Cleveland Alzheimer's Residential Centre Limited

Allison House

Inspection report

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16 August 2017
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19 September 2017
02 October 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 16, 21 August, 18, 19 September and 2 October 2017. On some visits the staff and people using the service did not know that we would be carrying out an inspection of the service. In order to obtain the information we needed for other visits we announced that we would be visiting.

The service was previously inspected in June 2016 and was not meeting two of the regulations we inspected. These related to staff training and good governance. We took action by requiring the provider to send us action plans telling us how they would achieve compliance. When we returned for this inspection we found some of the issues identified had been addressed but others had not.

Following the first two days of this inspection we had a number of concerns which were shared with the provider. We invited them to submit an interim action plan but this was not received. During our visits we were also alerted by the local authority and Clinical Commissioning Group (CCG) to concerns they had following a joint visit. In response to these concerns we carried out a third day of inspection on 18 September which was unannounced. The registered manager was not available on 18 September and some information was inaccessible therefore we returned on 19 September 2017. Following our visit on 19 September 2017 we wrote to the provider outlining our findings and the concerns they raised. We again requested an action plan and following receipt of this, two inspectors visited the service on 2 October 2017 to review progress and complete the inspection.

Allison House provides accommodation, nursing care and support for up to 38 people living with dementia. The service is single storey and purpose built around a secure central garden and seating area. There are a number of communal areas around the building including four lounges and three dining rooms.

The service had a registered manager in place. 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.

Staff training had improved since our last inspection. Staff were up to date with most training, however, 20 out of 54 staff were in need of refresher training in dementia awareness.

The system of audits in place was still not effective. The issues we found during the inspection had not been picked up by the checks being undertaken by the manager and senior staff.

We looked at the arrangements in place for the management, storage, recording and administration of medicines. There were discrepancies and unexplained gaps on people's medicine administration records and prescribed creams were not being marked with a date of opening. Records relating to covert administration of medicines were not clear.

The service had safeguarding and whistleblowing procedures in place. Staff knew how to identify signs of abuse and told us they would report anything they were concerned about. However, incidents of a safeguarding nature were not always reported to the local authority or the Care Quality Commission.

Checks of the building and maintenance systems were undertaken however when repairs were needed these were not always undertaken in a timely manner. Fire doors and emergency lighting that were identified as faulty were not replaced or repaired as a matter of urgency with some remedial work taking up to five months. We observed a window in one of the bathrooms had no restrictor in place. This was a large window which was very easy to access and opened wide enough to climb through. The manager told us they would ensure restrictors were fitted to all windows and when we returned to the service we found this had been done.

Individual risk assessments were not in place for all recognised areas of risk and some records were out of date. This meant that staff were not made aware of how to mitigate risks to people's safety. A person had moved to the service who was at risk of self- harm. No risk assessment had been put in place to advise staff how to mitigate this risk. We highlighted this on the first day of our inspection and this had been addressed when we returned for the second day.

Information on how people should be supported in an emergency evacuation was not tailored to the needs of the individual and these documents were not in place for every person. Files containing information on how to deal with an emergency situation were locked in the manager's office on one of the days we visited. Recommendations made by the fire service at a fire safety audit conducted in January had not been acted upon and fire drills were not scenario based or adequately recorded.

There were concerns regarding the infection control processes in place. Some improvements were made to the cleanliness of the service over the course of the inspection but areas of malodour were still present. Furniture was worn and stained and carpets were frayed and in need of deep cleaning. Some flooring and furniture was replaced after our first visit but further action was needed to bring the environment up to an acceptable standard.

People's weights were not being accurately monitored and malnutrition risk was not being correctly calculated. We saw that the MUST scores were incorrectly recorded and appropriate action had not been taken when weight loss had occurred. The provider stated in their action plan that a new MUST tool would be introduced and people would be weighted weekly where necessary. When we returned to the service on 2 October 2017 we found that MUST scores were still not being calculated correctly and weights records were not always complete. This meant people were placed at risk of malnutrition.

The environment was not suitable for people living with dementia to navigate their way around independently. There was inadequate signage and poor use of colour as an aid to orientate people.

The dining experience was in need of improvement. People were not given appropriate support to make choices at mealtimes and there was nothing in place to support staff to do this, for example pictorial menus. People were seated at dining tables for up to half an hour before receiving their meal. We were told that mealtimes were to be staggered after the first day of our inspection but when we returned we saw that this was not effectively being put into practice.

Records relating to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were poorly organised. Best interest decisions were not adequately recorded and staff knowledge was limited in this area.

People's care plans did not always contain detailed information about how they would prefer their care to be delivered. Information was not comprehensive, accurate or up to date.

There appeared to be sufficient staff to meet people's needs however the manager was not able to evidence that staffing levels were safe or how they were calculated as no dependency tool was in use.

We saw evidence of safe recruitment and selection procedures. Appropriate checks were undertaken before staff started work at the service. Existing staff felt supported. They received regular supervision and annual appraisal.

People had access to healthcare professionals to ensure health and wellbeing was maintained.

People and relatives were happy with the care delivered by staff. There was a calm atmosphere during our visits and staff engaged well with people throughout the day.

An activities co-ordinator was employed two days a week. On the days when they were not working there appeared to be very little to occupy or entertain people.

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

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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.

There were discrepancies and unexplained gaps on people's medicine administration records and prescribed creams were not being marked with a date of opening.

Risk assessments were not always completed or kept up to date. The falls risk assessment tool did not accurately reflect risk levels

There were concerns regarding infection prevention and control and health and safety.

People's emergency evacuation information was not accurate or up to date.

Is the service effective?

Inadequate

The service was not always effective.

The environment was not suitable for people living with dementia to navigate their way around independently.

People were not given appropriate support to make choices at mealtimes and there were no pictorial menus in place.

Best interest decisions were not adequately recorded and staff knowledge was limited in this area.

Staff were up to date with most training, however, some staff were in need of refresher training in dementia awareness.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider was not ensuring adequate standards of care were being met.

People and relatives were happy with the care delivered by staff.

There was a calm atmosphere within the service and staff

engaged well with people throughout the day.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always person centred.

An activities co-ordinator was employed two days a week. On the days when the activity co-ordinator was not working there appeared to be very little to occupy or entertain people.

The complaints procedure was followed correctly when a complaint was received.

Is the service well-led?

Inadequate

The service was not well led.

There was insufficient managerial oversight of day to day operation of the service.

The system of audits in place was not effective.

Records relating to the care and treatment of people were not always complete, up to date or accurate.

Incidents of a safeguarding nature were not always reported to the local authority or the Care Quality Commission.

Actions from the last fire safety audit had not been completed and therefore people were placed at risk.

Allison House

Detailed findings

Background to this inspection

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

The inspection took place on 16 August 2017, 21 August 2017, 18 September and 19 September 2017 and 2 October 2017. Three of these dates were unannounced.

The inspection team consisted of three adult social care inspectors, one specialist professional advisor and an expert by experience. A specialist professional advisor is someone who has a specialism linked to the service being inspected, in this case a nurse. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed all of the information we held about the service, such as notifications we had received from the service and also information received from the local authority who commissioned the service. Notifications are reports about changes, events or incidents that the provider is legally obliged to send us within the required timescale.

We sought feedback from the commissioners of the service, the local NHS clinical commissioning group and Healthwatch prior to our visit. Healthwatch is an independent consumer champion gathers and represents the views of the public about health and social care services in England.

The provider completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

On the first day of our inspection visit there were 38 people who used the service. There were 37 people using the service on subsequent visits. We spoke with four people who used the service and eight relatives. We spent time in the communal areas and observed how staff interacted with people.

During the visit we spoke with the manager, deputy manager, four nurses, seven care assistants, the

activities co-ordinator, chef and domestic staff.

As part of the inspection we reviewed a range of records. This included medicine administration records, five people's care records and five staff files, including recruitment and training records. We also looked at records relating to the management of the home and a variety of policies and procedures developed and implemented by the provider.

Inadequate

Is the service safe?

Our findings

We looked at the arrangements in place for the management, storage, recording and administration of medicines.

We found there were discrepancies and unexplained gaps on several of the medicine administration records (MAR) we looked at. For example, one person was prescribed a fortified drink to be given twice a day but records indicated this had regularly been given three times. Another person needed their pulse to be taken and recorded prior to the administration of one medicine but there were gaps in the records that meant it was not possible to be certain this had happened. Gaps and errors on MARs meant it was not possible to be certain people had received their medicines as prescribed.

Two people received medicines covertly. Information relating to covert medication stated 'refer to MAR' or 'as MAR'. There was no reference made to covert administration on either person's MAR chart. The paperwork we saw stated tablets were to be crushed in food and the member of staff we discussed this with appeared unsure of the correct procedure but stated they had given medicine in porridge. No information from the GP was on file. We requested the manager to obtain this guidance along with confirmation that medicines could be given covertly. Guidance received from the GP stated the medicines were to be mixed with water on a spoon. This meant that staff had not had the necessary information available and people were being given medicines in a way that was not in line with medical advice.

We checked the stock of medicines and found that creams were not being marked with a date of opening. One container stated any unused cream was to be discarded three months after opening. Creams may no longer be effective if open for longer than the manufacturer's guidelines state however there was no way to know how long these items had been in use.

When we arrived and walked around the building we found that in one lounge the seat pad had been removed from an armchair. A nurse told us that this had been taken for cleaning. This had left the chair available for people to sit on but there was a hole in the seat webbing meaning that anyone who sat on the chair would fall straight through to the floor and be at risk of injury.

There were areas of malodour around the service and carpets were stained and worn. Seating in lounge areas was very worn and threadbare in some areas with the internal wadding visible. This made the chairs difficult to keep clean and therefore increased the risk of cross contamination. We saw people sitting on sofas where the seat pad had been removed and a folded blanket left in its place. The manager told us that replacement seating being ordered and when we returned on 2 October 2017 we saw replacement seating had been provided in one lounge. We were told that the rest of the seating was to be replaced by 20 November 2017.

When we first visited the service some areas within the clinic room where medicines were stored were not clean. There were floor tiles missing and the floor was dirty. The cupboard under the sink where items were stored was dirty and the shelves were stained. Moving and handling equipment was very dirty and soiled

linen in red bags was left on bathroom floors on the first two days of the inspection. The service was visited by an infection control nurse on the second day of our inspection and an action plan was produced as a result of their findings. We found that some improvements were made throughout the course of the inspection however the action plan had not been fully completed and there were still areas of malodour around the service when we returned on 2 October 2017.

On the first day of our inspection sluice areas were filled with unused furniture making it almost impossible to reach the sinks and other equipment in there. Some improvement had been made on the second day but there were still chairs being stored in the sluice rooms and we highlighted that this was a contamination risk. All items that should not be present had been removed when we visited on 2 October 2017.

On the first day of our inspection the sluices were not adequately secured. One door was not locked at all and the second only secured by a small bolt. When we returned to the service the rooms were locked but a key was left hanging by the lock and could therefore be easily accessed by people using the service. As this area is where items such as bedpans are dealt with people would be at risk of cross infections or injury from equipment if entering. Hot water temperatures within the sluice areas posed a scalding risk. Leaving sluice rooms accessible meant people were at risk of illness or serious injury. We highlighted this to the provider and when we returned on 2 October 2017 the doors were secured with keypads.

During the inspection we found communal toiletries, including bubble bath, aerosols and creams in unlocked cupboards in bathrooms. Prescribed shampoos and creams were in amongst these generic items. There were bottles of raspberry bubble bath in every bathroom. These had pictures of fruit on the labels and looked and smelled like food items. As the bathroom was unlocked there was a risk people using the service could walk in and drink the bubble bath, causing them to become unwell. We also found used disposable razors in three bathrooms. Not only was this a health and safety risk but there was no way to identify who the razors belonged to and this was further evidence of the communal use of toiletries.

We were told by the manager that a person who used the service was at risk of self-harm. There were a number of high risk areas around the service given this situation. Items in bathrooms not only included disposable razors but we also found a drill bit and a men's leather belt. We raised these issues with the manager who ensured that all the items were removed from bathrooms by the end of the first day of inspection.

A window in one of the bathrooms had no restrictor in place. This was a large window which was very easy to access and opened wide enough to climb through. We highlighted this to the manager who told us that this window opened on to the enclosed garden and this was why a restrictor was not in place. During our visit we observed one person walking around the service trying windows to see if they opened. We discussed the risks associated with someone being injured by trying to climb out of the window or successfully exiting the building without staff being aware, particularly at night time, even if this was only into the garden. The manager told us they would ensure restrictors were fitted to all windows and when we returned to the service we found this had been done.

Personal emergency evacuation plans (PEEPS) were in place for most of the people who used the service however they were generic forms that had not been specifically tailored to each person's needs. PEEPS provide staff with information about how they can ensure an individual's safe evacuation from the premises in the event of an emergency. There was a standard form for those people who were mobile and those who were not. Only one form contained information specific to that person.

PEEPS were kept in people's individual files but also in a central file that was to be used in an emergency.

This file had not been updated and therefore did not contain PEEPS for everyone who was living at the service on the second day of our inspection. We highlighted this to the manager who told us they would address this immediately. When we returned for the third day of our inspection we found the emergency file was locked in the manager's office and none of the staff on duty had a key to access it. On the fourth day of the inspection we found that there were still two people using the service who did not have a PEEP in place. This meant that the information on how to evacuate people in an emergency was not up to date, accurate or easily accessible at all times and people were therefore at risk of serious harm in the event of a fire.

We looked at the procedures in place to ensure fire safety. Fire alarms and equipment were regularly tested however when issues were identified these were not addressed as a matter of urgency. We saw records of fire door checks that identified two areas of concern where doors were not closing properly. This was highlighted as a problem during checks on 21 July 2017 and 11 August 2017. We asked to see earlier records but they were not available. We later received email confirmation from the provider that the doors had last been fully functional in May 2017 and evidence that repairs had been carried out in August 2017.

Emergency lighting tests were taking place monthly. We saw that five units had failed in tests between January and April 2017. These repairs were carried out on 1 June 2017. Tests from 9 June 2017 identified one failed unit. On 6 July 2017 two units failed and on 4 August 2017 this had risen to three. Records show that a quote was waiting approval. We contacted the contractor and were told that they had been called out to provide a quote on 23 August 2017. Following our inspection we received confirmation that work had been done to repair the units however this had not been done in a timely manner.

We looked at the arrangements in place to manage risk to people's safety. People had individual risk assessments in place for areas such as falls and skin integrity. We found that several people had risk assessments that were out of date and other risk assessments were not present at all. For example, one person had a falls risk assessment that stated they mobilised independently, however, they now used a wheelchair and the risk assessment had not been updated to reflect this. We fed this back to the manager on the first day of the inspection but when we returned on 18 September 2017 this had still not been amended. We highlighted this to the provider in a letter of concerns and when we returned on 2 October 2017 the record had been updated.

Another person had moved to the service immediately prior to our inspection and we were told they were at risk of self-harm. No risk assessment had been put in place to advise staff how to mitigate this risk. We highlighted this on the first day of our inspection and this had been addressed when we returned for the second day. When we returned on 18 September we found that no other care plans or risk assessments had been completed for this person. We pointed this out to the provider and documents were in place when we returned on 2 October 2017.

The falls risk assessment tool that was in use was not successfully identifying those people who were at high risk of falls. We saw two people who were at high risk of falls and had care plans in place to reflect this but the score from their risk assessment indicated their risk level was not high. We highlighted this to the manager who told us they were aware of the discrepancy. The tool in use was not fit for purpose and it was possible that some people who had an elevated risk of falls would not be identified.

The Malnutrition Universal Screening Tool (MUST) was being used to assess people's risk of malnutrition. We saw that the MUST scores were incorrectly recorded for two people and appropriate action had not been taken when weight loss had occurred. Records for one person showed a significant weight loss over a one month period. This person was on monthly weights however following the lower weight being recorded they were not weighed again for a period of two months. There was no explanation for the weight loss and no

record of any action taken in light of this significant change. The MUST score for this person was recorded as '2' on 24 April 2017, 24 May 2017 and 24 June 2017. According to the provider's nursing practice guideline for nutrition and hydration a MUST score of two identifies a person as high risk. The guideline states that action should be taken where a high risk is identified, such as referral to a dietician.

We spoke to the manager about this and they stated the weight loss was possibly an error as such significant weight loss would have caused obvious physical change and staff had not reported noticing this. When the person was weighed two months later they were found to have gained a significant amount of weight, however records show that different scales were used. They could not explain why the person was not weighed again immediately to ensure the data was accurate or why different scales were used the next time they were weighed. Although both sets of scales were calibrated on 25 April 2017 there was no evidence of any safeguards in place to avoid inconsistency of records caused by using different scales. We also identified the most recent MUST score had been incorrectly calculated. It was not possible to establish whether this person's weight had actually fluctuated dramatically over a two month period but records showed this was the case and no action had been taken as a result.

The provider stated in their action plan that a new MUST tool would be introduced and people would be weighted weekly where necessary. When we returned to the service on 2 October 2017 we found that MUST scores were still not being calculated correctly and weights records were not always complete. This meant people were placed at risk of malnutrition.

These findings evidenced breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12: Safe care and treatment.

One of the lounges had a carpet that was fraying in the area by the door causing a trip hazard. Around the service we found that laminate flooring was lifting and in other areas had pieces missing altogether. This was also a trip hazard and a potential infection control issue as the damage would make these areas more difficult to keep clean. The manager told us they were in the process of getting quotes for new flooring but a date for the replacement had not been set. When we returned to the service we found that laminate flooring in lounge areas had been replaced but flooring in other areas was still in need of renovation and the carpet was still in a state of poor repair.

Moving and handling equipment was very dirty and rusty. Other equipment such as shower seats and commodes were also found to be dirty and rusty. An infection control nurse visited during the second day of our inspection and advised the manager how these issues could be addressed. The manager agreed to work through an action plan with advice from the infection control nurse. When we returned to the service we saw that work had been done to improve the standard of the equipment however the manager and provider had failed to identify the need for these improvements until it was brought to their attention.

On the first day of our inspection we noticed a female eating lunch in the dining room whilst using a wheelchair with the name of a male clearly marked on the back. We had seen in the PEEP for the male concerned that he needed his wheelchair to evacuate in an emergency situation and that this was kept in his room. This meant that the person was at risk of not having the appropriate equipment to hand in case of an emergency. There was also a health and safety risk in using equipment intended for someone else and a potential cross contamination risk. We looked at the records of wheelchair checks and found that chairs were often found in other people's rooms, which is evidence that this practice was occurring regularly. We asked the manager for their policy on wheelchair use but there was not one available. They acknowledged that people should use their own equipment and said they would monitor this more closely in future.

These findings evidenced breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 15: Premises and equipment.

We saw documentation and certificates to show relevant checks had been carried out on the electrical hardwiring and gas safety. Hoists and stand-aids were regularly serviced and scales calibrated. Water temperatures were checked and Legionella tests were undertaken.

All the staff we spoke with said they would have no hesitation in reporting safeguarding concerns and they describe the process to follow. They told us they had been trained to recognise and understand all types of abuse, records we saw confirmed this. One member of staff told us, "You would have to report it if you saw something that worried you. Even if they (staff member) were your friends, it's the right thing to do. You just have to." Although staff were recording incidents correctly these were not always escalated to the local authority or CQC.

The provider had a whistleblowing policy in place. Whistleblowing is when a person tells someone they have concerns about the service they work for. Staff we spoke with were aware of this policy and also told us that information was on display in the staff room.

We looked at staff rotas and discussed staffing levels with the manager. We were told that the service was fully staffed and agency staff were only used to cover additional one-to-one support for those people who required it. The manager received information from agencies used so they could ensure the staff provided had the necessary training, experience and pre-employment checks.

We asked the manager how staff numbers were calculated to ensure sufficient staff were available to safely meet people's needs. They told us they did not use a dependency tool but relied on their knowledge of the people using the service. We discussed the potential problems that may arise if the manager was not available to share this knowledge or how they would evidence safe staffing levels if the need arose. The manager told us they would look for a suitable dependency tool to use going forward.

During the inspection we observed staff responding to people's needs in a timely manner. Staff we spoke with felt there were enough staff to provide care across the service. The number of people who needed support at mealtimes meant that staff were not always able to give people appropriate one to one assistance. One the second day staff told us the introduction of staggered mealtimes across dining rooms would help with this but when we returned to the service for a third day we saw staff continued to support two people at once indicating deployment of staff at mealtimes continued to be an issue.

The provider had effective recruitment procedures in place to ensure new staff were suitable to work at the service. A range of pre-employment checks were undertaken, for example requesting and receiving two references and undertaking Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps employers make safer recruiting decisions and also helps to prevent unsuitable people from working with vulnerable adults.

Inadequate

Is the service effective?

Our findings

We saw that some communal lounge areas had been decorated in a dementia friendly way with some reminiscence items and activity equipment. However, the physical environment throughout the home did not always reflect best practice in dementia care. The Department of Health, Health Building Note 08-02 Dementia-friendly Health and Social Care Environments (March 2015) states; The use of colour and the layout of the buildings, can make an enormous improvement in people's quality of life, and can reduce the impact of their dementia and help them live more independent lives. The correct colours, textures and layout of the buildings can help to reduce confusion, isolation, and anxiety, and help people live well with their dementia.'

There was limited evidence of contrasting colours being used to aid independence. Blue crockery was used at mealtimes and we saw that some toilet seats were of a bright contrasting colour but this was not consistent in every case. We did not see any further evidence of adaptations to the environment to show good practice guidelines had been put into practice to enable people to navigate around the home independently. No contrasting colour was used on light switches, grab rails and bathroom/bedroom doors. Corridors were all similar in colour, and bedroom doors did not have a photograph, picture or memory box people could associate with to help them find their personal space. The numbers on bedroom doors were located on the door handle and difficult even for the inspection team to make out.

We saw one person walking around the corridors with two visitors. They stopped to ask where their room was as they had been unable to find it. A member of staff directed them and the person stated, "Oh we've been right round there already." Without appropriate signage even the person's visitors had been unable to assist. The person walked with an aid and was evidently becoming tired and frustrated.

We observed one person in a room that was not theirs on two separate occasions. On the first occasion a member of staff walked past and called out "Hey [person A's name], that's our [person B's name]'s room." However the staff member did not go in the room or attempt to guide the person to their own room. The room was unoccupied and we observed this person lie down on the bed. The second time we observed the person laid on the bed in another room that was not theirs. We asked a nurse and the manager about this and we were told that this person tends to wander into other peoples' rooms. In this person's care plan there was information from a clinical psychologist that stated if the person was lost, anxious or agitated staff should direct them to their room and show them their name on the door. We found there was no name on the door of their room.

Most of the bathrooms and toilets did not have any signage to indicate this was what they were and those signs that were in place were in need of improvement. Sluice doors were also the same colour and without signs. We asked why people's room doors were not personalised and were told that when they put signs up 'people just remove them'. We discussed looking for alternative means of attaching signs to avoid this. When we returned to complete our inspection some people had photographs on their doors and there was more signage on dining rooms and bathrooms but this was still in need of improvement to support people living with dementia to maintain their independence.

At lunchtime we saw one member of staff was sitting between two people who needed assistance and helping them both simultaneously. This had also happened in another dining room until a second staff member offered support. We saw further evidence of this practice on subsequent visits.

These findings evidenced a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 10: Dignity and respect.

We observed lunch being served in all three dining rooms. On the first day of inspection dining tables were not set with tablecloths or appropriate cutlery and condiments. There was no pictorial menu available and on the first day of our inspection there was no menu in the dining room at all. There were no visual prompts to orientate people that they were in a dining room or about to have a meal. We fed this back on the first day of our inspection and on the second day we saw tables were set with tablecloths and placemats. The menu had also been written on a chalkboard but this was positioned in an area away that was difficult for people to see and the chalk writing was difficult to read. We found that further work was needed to improve the dining experience.

There did not appear to be a choice of meal at lunchtime. We were told by the manager that people were given visual prompts to make food choices but we did not observe this on any of our visits in any of the three dining rooms. There was an A4 poster on the wall listing the alternative menu choices as sandwiches, toasties and jacket potatoes but this was not clearly visible from the dining tables. Only one person was asked if they wanted a sandwich after repeatedly refusing their meal. No visual prompts were used to offer this alternative.

The meals were plated up from the hot trolley in the dining room. On the first day everyone was given lamb casserole mashed potatoes, sprouts and gravy was poured over the whole meal without anyone being asked what they would like on their plate, such as vegetables, gravy etc. We saw one pot of salt and pepper in the dining room but this remained on the trolley. Meals were served in a similar way on each of our subsequent visits.

These findings evidenced a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 9: Person-centred care.

People were already seated around tables in all three dining rooms at 12:30pm, the time we were told lunch was served. In one dining room, people had been seated for ten minutes when staff decided to move them around to make assisting them easier. A number of people were moved around in this way. We also saw people falling asleep whilst waiting for their meal. Food did not arrive until 12:50pm and by the time the last person was served it was approaching 1:00pm. We were told this was because the same trolley went to each of the three dining rooms and dining room one was the last to be served on this occasion. There was not any staggering of people being taken to the different dining rooms to reduce waiting time. We fed this back to the manager at the end of our first day and we were told that staggered mealtimes would be introduced. When we returned to complete our inspection staff told us staggered mealtimes had been introduced and this made it better for people and easier for staff however we saw people were still being seated in two dining rooms at 12:30pm. The nurse in charge told us this should not have happened.

People and their relatives told us they were happy with the food provided. One person told us, "The food is lovely." A relative told us, "The food is good, [family member's] appetite is much better now. They have put on a little bit of weight which I am glad about."

People were provided with hot and cold drinks and snacks throughout the day. There were fortified

milkshakes on the tea trolley for specific residents and a milk substitute for a resident who was lactose intolerant.

At the last inspection we found the provider to be in breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff were not up to date with their training. At this inspection we found that some improvements had been made and the provider was no longer in breach of this regulation. However improvements were still needed.

An action plan was completed following our last inspection. In this document the provider stated that training records would be audited monthly to identify staff whose training had expired or was due to expire. The action plan also stated a target of 90% for completion of training. The date for completion of these actions was January 2017.

At this inspection we saw that the majority of staff were up to date with training. However, the training matrix identified 20 out of 54 staff were overdue refresher training in dementia awareness. This meant that only 63% of staff were up to date with this. This is particularly significant as the people who used the service were all living with a dementia.

We highlighted this to the manager who assured us that they would discuss this with the providers training and development manager and training would be sourced and booked as soon as possible.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards.

We checked whether the service was working within the principles of the MCA and applying the DoLS appropriately. Applications had been submitted to the supervisory body for authorisation when people were identified as at risk of being deprived of their liberty. DOLS records were disorganised and this made oversight difficult. Some information was kept on individual files other documents were kept in two central DoLS files. The DoLS files contained some out of date information, a whiteboard system in place in the nurses' station was not up to date. We saw one authorisation had expired on 8 September 2017 and a request for renewal was sent via fax on the same date. The manager told us this was a one off but there was no evidence of an effective system in place and there was therefore a risk this may happen again.

Two people received medicines covertly. Best interest decisions were referred to in their care plans but there was no record of these discussions or when they had taken place.

Staff had received training on MCA and DoLS however when we spoke with some staff they were not able to explain the key principles. We discussed with the manager the importance of ensuring that training undertaken had provided staff with the required information and necessary level of knowledge. The manager told us they would look into sourcing some refresher training that may assist staff in this area.

Staff we spoke with during the inspection told us they felt well supported and received regular supervision and an annual appraisal. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. One member of staff told us, "I have supervision every three months. You can say anything, if something's bothering you or someone's annoying you." We saw records to confirm supervisions and appraisals had taken place.

We saw that people had access to healthcare professionals to ensure their health and wellbeing was maintained. Records showed evidence of visits by opticians, chiropodists, GPs and the speech and language team (SALT).

Requires Improvement

Is the service caring?

Our findings

People told us they were happy with the care being delivered. On person said, "I like it here, staff are very nice." Another person said, "Staff sit and chat with you, it is like home from home."

Relatives also spoke positively about care. One relative told us, "Staff are second to none. [Manager] has gone above and beyond to fit my [family member] in. The staff really are fantastic." Another relative said, "Staff are lovely and very caring." Relatives also told us they appreciated the care staff extended to them, particularly if they became upset.

During the inspection we spent time observing staff and people who used the service. There was a calm atmosphere around the service and we observed staff engaging with people in a kind and caring way.

Staff demonstrated a good knowledge of the people they cared for; they addressed people by name and interacted with them in a relaxed and friendly way. Staff took time to sit and talk to people and also chatted as they went about their tasks.

The whole staff team had a good rapport with the people who used the service. The maintenance person was laughing and joking with people in one of the lounges and also knew people by name. We saw the manager, deputy manager, and housekeeping staff all engaged with people as they moved around the service.

Staff we spoke with told us they enjoyed supporting people. One member of staff told us, "We have a lovely team. I love it here, the people we care for are great and it is a very rewarding job." Another member of staff said, "I love my job, I love the residents."

During observations we saw people occasionally became upset, agitated or angry. Staff knew how to reassure them. They spoke to them respectfully in a soft tone until the person became calm again or distracted them to another area or task.

Staff told us ways in which they protected people's privacy and dignity. One member of staff told us, "I always make sure that personal care is done in their room, or a bathroom. Behind a closed door." Another member of staff said, "I make sure I talk to people and explain what I'm doing, it's important make sure they're ok."

We saw staff adjusting people's clothes to ensure their dignity was preserved and knocking on people's doors before entering. However, we also observed one member of staff shaving a male service user in a lounge area whilst other service users were standing around him. The member of staff then offered to shave another man in the same lounge.

People could move freely around the service and could choose where they wished to spend time. We saw people going to spend time in their rooms when they wished to, although they had to be directed by staff on

occasion.

People's bedrooms contained personal items, photographs and furniture which made them feel homely.

A relative told us, "Staff encourage [family member] to be independent, like getting dressed and going to the toilet."

At the time of the inspection there was nobody who required the services of an advocate. An advocate is someone who supports a person so that their views are heard and their rights are upheld. There was information available on local advocacy services if the need arose in the future.

Whilst we observed staff to be caring throughout the inspection, it is evident from the issues we found the provider was not ensuring the service was caring overall.

Requires Improvement

Is the service responsive?

Our findings

The care plans we looked at included information regarding people's care needs but did not always give an insight into the individual's personality, preferences and choices. In order to make the plans personalised they required the inclusion of more detail about the way people preferred to have their care delivered. People's life history, likes and dislikes were noted in an 'all about me' document within care files. The level of detail in these documents varied from person to person but this information was not incorporated into people's care plans. Generic statements were often made referencing clinical guidelines without tailoring these to the individual.

We saw that care plans for oral hygiene were duplicated in two of the files we looked at. The same information was contained in each plan, however one person had all of their own teeth and the other wore a partial denture. This difference in need was not reflected in the plans and no reference was made to the care required for the denture. This is further evidence that care plans were generic rather than person centred.

One family member we spoke with raised concerns about their relative's clothing. The person required special socks which the family had provided. However they had discovered on more than one occasion their relative was wearing someone else's socks which had caused pain and swelling. They also told us that they had found female underwear and pink socks in their male relative's room. On the day of our inspection we were told this person had been very agitated when family members had arrived because they were wearing someone else's clothing.

Two other relatives we spoke with during the inspection told us that clothing went missing despite being marked with the person's name. One relative said, "When I came to visit yesterday my [relative] had other people's clothes on, their jumpers are missing. I have spoken to staff about this." Feedback from a quality assurance survey conducted in February 2017 also highlighted this issue. A relative had written, 'It is depressing to see my loved one in other people's clothes, especially socks which are ragged.' An action plan was drawn up in May 2017 following the survey and this stated the manager was to meet with housekeeping staff to discuss laundry issues. The minutes from the housekeeping meeting held in June 2017 does not make any reference to laundry.

These findings evidenced a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 9: Person-centred care.

The provider employed an activities co-ordinator who worked at the service for two days. The notice board showed details of activities that had taken place or were scheduled to. These were only on a Thursday or Friday when the activities co-ordinator was in work and there were no activities organised outside of this time. We were told that staff did involve people in more informal activities. The activities co-ordinator was not working on the first day of our inspection however there was music playing in the lounge and staff were sitting chatting to people. We saw staff manicuring people's nails and brushing their hair and people were relaxed and calm during this interaction.

One the second day of our inspection we observed people participating in a sing-a-long in the downstairs lounge. The activities co-ordinator had printed song sheets so that people who wished to could join in and several people did. Staff demonstrated a good knowledge of the different music certain people preferred and a good range of songs were played to cater for different tastes. A member of care staff was getting people up to dance and was patiently guiding them when they were less steady on their feet. People were engaged and smiling during this activity.

The activities co-ordinator kept comprehensive records of activities they led. They also kept detailed records within people's care files of the activities they enjoyed.

No records were kept of what activities took place on the days the activity co-ordinator did not work. On those days we observed there to be very little to occupy or entertain people. We discussed this with the manager who said they would trial an activity diary so that staff could record what they had done throughout the day and who had been involved. This would assist the activity co-ordinator to keep a comprehensive record and ensure that people were regularly offered activities to provide both entertainment and social stimulation.

There had only been one formal complaint received in the previous 12 months. This was appropriately recorded and followed up in line with the provider's policy. The issue was resolved to the satisfaction of the person who had made the complaint.

Inadequate

Is the service well-led?

Our findings

At our previous inspection we had found the registered provider was in breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. This was because effective governance arrangements were not in place.

The registered provider completed an action plan which stated the service would be compliant with this regulation by the end of October 2016.

At this inspection we found that adequate steps were still not being taken to monitor and improve standards at the service.

The manager was not able to provide details of fire drills on the first two days of the inspection as drills were conducted by the provider's Health and Safety officer and records were not kept on the premises. We were sent a copy of the information following our visit, however, this was just a list of dates drills had taken place and the number of staff involved on each occasion. There was no supporting evidence to identify which staff had taken part and therefore no way to ensure all staff had participated in a drill. There was also no information relating to the time it had taken to perform the drill, whether it was during a day or night shift and whether there had been any lessons learned.

A fire safety audit of the premises was undertaken by Cleveland Fire Service on 12th January 2017. One of the areas requiring attention was 'Suitable and sufficient fire drills should be conducted at appropriate intervals and all outcomes recorded in a log book. Cleveland Fire Brigade recommends that a scenarios based approach to fire drills should be undertaken. Where the participation of residents is not possible it is advised that staff take on the role of the residents. Drills should incorporate the use of evacuation aids or equipment if provided.' An action plan created by the manager on 1 February 2017 stated that fire drills would in future be conducted with a scenario based approach and outcomes recorded in the fire log book. Evidence seen during the inspection did not meet these criteria. People were at risk of serious injury or death in the event of a fire because staff were not experienced in emergency evacuation procedures by participating in fire drills.

We informed the provider that a more detailed record was needed to show the fire drills taking place were adequate to prepare staff for an emergency situation. We were told that the forms used to record drill had been improved however when we visited on 2 October 2017 we found the new forms were still not recording drills in sufficient detail.

Issues around staff training were highlighted following our last inspection. The action plan stated the manager would audit the training matrix monthly to identify staff whose training was out of date or almost out of date. We found that 37% of staff were overdue dementia awareness training. The majority of lapsed training had been due for renewal in February and March 2017 but had not been booked at the time of our inspection. This means the training audit was not effective.

Records relating to the care and treatment of people were not always complete, up to date or accurate. This meant the care plan audit was not effective.

One person had two care plans in place for communication. These were both produced on 19 September 2017 by the same person but contained different information. One care plan mentioned the person was partially deaf and directed staff to use visual cues and gestures, the other plan did not include this information. Another person had a care plan in place for their behaviour which stated they were on 24 hour 1:1 care but we were told this was no longer the case and 1:1 care was now only for 15 hours overnight. Care plans had not been updated since the arrangement changed in May 2017.

Care plan documents were not completed in a timely manner when people moved in to the service. We saw one person had been at the service for a month and their care plan was still not completed. Another person had fallen and sustained a head injury but did not have a complete care plan at the time of the incident. This was almost two months after the date they had moved to the service. This meant people were at risk because staff did not have access to accurate up to date information about their care needs.

Quality assurance surveys were undertaken annually and we saw the results from the most recent which had been conducted in February 2017. An action plan had been created to address some of the issues raised. However six of the 19 people who responded said they were not sure they were aware of the complaints procedure and another said they did not know what action to take if they had a complaint. This was not included on the action plan. We saw that some of the actions had been completed but we did not see any evidence of action being taken in respect of the laundry issues. This meant that although feedback was being sought this was not being used effectively to make improvements to the service.

Infection control and health and safety audits were not picking up on the issues and errors we found. Following our second day of inspection the manager told us they would introduce a daily health and safety checklist to be completed during a walk-around of the service. When we returned on 19 September this had not yet been introduced. When we returned on 2 October 2017 we found it had been introduced but was not always completed correctly.

These findings evidenced a continuing breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17: Good Governance. We are currently reviewing our regulatory response

Notifications of safeguarding incidents involving incidents between people who used the service were not being sent to us or the local authority safeguarding team. We saw seven incidents had occurred in August 2017 and only one of these had been reported. The manager acknowledged these should have been sent. They stated they were not currently overseeing this but would start to audit them on a regular basis.

These findings evidenced a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 13: Safeguarding service users from abuse and improper treatment.

The provider had failed to ensure the directors responsible for carrying out the regulated activity had taken reasonable steps to ensure people were receiving safe care and treatment under Regulation 12 of the Health and Social Care Act 2008. There had been a failure to evaluate and improve practice by way of quality assurance and monitoring of the service. This failure of governance and lack of appropriate oversight exposed people to a continuous risk of on-going harm.

Following the first day of our inspection we contacted the provider and told them about the issues we had found during our visit. We gave them opportunity to respond to our comments and provide an interim

action plan to detail what immediate steps they would take to address these matters. We received acknowledgement from the nominated individual that the information had been received however we did not receive any further comment in relation to this feedback until we wrote to them again more than three weeks later.

We sent a formal letter to the provider requesting an urgent action plan and this was received on 25 September 2017. Some areas within the action plan did not contain sufficient detail or propose a suitable timescale for remedial work. Consequently, an ongoing letter of serious concerns was sent on 28 September 2017 requesting a detailed improvement plan in order to address these concerns.

We received an improvement plan on 30 September 2017 which included timescales for the completion of each action. We visited the location again on 2 October and found that some of the remedial actions had not been completed within the given timescale. For example, weekly medicines audits had not commenced and the infection control nurse had not been contacted to arrange a return visit. Other work had begun but we found this had not always been done to a satisfactory standard.

These findings evidenced a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 5: Fit and proper persons: directors and Regulation 6: Requirement where the service provider is a body other than a partnership.

The provider had failed to ensure the manager was demonstrating compliance with the fitness requirements for Registered Managers. Feedback was given to the registered manager on 16 August 2017 and 21 August 2017 however when we returned to the location on 18 and 19 September 2017 we found that whilst some of this feedback had been acted upon other concerns remained. For example some care plans had not been completed, risk assessments had not been updated PEEPS had not been put in place for all those people who did not have them and daily walk-around record had not been introduced.

On 2 October 2017 we saw that a number of areas from the action plan that had been the responsibility of the manager had not been completed or had not been completed satisfactorily. This meant that the manager was not able to properly perform tasks intrinsic to their role.

These findings evidenced a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 7: Requirements relating to registered managers.

We saw minutes from staff meetings. The most recent meeting for all staff had taken place in June 2017. Prior to this the previous all staff meeting was November 2016. Topics discussed included mobile phone usage, uniform policy and housekeeping issues. Ensuring appropriate delivery of care to people using the service was also raised where issues had been identified. For example at the meeting on 15 June 2017 it was highlighted that people were not being regularly shaved or having their nails done and that this needed to be addressed.

The manager told us that suggestions made by staff were taken on board. For example a member of staff suggested that when a new person moved in to the service an extra member of staff should be on the night rota for the first three nights whilst the person settled in. The manager told us, "A member of the care staff suggested this as people can be disorientated and unsettled for the first few nights they're here. It was a good idea and we listened."

Staff told us they felt supported by the manager. One member of staff told us, "[Manager] is a marvellous manager they really are. They lead by example." Another member of staff said, "I think [manager] is lovely. I

could go to them with anything."

Residents and relatives meetings were arranged but minutes indicate these were not well attended. However, the manager operated an open door policy and throughout the inspection we observed relatives calling in to the office and chatting with the manager and deputy manager.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not receiving care that appropriately met their needs or reflected their personal preferences.

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 RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Personal care was on occasion delivered in communal areas. The autonomy and independence of the people using the service was compromised due to the lack of dementia friendly signage and adaptations.

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 RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider was not making the necessary referrals to the local authority of notifying CQC when safeguarding incidents involving people using the service occurred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider was not ensuring the premises and equipment were clean and properly maintained. Flooring and furniture was in need

of replacing.