the care and support being provided. In order to find out about people's experiences of the service they received, we observed interactions and spoke to five relatives. We also spoke with the provider, the manager, two nurses, three carers, two housekeepers and a cook. We looked at five people's care records and documentation in relation to the management of the home. This included staff supervision, training and recruitment records, quality auditing processes and policies and procedures. We looked around the premises and observed care practices.

Before our inspection, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. In August 2014, we asked the registered manager 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. The PIR was sent to the registered manager's current e mail address but the registered manager told us the information had not been received. We obtained the information that would have been provided on the PIR during the inspection.

Inadequate

Is the service safe?

Our findings

Not all risks to people's safety had been identified and addressed. There were radiators in some people's bedrooms and communal areas, which were hot to touch. This presented a risk of people burning themselves if they touched or fell against the hot surfaces. The provider did not agree with this and told us the radiators had been there for many years and were low surface temperature units, which would not cause injury. We asked to see the risk assessments in place regarding the radiators. The registered manager confirmed the assessments were out of date. They were dated 2012 but confirmed all radiators should be covered to minimise the risk of potential injury. During our inspection, the provider telephoned the registered manager to confirm covers would be fitted to the radiators. Later in the day, a maintenance person measured the radiator in the lounge/dining room and told us that covers would be fitted without delay.

The hot water from the hand wash basins in two upstairs bedrooms was hot to touch and presented a risk of people scalding themselves. Staff could not locate a thermometer to check the temperature of the water. On the second day of our inspection, a thermometer was found. The water temperature from these two outlets had reduced. However, water from a hand wash basin in a downstairs toilet was 47°C. This was higher than the Health and Safety Executive's recommended level of 43°C. The registered manager told us there were two hot water cylinders which were individually thermostatically controlled and adjusted. Valves to control the water temperature at source had not been fitted. This increased the risk of high or unpredictable water temperatures, which could cause scalding. There were no records to show that staff had regularly monitored the temperature of the hot water or that they checked it before supporting people to have a bath. The registered manager told us it was something which used to happen but over time, it had lapsed. This placed people at risk of scalding. At the end of the inspection, the registered manager showed us a water temperature monitoring chart they had developed. A chart to monitor the temperature of the hot water when supporting people to have a bath, had been placed in the bathroom.

A kitchenette in the lounge/dining room had been installed so that people and their visitors could make hot drinks whenever they wanted them. This created a homely feel, as intended. The kitchenette contained a hot water device, which was fully accessible to people. This presented a risk of people scalding themselves. The registered manager explained the risks had been considered but it was felt the positives to people's emotional wellbeing, far outweighed the risks of scalding. This assessment was documented and identified ten risk reduction measures. These included a hot water warning sign and the area being regularly monitored by staff. However, people's cognitive impairment had not been considered in the risk assessment.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that staffing levels were determined according to the number and needs of people. They said staffing levels had recently increased and the numbers of staff on duty were sufficient to meet people's needs. They said this was especially so, as there were vacancies and the home was not fully occupied. The registered manager told us that staffing levels were flexible and could be increased if there were people who were particularly unwell.

In response to being asked if there were enough staff on duty, one person told us "sometimes staff come quickly and sometimes not. If there are staff shortages there can be a long wait". Relatives told us the numbers of staff on duty were not always sufficient to meet people's needs. One relative told us "there are rarely or never enough staff. There's not enough staff to help people eat properly. One day when I was visiting, staff served afternoon drinks at about 3pm. When I left at 4.20pm, one very frail lady was still sat with the plastic beaker hanging from her finger. They had given up long ago trying to get someone's attention and no other cups had been collected". The relative told us this was quite a common event. Another relative told us "the people who live here are very dependent and need a lot of help. They can't be rushed and need a lot of time to eat, for example. There aren't always enough staff to do this properly and there's no kitchen staff in the afternoon so care staff have to get tea. This puts added pressure on them and takes them away from the residents". Another relative told us "there seems to be either a lot of staff around or no staff at all, it varies".

Inadequate

Is the service safe?

Staff gave us varying views about whether there were enough staff to support people effectively. One member of staff said "it's fine, we're a good team". Another staff member told us "generally it's ok but we do have a lot of people with complex needs who need of lot support so it would be good to have a few more staff so we could spend more time with people or take them out." Within a staff survey, there were comments which indicated staffing levels were insufficient to meet people's needs. This included "not enough time to take people to the toilet", "not enough time to lavish on their care" and "need more staff and a tea time cook". There was no action plan to show how these comments were to be addressed.

Whilst the registered manager was positive about staffing levels, not all people were appropriately supported. There was generally a staff presence within the communal areas of the home. However, this was not consistent or in all other areas such as the corridors and the first floor. There were interactions between people, which created a potential risk of retaliation but staff were not in the vicinity to intervene. This included a person trying to take another person's meal and another moving another person's drink. There were two occasions of people touching other people's hair, face and clothing. Another person was walking around with only one slipper on and was trying to open the front door. There was not a staff presence, to identify this and to offer the person support.

One person told us they felt safe living at the home. They said "There is never any trouble. One or two people get stroppy but it's not worth arguing. I just move away". A relative told us they were slightly concerned about their family member's safety. They told us "there are often disagreements between people but not always the staff around to sort it out. I do worry about X being caught up in things".

Staff told us that people were encouraged to eat their meals where they chose. Whilst this promoted choice and independence, staff said this impacted upon their work, as there were people in three lounges, one lounge/dining room and individual bedrooms. Staff said there were 10 people who needed full assistance and a high number of other people who needed prompting and supervision to eat. At lunchtime on the first day of our inspection, there were four care staff to do this, as one member of staff had called in sick. The main dining area was chaotic. Some people were waiting for their meal and at 1.20pm, not everyone had eaten. One member of staff noted another person required support, whilst they were assisting a person to eat. They left who they were helping to do this. This gave inconsistency and interrupted the person's eating. The registered manager told us they saw the mealtime had been chaotic but they did not feel this was usual practice. They said meal times were usually pleasant and relaxed.

After lunch, one member of care staff began rinsing the crockery before it was passed back to the kitchen to be put into the dishwasher. This took them away from helping people with their personal care. They told us the home did not have a kitchen assistant so rinsing the dishes and providing food after the cook had gone home at 3pm, was the responsibility of the care staff. The member of staff told us this could be difficult, especially at teatime, when some people often became increasingly anxious, unsettled and disorientated. They explained that being in the kitchen and undertaking such responsibilities reduced their ability to support people as required.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were comfortable and relaxed in the vicinity of staff. Some people responded to staff affectionately and benefitted from close contact, such as a reassuring stroke to their arm. However, a relative told us they were concerned, as they had noted bruising on their family member, which they had not been informed about. They said their family member had told them that they were experiencing pain when staff were moving them. The relative told us they had raised this with the registered manager but were unhappy with the investigation and its timescale. The registered manager told us it was not clear how the person's bruising occurred but they had met with the person's family and discussed the bruising with the safeguarding team. There was not a record of this discussion or any matters arising from the discussion. There was no written guidance to staff about how the person should be moved, more comfortably to minimise their pain. This did not minimise the risk of further occurrences. Records were in place to demonstrate other incidents which had been raised with the local safeguarding team. All actions were appropriately taken.

Inadequate

Is the service safe?

Staff told us they would immediately report any poor practice or abuse they suspected or witnessed, to the senior nurse on duty or the manager. They said they would have no hesitation in doing this and felt confident any issues would be addressed appropriately. The registered manager was clear about their responsibility to report any concerns. However, the safeguarding policy stated that minor issues would be dealt with directly and those more serious in nature would be raised with the Registration Authority and if necessary the Police. This did not reflect local safeguarding protocols. Staff told us they had undertaken training in safeguarding vulnerable people. Records showed this had been undertaken within induction but not all staff had received up dated training. This increased the risk of abuse going unnoticed and the inappropriate management of any allegation.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Procedures for the administration of medicines were in place and being followed. However, we noted a white tablet on the floor in one person's bedroom which indicated they had not taken their medicines effectively. Medicines were orderly stored and short life medicines had been dated once opened. Staff had consistently signed the medicine administration record to show people had taken their medicines. Records showed that some people who were resistant in taking their medicines, were administered them covertly. This involved medicines being disguised in food or drink and given to people without their knowledge or consent. This practice was agreed in writing by a GP but had not been regularly reviewed. A member of staff told us that giving medicines covertly was always the last resort. They said people would initially be asked to take their medicines and distraction techniques would be used, if needed. If people refused to take their medicines, staff would try again later. Some people were prescribed medicines for pain and anxiety, to be taken as required. A member of staff confidently explained when these would be administered. However, there were no written protocols in place, which did not enable consistency or ensure the medicines were given with maximum effect. The registered nurse confirmed such protocols should be in place and agreed to address this. There were records to show that people's topical creams had been applied. However, the instructions for use were not always written in full. This included "apply to affected areas regularly" and "any areas affected by thrush". This presented a risk that the topical creams would not be applied in a way, which would maximise effectiveness.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were subject to a robust recruitment procedure when they first applied for their position at the home. They completed an application form, attended an interview and were required to supply the names of two people, who would support their application for the job. Staff were offered the position subject to satisfactory references and a disclosure and barring service check. This ensured that staff had been thoroughly checked and the registered manager had assessed them to be suitable to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

Records showed not all staff were up to date with their training. Staff had received training in a range of subjects when they first started employment at the home. Training after this was inconsistent. Four staff had completed training in 2012, which remained valid for two years. This timescale had elapsed so staff were now out of date with their training. Out of 30 staff only seven had completed infection control training in the last year. 15 staff had not completed any up to date fire safety training and eighteen staff who handled food, had not completed food safety training. Some records showed that staff had completed training with their previous employer but had done little since working at Annabel House. One record showed that in 2014, a member of staff had completed training in manual handling, safeguarding and first aid but they had done nothing else. Another member of staff had only undertaken training in manual handling. There was no evidence of training related to people's needs such as managing challenging behaviour, the prevention of pressure ulceration, nutrition or hydration. There was minimal clinical training which evidenced the development of the registered nurses.

The registered manager told us the majority of recent staff training had been around the Butterfly Project. However, this had not been documented so there was no evidence of what topics had been covered. The Butterfly Project, in conjunction with Dementia Care Matters, enabled a focus on providing a holistic approach to improving the culture of care. The project provided a focus on improving the lived experience for people living with dementia through a mix of methods. The main aim being increased well-being and enhanced quality of life. The registered manager told us they were aware of the shortfalls in training but a new online training system was being implemented. They said each member of staff was in the process of being set up with an account. Once given access to their password, staff would be able to access a range of training sessions which would cover varying topics. The registered manager told us this system was intended to help staff complete their training at a time convenient to them. In addition to the on line training, the registered manager told us that nutrition and hydration training was planned for February 2015 and first aid training was planned for March 2015.

Staff told us they generally felt supported in their role and received training related to their work. They said they had regular handovers to ensure they were kept up to date with people's needs. In addition, they said the registered nurses were readily accessible and could be called upon at any time for help or advice. One member of staff told us they had regular formal supervision where they met with their manager to discuss their work and performance. Other staff told us they had supervision but it was not regular and they had not had an annual appraisal. They said they would ask to see the registered manager informally if there were any issues and would not wait until their scheduled formal supervision session. Records showed that the frequency of staff supervision was widely inconsistent and not in line with the supervision policy. This included one record stating the member of staff had last received formal supervision in 2013. Some records showed that staff had asked for specific support such as training in dementia care and the control of substances hazardous to health. A staff survey showed one member of staff had requested manual handling training specific to the home. There was no action plan to detail how, when or by whom, these requests would be addressed. The record identified that the staff member should be more sympathetic towards others. There was not a plan to detail how this would be monitored, which meant that the staff member could continue their practice, without improving. There was a policy which stated that staff should have observational checks of their work and an appraisal to review their work performance. Records did not show these systems had taken place. The registered manager showed us they had a schedule of formal staff supervision in place although they were not up to date with all sessions.

This is a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt supported by the team and the registered manager. They said there was a mixture of long established and new staff, which enabled different experiences and skills to be shared. Staff told us they shadowed more experienced members of staff when they started work at the home. They said they undertook a number of training courses before working directly with

Is the service effective?

people. This included manual handling, safeguarding vulnerable people and infection control. Staff told us they felt they could request additional training if needed and would ask if there was anything they were not sure of.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are an amendment to the Mental Capacity Act 2005, which allow the use of restraint or restrictions but only if they are in the person's best interest. Staff were aware of encouraging people to be involved with making day to day choices and decisions. This included people choosing what they wanted to eat, where they wanted to spend their time and what clothes they wanted to wear. The registered manager had taken the legislation into account for some people who did not have the capacity to make certain decisions. This included the decisions to initially to move into Annabel House. A best interest meeting had also been arranged to discuss one person moving to be nearer their family. However, specific parts of people's care had not been considered. For example, staff told us one person was nursed in bed, as they slipped from a chair and could not manage the stair lift to access the communal areas. This restriction was not addressed in the person's care plan and there was no evidence the decision had been discussed with their family or associated others. Staff told us they had not received training in the Mental Capacity Act 2005. Records showed that only six staff had received this training in the last year. This presented a risk that staff would not be aware of what processes to follow if they felt a person's freedom and rights were being significantly restricted.

Two visitors raised concerns about the nutritional content of the food provided. They said there was a high level of convenience foods such as chicken nuggets and a limited amount of fresh vegetables. One relative told us "the standard of food is not good at the moment. The Cook seems to have pride in her work but the week before last, the main meal included chips on two days. The first day it was with baked beans and there were peas on the second day. On Saturday the main meal was quiche, mashed pots and baked beans. The lack of colour in vegetables for a balanced diet is without doubt a major concern". Positive comments about the food included "the food here is excellent. It looks and smells lovely" and "I always choose a salad at lunchtime but they will give me anything I want. It's always nice". One visitor told us of an occasion when their relative had lost their appetite and how staff had encouraged and tempted them to eat. They said they asked for their relative to have poached egg on toast and this was cooked specially for them.

The lunch time meal was served plated from the kitchen through a serving hatch. There was a choice of two dishes, which people could decide upon at the time. The meals on the day of the inspection looked colourful and were served according to people's appetites and preferences. Some people were eating well but others had limited amounts and pushed their food away. Not all people were supported to eat in a way which met their needs. Some people sat with their meal in front of them without eating. Staff provided some encouragement or prompting but went between people without giving specific assistance. This was not successful, as people started to eat once prompted but stopped again shortly afterwards. One person told us they were not hungry and they did not like their meal. Staff told us it was not unusual for some people to eat very little but they would then 'top up' during another meal. They explained that some people preferred foods such as ice-cream, so this would be offered, to encourage eating. One member of staff told us one person in particular was losing weight and this had been referred to the GP and the dietician. The person ate very little of their lunch time meal on the day of our inspection. They were not offered an alternative. Staff told us other people were being monitored and were encouraged to eat a little, but often. Staff had assessed these people in relation to their risk of malnutrition and there was a record of their food intake. However, some records showed people had refused meals but alternatives or additional snacks, had not been given.

In the afternoon on the second day of our inspection, there were a number of plated meals in the kitchen. These were on the kitchen work top and not stored appropriately in the fridge. This increased the risk of food poisoning. Staff said the meals would be offered for tea, if people did not want sandwiches. Two people choose these meals but then pushed them away, just after they had started eating. One person made a repeated attempt to eat the food but only had a couple of mouthfuls. Staff asked these people if they wanted an alternative, but this was declined. There were no further attempts to encourage better intake.

There was a four weekly menu in the kitchen, which showed the range of foods on offer. The menu did not reflect the meals provided and it was difficult to see, which

Is the service effective?

menu related to the day of our inspection. Staff told us that whilst the menus were in place, the decision of what meals to cook were decided on the day, depending on the produce available. They said people were not involved in developing the original meal choices but could make a choice of two items on the day. Staff told us the second choice generally involved foods from the freezer such as sausages. A record of these meals was not maintained. The lack of recording did not enable a nutritious, balanced diet to be evidenced. One member of staff told us that they thought meal provision could be further developed with greater consultation and planning and adhering more to a specific menu. They said that preparing food with the produce available was sometimes a challenge.

The store cupboard contained basic ingredients such as cereals and rice, tinned goods including baked beans, corned beef and tomatoes and snack foods such as biscuits. There were also gravy granules and scone, sauce and soup mixes. The vegetable trolley contained half a cabbage, which staff said had "gone past its best, so needed to be thrown".

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us people received a good service from visiting health care professionals. They said a GP would routinely visit the home every two weeks, to monitor particular health care conditions or discuss any concerns. They said people were registered with their preferred surgery and were supported to see the same doctor if possible, to ensure consistency. Staff told us people did not have to wait for the fortnightly GP's visit, as they would visit at any time, if requested. Staff told us other professionals such as the podiatrist visited people on a regular basis. People were supported to attend specialist appointments. One relative spoke highly of the service provided by the GP and said they were able to speak to them to discuss their family member's care. Records showed that people received regular support to meet their health care needs.

The registered manager told us that due to the Butterfly Project, people were being encouraged to spend time with others who were at a similar stage of their dementia. People were directed to various lounges, which contained specific furnishings or items of interest dependent on need. For example, people with significant cognitive impairment spent time in a lounge, which contained sensory stimulation items such as a bubble tube and fibre optic strobe lighting. Another lounge, generally used by people with less advanced dementia contained rummage boxes and sensory 'fiddle' cushions. There was a separate lounge or activities room, which contained memorabilia and a further lounge with a television mounted on the wall. The registered manager told us people were able to go from room to room but it appeared certain individuals were more relaxed when sitting in specific areas.

Requires Improvement

Is the service caring?

Our findings

Staff spoke to people in a caring, kind and friendly manner. However, they were not proactive in managing certain aspects of people's care. This included supporting people to have clean clothing and enabling people to use utensils or to receive assistance rather than using their fingers to eat food which was not considered "finger food". Some people received limited stimulation and did not have things to occupy their time. This impacted upon their anxiety.

Whilst staff were clear about the ways in which to promote people's privacy and dignity, this was not always applied in practice. One person, sitting in a wheelchair had their skirt rolled up, showing their bare legs. Staff did not offer assistance to enable the person to be covered. Another person still had their clothes protector on at 2.45pm after they had used it for their lunch time meal. They had food debris on the protector and on the floor around them. This did not promote their dignity.

Staff were polite and used a soft tone and volume to their voice. Staff asked people how they were feeling and gave compliments such a "Hello X, you look very nice today" and "Good afternoon X, you're looking well. I like the colour of your cardigan, it suits you". People responded to the interactions well by further engaging with conversation or smiling. One person told a member of staff "I do like you, you look lovely" as the staff member was clearing the dining room table. The staff member responded and the person laughed. Some people repeated certain phrases or requests. Another person was unsure as to where they were. Staff were patient, understanding and responded appropriately to people in a quiet, respectful manner. One relative told us how they felt the staff showed great patience with some people. They commented how kind staff were to them. Staff told us how they knew people well. They said this enabled them to interpret gestures and facial expressions of those people who were not able to express themselves verbally.

There were positive interactions with some people. One person became upset and put their arms around the staff member to gain support. The staff member responded well by talking to the person in a quiet manner, giving reassurance and brushing the person's hair away from their eyes. They asked the person what they wanted to do and gave them time, whilst giving them focused attention. The staff member stroked the person's arm and told them "it'll be ok, don't worry". They then distracted the person by asking if they could accompany them to make a drink. This was successful and the person appeared brighter and more relaxed. Another person was being distracted by a plate cover whilst receiving assistance to eat. The staff member gave the person the cover and asked them what it felt like. The person spent time feeling the cover and the staff member used short questions to enable further engagement. After this, the person was content to continue with their meal.

People were encouraged to sit with staff in the office if they wished to do so. The office was a thoroughfare from the hallway to the lounge. Staff acknowledged people as they walked through, often asking if they were alright or if they wanted a drink. People were then offered a range of choices and were given time to make their decision. Staff used people's preferred names and showed an understanding of what was important to them. This included discussions about family members or preferred television programmes.

Staff involved people in their care. One person was assisted to move from their armchair to their wheelchair with the use of the hoist. Staff gave reassurance and informed the person what was happening. They asked the person to lift their arms so that the hoist sling could be placed around them. Staff then told the person "well done. That's it. We're going to lift you up now". The intervention was undertaken well although the person was left hanging in the air whilst a staff member manoeuvred the wheelchair to them. This did not promote the person's dignity. Another person was moved using their wheelchair. The staff member asked the person to lift their feet on to the footplates. They then asked the person to move their elbows in so they did not hit them on the doorframe, whilst going through. This showed consideration and respect. One person appeared unsettled and a staff member asked them if they wanted to help wash up. The person replied no, strongly. This was respected and a joke was made about work and not needing to do it if you did not have to. The person responded to this well and talked about their previous responsibilities.

Staff asked people before doing certain tasks. For example, one member of staff asked a person if they could move their magazines so they had room for their lunch time meal. Another member of staff asked "do you mind if I move you in towards the table a little, so that X can get

Requires Improvement

Is the service caring?

past". People were asked if they wanted to wear a clothes protector whilst they ate their lunch. One person requested a protector before staff had got to them. The staff member replied "X, I am sorry. I forgot you liked one. I'll get it now". A joke was made about the staff member's memory and the person laughed. Staff explained the contents of people's meals to them. They offered condiments and asked specifically where they wanted them to be put.

One person told us "staff are all lovely and look after me. There is no nastiness, they're always polite. When they bath me I am not embarrassed". Staff confidently described ways in which people's privacy and dignity were maintained. This included making sure people were covered when receiving intimate personal care and not talking over people. Staff described how they put themselves in the person's shoes so they had an understanding of what it felt like to be supported. They said they would always close doors and curtains before providing any intervention and would ensure people had time, without being rushed. Staff spoke about people and their role with fondness. They said they enjoyed their work and found it rewarding. They explained the home was like a family and they all cared and looked after each other. Another member of staff summed up caring as "treating residents in a way you would like to be treated yourself and how you would like your own parent to be treated. Respectfully and preserving their dignity".

Inadequate

Is the service responsive?

Our findings

Some people did not look well cared for. They had food debris on their clothing and their fingernails were not clean. One relative told us the physical appearance of their family member did at times, concern them. They were aware that the person could demonstrate some resistance to support but felt the staff should be sufficiently trained to address this. Another relative told us their family member liked to have their finger nails painted but they were often dirty underneath. Another relative told us they felt the care was good, but they did not feel the staff went over and above what they need to do. They too said their family member's finger nails were often not clean and their eyes were often 'crusted'. Another relative was concerned because when they visited, their family member appeared anxious, tearful and depressed. In addition, they said their family member was not always physically clean. One visitor was more positive about the care their family member received. They said staff were good at enabling their family member to choose whether they wanted to get up or to stay in bed, dependent on how they were feeling.

Staff told us about some people's individualised care. This included specific ways in which people were supported to take their medicines. Some people had bed rest to promote healing, whilst others had specialised diets to minimise the risk of choking. Staff were aware of people's previous history and could talk in detail about individual preferences and family members. Staff responded well when approached by people who were anxious or upset. One member of staff talked to a person about their favourite football team and the colours of the strip the team used to wear. Staff responded quickly if people asked for a drink.

Whilst there were positive interactions which showed individualised care, not all people received care, which was responsive to their needs. Some of those people who were more ambulant were walking around the corridors at times looking anxious, as if searching for something. Staff were not proactive and did not notice this unless they were completing a task and 'came across' the person.

Staff looked at a book with one person and another member of staff offered people a hand massage. Another member of staff assisted a person to look out of the window to see the snow falling. They talked about sledging and recalled childhood memories. However, other people received very little stimulation and remained in the same position in their armchair for much of the day. Not all people were assisted to use the bathroom. Staff told us one person was nursed in bed. They said they helped the person to change their position every two to three hours, to minimise their risk of pressure ulceration. This was identified in the person's care plan. However, throughout our inspection, the person remained in the same position in bed, laid on their back. Their care chart showed they had received assistance at 9.10am but there were no other entries on the record, later in the afternoon.

Another person remained in the same position in a wheelchair all day. They sat for much of the time with their head in their hands with their elbows leaning on the arm rests. Staff told us the person was not too well and they were losing weight. They were not sure why the person had remained in the wheelchair, as they were usually supported to transfer to an armchair. The staff member told us the person was supported to use the bathroom after meals. This support was not given during our inspection. We asked to look at the person's care chart to show when they had received assistance with their personal care. Nothing had been written on the chart for the whole day. At lunchtime the person was not supported or encouraged to eat. They repeatedly used their fingers to pick up their cooked meal, which was not classed as "finger food". The person was very slow and ate a minimal amount, dropping food over them. One member of staff asked the person if they wanted to use a spoon. This was given but the person was not able to load the spoon and they repeatedly tapped the table with it. The person's care chart showed they ate minimal amounts but there was no evidence of alternatives or snacks between meals. One member of staff told us the person refused assistance with eating so they were enabled to remain independent. Their care plan had not been updated to incorporate further strategies to assist the person to eat and maintain a healthy weight. The person's bedroom was sparse, with no personal possessions other than their clothing. A staff member told us this was because the person did not have contact with their family. The person had not been supported by the home to personalise their room.

One person had been assessed at very high risk of pressure ulceration. Their care chart did not consistently evidence they had been assisted to change their position as detailed in their care plan. The person had a pressure ulcer but the care plan did not reflect the severity of the risk or the

Is the service responsive?

wound. Records to show the management of the wound were detailed in a separate file but these were difficult to follow. There was not a clear record of treatment, monitoring and reassessment. Photographs had been taken but these were disorganised and not clear. This made it difficult for them to be accurately used for monitoring purposes. Staff had recorded a newly noted red area to the person's skin. There was no evidence of any follow up action or details of any deterioration or healing of the area.

The registered manager told us they had recently appointed an activities co-ordinator from within the existing staff team. They explained they were trying to get away from large, group activities and were providing more individual, spontaneous time with people. They said this had proved positive. However, two relatives told us they paid extra for their family member to have one-to-one time with a staff member. They said in the beginning, they were happy for this, as it meant their family member undertook an activity of their choice and they received individualised time. More recently, they said there was little evidence of any activity taking place. Another relative told us they had concerns about the lack of mental stimulation available to people.

One person was staying at the home on a short term basis. We asked to see their plan of care. Staff told us that due to the person being on respite, a care plan had not been developed. There was an assessment and care plan from a previous setting but this was not relevant to the home. We asked staff how they knew about the person's needs if a care plan was not in place. One member of staff said they would be told at handover if there was anything they needed to know. Another member of staff said they always asked the person what help they needed before supporting them. Without a written plan in place, the person was at risk of inappropriate or unsafe care.

Other care plans were stored on a shelf in the office. They were not secured so there was a risk that unauthorised people could have access to the information. The care plans contained up to date information but were not person centred and did not detail some aspects of people's support. For example, it was stated that one person could have vacant episodes but there was no guidance to staff about how to manage this. Another care plan stated "staff will observe my body language and facial expressions and respond accordingly". The record did not detail what this meant in practice, so there was a risk that the person would not be supported as required. One person had a behavioural chart in place. Staff had made an entry stating the person had been violent but there was no explanation about the potential triggers, who else was involved, the actual behaviours or how the person was supported. Their care plan did not detail the behaviours or any aspects of their care the person found difficult. Where people were unable to voice their daily preferences, there was no confirmation of who had been involved in the decisions made. The registered manager told us people's care plans were in the process of being developed to ensure they were more person centred.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 9(3)(b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not able to tell us about the care they received or if they had any concerns. Two relatives told us they had raised concerns previously. One relative told us "things seemed to improve but then they revert back." Another relative told us the home had the occasional resident and relative's meeting but they were very poorly attended. They said they believed this was partly due to other commitments but also because people were not confident in sharing their views. Records showed the last relative's meeting took place in November 2014 and only two relatives attended. The manager told us they were planning to develop the forums to improve communication and were hoping the Butterfly Project would enable this. Within people's bedrooms, there was a copy of the home's complaint procedure. This was dated 2013 and not in a format which was easy to understand by the people who used the service.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had worked at the home for a number of years and became the registered manager in April 2014. The management team included a clinical lead, registered nurses and three newly developed team leader posts. The registered manager told us they were well supported by the provider and the staff team as a whole. They said the provider visited the home often daily and discussions took place about any key issues. These discussions were not consistently documented although a record was kept of more formal meetings. The registered manager had an office in the basement of the home which was not routinely accessible to people due to the stairs. They said that due to this, they tried to spend as much time as possible with people and used the office only when they needed to concentrate on managerial responsibilities.

The registered manager told us the ethos of the home was all about providing a good standard of person centred care, within a homely setting. They told us they had a good team who cared for the people they supported. The registered manager explained they were passionate about the Butterfly Project and spoke enthusiastically about it. They said the project was going well and they believed people were already receiving an improved and more homely service. The registered manager said they wanted all clinical aspects of the home to be removed as far as possible and replaced with a culture which put people at the heart of the care, within a family environment. They said staff were no longer wearing institutionalised uniforms but wore their own clothing and they used aprons made out of floral material when serving meals. In addition, they said the lounge/dining room had been redecorated and a kitchenette installed, for people to help themselves to drinks. Staff told us the Butterfly Project had enabled the home to be more relaxed, with less emphasis on routine. They said people were being encouraged to make decisions such as when they got up in the morning, which enabled a more leisurely pace. The registered manager told us the project was keeping them up to date with best practice in relation to dementia care.

There were systems in place to monitor the quality of the service. This included a recent infection control and medicines audit. The personal identification numbers (PIN) of the registered nurses had been recently checked to ensure the staff were able to continue their professional practice. An audit had recently taken place in relation to the Butterfly Project by Dementia Care Matters. This identified positive aspects of the service, as well as certain areas which could be improved upon. An action plan to address the areas of improvement however, was not in place. The registered manager told us most of the issues raised during audits were addressed straight away without being documented. They said they had lists of things to do, which they ticked off when completed. Whilst this was acknowledged, the lack of records did not evidence the work undertaken to develop the service. There was no refurbishment plan for the environment in place although doors to people's bedrooms were being painted in bright colours, on the day of the inspection. Staff told us the hallway and the main lounge/dining area had been redecorated with new carpet fitted. New flooring to the kitchen had also been applied.

The registered manager did not have a full overview of the service and the improvements required. On the first day of our inspection, there were some issues with the environment, which had not been addressed. The surfaces on some over-bed tables had risen and were chipped. Commode frames were rusty and bumpers on bed rails were frayed, which made the items difficult to keep hygienically clean. One tap on a vanity unit in a person's bedroom was broken and the door had come off its hinges. The registered manager told us they had identified these issues, as they had recently undertaken an audit of people's bedrooms. They said the areas needing attention were documented on their list although the list could not be located. On the second day of our inspection, over-bed tables and commodes had been replaced.

Not all areas of the home were clean. The registered manager had not identified this. Commode pots were stained and on one commode, there was brown staining on the seat. This had not been cleaned at the end of the day. Armchairs showed some staining on the arms and there was debris underneath the seat cushions. The grating on the top of the oven was heavily stained with food debris and there was some dust on the shelving in the kitchen. Saucepans had brown staining on the base. Staff told us the kitchen was difficult to keep clean due to the lack of time for deep cleaning. They said they had tried to clean the saucepans but had been unsuccessful. The registered

Requires Improvement

Is the service well-led?

manager told us new saucepans had been purchased so she was not sure why the old ones were still in use. Staff told us there were cleaning schedules in place but these could not be located.

Not all checks to ensure the safety of the environment had been consistently undertaken. Risk assessments were not up to date. There were no records to demonstrate the testing of the emergency lighting and the fire alarm systems had not been tested on a weekly basis as recommended, since December 2014. The registered manager told us they were aware that this testing had slipped and they did not do it, as often as they should. They said particularly, when they had a day off, the testing of the fire alarms did not get done. Records showed that the external contractor, who serviced the fire alarm systems, had identified some fire doors did not close properly. There was no record to show the work had been completed so it was not clear if the work remained outstanding. There was a small gate at the bottom of the main staircase to restrict access to people, to minimise the risk of falls. This restricted access had not been assessed in terms of fire safety risks. This was discussed with the registered manager who requested this assessment without delay. Records showed that some staff had participated within a fire drill but there was not an overview to show which staff had not received this training.

The registered manager had assessed the number of falls, incidents, safeguarding alerts, complaints and pressure ulcers, which had occurred on a monthly basis. Details such as where each fall occurred and at what time were identified. However, the information had not been analysed to determine possible trends. The number of falls each month was high with 19 people found on the floor in November 2014. There was no action plan in place to show how this high number was to be reduced to enhance people safety.

The registered manager told us that the last meeting they held for people and their relatives was in November 2014 and only two people attended. The registered manager said they were looking at more positive ways to engage with people and their families. They said they talked to people and their relatives informally on a daily basis, about their views of the service. These discussions were not recorded so there was no record to show how feedback directed improvement. The registered manager told us ways in which feedback was gained from relatives was being developed but they did not want opportunities turned into “moaning” sessions. Records showed that concerns had previously been raised about lack of leadership, reduced attention to people at weekends and the unsatisfactory appearance of some people due to lack of support with personal care. There was no action plans to show how these issues were to be addressed. Similarly, staff feedback within surveys and staff meetings did not detail what action was to be taken to make improvements. The records showed that some shortfalls identified during this inspection had been raised with staff. This included the completion of care charts, which remained outstanding.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **Auditing systems were in place to assess the quality of the service but potential risks to people's health, welfare and safety were not being identified. This included the risk of hot surfaces and hot water from hand wash basins.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **There was insufficient staff to meet people's needs effectively particularly at key times of the day.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **Not all staff had received updated training in safeguarding vulnerable adults. There were some concerns about people's safety and not all bruising had been clearly identified and properly investigated.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Some people were prescribed medicines to be taken 'as required'. There were no written protocols in place to**

This section is primarily information for the provider

Action we have told the provider to take

ensure these medicines were administered consistently and as directed by the prescriber. Full instructions of the application of topical creams were not always stated, increasing the risk of error.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Staff did not consistently receive up to date training to undertake their role effectively. Whilst staff said they felt supported, formal systems such as supervision and appraisal were not routinely taking place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs There were concerns about the nutritional intake of the food people received. Not all people were supported to eat in a way which met their needs. A record of people's food intake was maintained but alternatives or further encouragement to eat following refusal was not always evident.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Planning and delivery of care was not always done in such a way to meet people's individual needs and ensure their safety and welfare. Some people did not appear well cared for. Others were not supported to change their position to minimise their risk of pressure ulceration. One person did not have a care plan and care charts were not fully completed.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints Systems to enable people to give their views were limited and action plans did not show how concerns raised were to be addressed. The complaint procedure had not been updated and it was not within a format that was conducive to people's needs.