Mr Steven William Saltmer & Mrs Penelope Alison Saltmer

Pennyghael Residential Home

Inspection report

Westbourne Grove, Selby, YO8 9DG
Tel: 01757 210204
Website:

Date of inspection visit: 16 and 17 Septmeber 2015
Date of publication: 02/11/2015

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?	Inadequate
Is the service well-led?	Inadequate

Overall summary

The overall rating for this provider is 'Inadequate'. The service was placed into 'Special Measures' by CQC at our last inspection on 28 and 29 April 2015. The purpose of special measures is to:

1. Ensure that providers found to be providing inadequate care significantly improve

2. Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

3. Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Summary of findings

The service had not sufficiently improved at this inspection. As a result of this it remains in Special Measures.

At the last inspection on 28 and 29 April 2015 we found that problems with the safety and suitability of the premises continued. We also found the service was breaching five other regulations; person centred care, the need for consent, safe care and treatment, good governance, and ensuring staff are suitably trained and supported to care for people.

CQC received an action plan from the provider on 22 July 2015. This contained information about the corrective action the provider would take to address the issues we raised at the last inspection.

This inspection was unannounced, and took place on 16 and 17 September 2015. We found the service had improved in relation to consent and cleanliness. However, it had not made sufficient improvements in; person-centred care, safe care and treatment, good governance and supporting staff and remained in breach of these regulations. In addition to this the service is in breach of the regulation relating to staffing levels and safe care and treatment.

Pennyghael Residential Home is a care home which provides residential, personal and social care for up to 16 people who are living with dementia. The home is on two floors with one staircase, two bedrooms are shared occupancy, although only one person was living in them at the time of our inspection. None of the bedrooms have en suite facilities. The home is in Selby. At the time of our inspection on 16 and 17 September ten people were living there.

The registered manager had left the service since our last inspection. At the time of the inspection they had not yet applied to cancel their registration with the care quality commission (CQC). A new manager had been appointed, they had been in post three weeks, and they told us they intended to register with CQC. 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.

We found some cosmetic improvements had been made to the environment. For example there were more photographs and art work on the walls. People had access to the conservatory which meant there was more quiet space. The immediate risks we identified at the inspection in April 2015 had been addressed however, there were still areas of improvement required and we identified further concerns.

There were insufficient staff available to meet people's needs at key times of the day. Care was planned and delivered based on how many staff were available rather than people's choices. This meant people did not receive person centred care.

Risk assessments contained basic information. Where risks were identified there was a lack of information for staff about what they needed to do to manage the risk. People's ability to request help from staff via the call bell system had not been assessed. The system needed updating and because of this a key was used to identify where the call bell had been activated. This meant there could be a delay in response which placed people at risk of harm.

Medicines were not safely managed. We saw staff had not completed medication administration records which meant staff could not be sure whether medication had been given and people could be at risk of receiving their medication again. This meant people could be at risk of harm.

Staff understood how to safeguard people from abuse. They could tell us about the procedures for reporting concerns. The service had made appropriate safeguarding referrals to the local authority.

All of the training staff had completed was on line and there were no systems in place to check whether staff had understood this learning and how they implemented this when providing care and support to people. There remained gaps in staff training. Of particular concern was the lack of moving and handling training by staff who worked overnight. This meant people were at risk of being supported by staff who did not have adequate training in safe moving and handling techniques. The manager had developed a training matrix and was monitoring the completion of training.

There was an improvement in relation to staff seeking consent from people. We saw staff offered reassurance

Summary of findings

and explanation to people and sought their permission to carry out care tasks. Staff were able to explain the basic principles of the mental capacity act and provided examples of how to support people to make decisions. In addition to this mental capacity assessments had been updated and we could see best interest decisions were recorded for people who were unable to make their own decisions.

We did not see any evidence of weight loss however; meals were planned around staff availability rather than individual's choices. One example of this was that everyone had a hot meal at lunchtime, this was because the chef finished work at 1pm and on an evening there were two care staff who worked. They made the evening meal which consisted of snack type food such as sandwiches and spaghetti on toast. We did not see evidence of meals being planned to take into account the need for a nutritious and varied diet. The meal time experience could be improved to make this a more enjoyable experience for people.

Staff interactions with people had improved. We saw staff were kind, caring and responded appropriately to people's distress. However the majority of interaction between staff and people was task orientated.

Although staff knew about people's preferences they were not using this information to plan, deliver or review people's care. This meant the service could not be sure people were receiving care and support which was based on their preferences and lifestyle choices.

Care plans were difficult to follow and were task based. They contained limited information about what was important to the individual receiving care and support. There was a lack of meaningful activity and stimulation for people, this took place at set times which was based on availability of staff rather than people's choices.

We saw evidence of institutional care practices. For example people were supported based on the routine of the service rather than individual choice. There was a lack of respect for people's confidentiality and privacy. Conversations about people took place in the main area of the service with other people and visitors around.

Relatives told us they knew how to make complaints and were confident in the new manager.

Staff morale was high despite the range of issues across the service. Staff expressed confidence in the manager and felt well supported.

The service was not well led. We found the manager was addressing issues as they arose, effectively fire fighting. Despite the range of issues we raised at the last inspection and the support being provided by the local authority staff we did not see an overarching service improvement plan. This meant we could not be assured the corrective action required would be completed and resulted in people receiving an inadequate standard of care and support.

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found.

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.

We found cosmetic improvements had been made to the environment. The conservatory had been made safe and this meant there was more space for people. Immediate risks had been addressed however, there remained some risks.

There were insufficient staff available to keep people safe and as a result of this care was not delivered in a person centred way. People were at particular risk in the later afternoon, early evening time when there were two staff available to support people to remain safe, take their medicines and make them something to eat.

People did not receive safe care and treatment. Risk assessments were poor and where risks were identified there was no clear plan to say how the risk should be managed. Medicines were not safely administered. The service was not clean.

Staff knew how to safeguard people and were aware of how to report safeguarding concerns.

Is the service effective?

Inadequate

The service was not effective.

Staff had attended online training courses but we did not see any evidence of competency checks following the training. Therefore the provider could not be assured staff had understood the training and had implemented this to provide people with appropriate support.

Mental capacity assessments had improved; there was a clear record of best interest decisions. Staff were able to explain the basic principles of the legislation and we saw people being asked to consent to care and treatment.

Meals were not effectively planned. People did not have access to a varied diet. Meals were provided at times which were in line with staff working patterns and not based on individuals choices. There was a lack of support from staff and a task based approach to care meant there was a lack of atmosphere. People were not supported to have an enjoyable meal time experience.

Is the service caring?

Requires improvement

The service was not consistently caring.

The atmosphere was calmer, and we saw less distress from people. We saw people had their personal care needs met. There was in improvement in the interaction between staff and people who used the service. We saw some examples of people being offered choice.

Summary of findings

However, we saw evidence of institutional care practices. The service had set routines which were not based on individual's choices. Care was delivered in a task orientated manner and was not person centred.

There was a lack of respect for people's confidentiality and privacy. We did not see people's likes and dislikes had been taken into account when planning and delivering care.

Is the service responsive?

Inadequate

The service was not responsive.

Care was not assessed, planned or delivered in a person centred way. Care plans were difficult to follow. People and their families were not involved in planning or reviewing care.

There was a lack of meaningful stimulation for people. Activities were at 'set times', again this was based on the availability of staff rather than on individual's choice. Activities were not planned in line with people's preferences or likes and dislikes.

Relatives told us they knew how to make a complaint. We saw the manager had kept a record of compliments. There had been five compliments since the manager took over the service.

Is the service well-led?

Inadequate

The service was not well-led.

Despite the extent of the issues within the service staff morale was high. Staff reported confidence in the manager and felt well supported.

However, there was no evidence of an overarching plan to address the extent of the issues we found on the last inspection. There was a lack of improvement across the service as a whole which meant people were not receiving an adequate standard of care.

The manager was 'fire fighting' issues and dealing with them as they arose. We did not see evidence of audits. Policies were out of date and record keeping was poor. There was no evidence care was being planned and delivered in line with dementia care guidance. The lack of governance and leadership meant people were at risk of receiving unsafe care.

Pennyghael Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 16 and 17 September and was unannounced.

The inspection team consisted of two inspectors, a specialist advisor who was a nurse and had experience in pressure area care and infection control, and an expert by experience. The expert by experience had personal experience of caring for older people.

Before the inspection we reviewed all of the information we held about the service, this included reviewing notifications we had received. We contacted Healthwatch. Healthwatch represents the views of local people in how their health and social care services are provided.

We had attended safeguarding meetings with the local authority. These 'collective care' meetings were in place due to the extent and scale of concerns within the service. The local authority continues to visit the service each day to assist them to provide safe, effective and responsive care for people.

During the inspection we spoke with three people who used the service, and because not everyone could tell us their views we spent time observing interaction between people and care staff. We spoke with three relatives directly, and telephoned a further three relatives to get their views on the service.

We carried out a tour of the premises which included communal areas and people's bedrooms. We looked at five support plans.

We spoke with nine members of staff including the manager, care staff and ancillary staff. We looked at three staff files; which contained employment records and management records. We looked at documents and records that related to people's care and support, and the management of the home such as training records, audits, policies and procedures.

At the inspection we spoke with three health and social care professionals.

Inadequate

Is the service safe?

Our findings

At the last inspection on 28 and 29 April 2015 we found the environment was not safe or suitable for people living with dementia. There was limited communal space, which meant the only quiet areas for people were their own bedrooms, this impacted on people's distress and agitation. We found that some people had broken bedroom furniture in their rooms; people did not have comfortable chairs in their rooms unless they bought their own, and none of the beds had headboards. A number of rooms were due to have new flooring fitted and one bedroom had a sunken floor which was awaiting repair, this bedroom was in use and therefore, this was a trip hazard.

The communal areas were due to be refurbished, in the main lounge area we were told a new carpet would be fitted the week after our inspection. This was because the carpet was torn and had been stuck down with tape; it was uneven and posed a trip hazard. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent a detailed environmental action plan to tell us about the corrective action they would take to address the issues we found.

At this inspection we saw some cosmetic improvements had been made to the environment. The conservatory had been made safe and was now a useable space for people. People enjoyed sitting in this room which was quieter than other communal areas of the service. We saw less distress from people who used the service.

The stair lift was stored safely at the bottom of the stairs with a sign to remind staff it should not be left at the top of the stairs. This was because it was a trip hazard. The garden had been improved and we saw garden furniture for people to sit outside and enjoy the fresh air. The path was no longer uneven so the potential for people to trip and injure themselves was reduced. We saw a gentleman resident come in from the garden independently.

People's bedrooms were more homely. The provider had purchased a comfortable chair for everyone for use in their own bedroom. Furniture had been replaced, and new flooring or carpets had been fitted in some bedrooms. However, the flooring in bedroom seven had not been repaired. It looked like padding had been put under the wardrobe and covered by carpet. Therefore the risk of tripping remained. We spoke with the manager who agreed to check this with the provider. The manager told us the provider believed this work had been carried out by a handyman the service had contracted with. In addition to this two screws were sticking out next to the door handle. People could scratch their skin on this and injure themselves. The manager agreed to remove the carpet and carry out any further work required to make this safe.

The bathroom flooring remained sticky. We had been told, in the action plan, the carpet in the downstairs lounge would be replaced. However, the provider decided not to do this as they are planning to undertake further refurbishment work which may alter the layout of the environment. The carpet had been stuck down and was no longer a trip hazard.

There was better pictorial signage for people living with dementia to help them find their way around. The walls had more pictures on for people to look at. However, a mural which had been made by the provider was fitted to one of the corridors. This contained different fabric material for people to touch as they walked past. The manager told us one person in particular enjoyed this. However, we found the material was hanging off and wall pins were sticking out. This meant people could have injured themselves. The manager agreed to make this safe whilst we were there.

This was a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we recommended that the provider reviewed the current staffing levels, in order to assure themselves there was sufficient staff available to support people, particularly when kitchen and cleaning staff were not available.

We asked the manager whether this review had taken place and were told it had not. Relatives we spoke with did not report concerns about staffing levels. One relative said, "I come a lot and I've never seen anything untoward and would say my relative is safe." Despite this we saw there had been no change in staffing levels and shift patterns for ancillary and care staff. This meant there were only two members of care staff on duty from either 1pm or 3pm

every day. The two staff on duty had to make the evening meal, which consisted of snack type food because this is all they had time to make, assist people with their medication and provide the support needed to keep people safe.

The staffing levels on an afternoon through until night time were unsafe. A member of staff explained there were four people whose behaviour could put themselves or other people at risk due to their dementia. They told us teatime was often difficult as people could become more unsettled, it is known that people with dementia can become more unsettled at this time of day. In addition to this two people needed support from two staff with their personal care. This meant whilst they were being provided with support, there would be no supervision of other people who used the service.

The cleaner was employed for fifteen hours per week, spread across five days and at other times care staff were expected to keep the service clean as well as provide support to people.

The service did not have sufficient staff to adequately provide the support people needed to keep them safe. It meant there were not enough staff available to provide person centred care. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found the service was not clean. This was a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent an action plan to tell us what they would do to rectify this. We found the manager had developed a cleaning schedule and had started to audit the cleanliness of the service. Relatives told us they thought the home was clean. On relative said, “The place has been tidied up a lot. Much more presentable now.” Despite this we found bathroom floors remained sticky.

At this inspection we found that the provider had followed the action plan they had sent us to meet the shortfalls in relation to the requirements of Regulation 12 section (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found people were not receiving safe care and treatment. Medicines were not being managed safely. The medication policy was out of date and did not contain any reference to National institute for health and care excellence (NICE) guidance. We saw gaps in the medication administration records (MARs) for two people. This meant people could be at risk as staff could not be clear about whether their medication had been given and therefore they could be at risk of being given it again.

The service did not complete an internal audit of medicines so there was no system to check medicines were being administered safely or to pick up any areas of concern.

A pharmacist visited the service on 17 September to complete their audit and found two people had not had their warfarin medication administered in line with the prescribing advice. This was on two occasions. This was important because medicines had been prescribed to keep people safe and well. If they were not administered correctly this meant people were at risk of harm. The pharmacist agreed to make a safeguarding referral to North Yorkshire County Council.

Risk assessments were poorly completed and when they were in place there was no clear action plan about how the risk should be managed. One person had a risk assessment in relation to falls which said the person needed a mattress on the floor at the side of their bed. We saw this was in place. The person was in a profiling bed with bed sides, staff told us they were told they were not allowed to put the bed sides up. They did not know who had given them this guidance and we could not see a risk assessment related to the use of bed sides. We suggested to the manager a request be made to the district nursing service to consider this.

The person had fallen twice in August 2015; once from bed and once from a chair. The service had not considered technology which could be used to alert staff if the person had fallen. This meant people were at risk because the service had not put adequate measures in place to manage identified risks to people.

The service had not completed an assessment of people’s ability to summon assistance from staff. We spoke with the manager who agreed most people would be unlikely to be able to call staff for help using the call bell system. This was due to their dementia. This was supported by comments from relatives. A relative said, “My relative wouldn’t know how to use a buzzer”. The call bells were seen to be consistently stored on the wall out of reach of people in their bedrooms. There were no risk assessments in place in

Inadequate

Is the service safe?

relation to this and no use of telecare to mitigate the risks to people. For example one person was in their bedroom throughout the inspection. We were told they could not call for help from staff using the call bell. There was no consideration to technology such as a pressure mat which would alert staff should the person have fallen.

The call bell system was not fit for purpose. A handwritten key was stuck to the wall to tell staff where the call bell had been activated. However, we heard a buzzer ringing. Staff ran to bedroom nine, as the number nine had come up on the call bell system. However, the number nine was not bedroom nine but was actually the downstairs toilet. We saw the person come out of the toilet independently as staff had gone to the wrong room.

Accidents and incidents were not reviewed. This meant there was no oversight of incidents or a plan of action which might be required to reduce the risk of incidents occurring again. The manager showed us an accident and incident book they had started. However, we saw one person with a bruise to their forehead. This had not been recorded in the incident book. The only record we could find was a brief reference on a body map. Therefore, we could not see what action had been taken to address any immediate risks to the person's health and wellbeing.

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

Staff were able to explain safeguarding procedures. They described the immediate action they would take if they witnessed abuse and were aware of how to report it. We were aware of recent safeguarding incidents which had been referred to the local authority safeguarding team for investigation. CQC will continue to monitor the outcome of these investigations. The service had reported safeguarding incidents to CQC.

Inadequate

Is the service effective?

Our findings

At our last inspection we found staff had not received the training and support they needed to be able to deliver effective dementia care for people who used the service. Supervision was not being held on a regular basis. This meant people did not have the opportunity to review their practice or discuss any development needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan telling us what they would do to correct the issues. Although we found some improvements we concluded the training provided was not sufficient to support staff to deliver effective care.

The manager had devised a training matrix. This meant they were able to see who had completed what training, and could keep a track on when the training update was due. The training matrix showed an improvement in training courses staff had completed since our last inspection. However, there were still significant gaps in training. These related to moving and handling training, record keeping, nutrition, and equality and diversity.

We discussed with the manager the lack of moving and handling training as we could see none of the night staff had received this. This meant people could be at risk of injury as staff had not received training about safe moving and handling practices. We identified one person who needed assistance with moving and therefore the lack of training posed an actual risk to a person who used the service.

All of the training was online. The manager told us they were keen to set up face to face training with local providers as they did not think online training was always the best way for staff to learn. Staff told us they did not receive any additional time to complete training. This meant it had to be completed whilst they were working or in their own time. The manager had not yet started any competency checks to ensure the learning had been put into practice. However, they said this was something they wanted to do.

During the inspection a member of care staff had come into the service to complete some on line training. They did this in the communal area. We spoke with the manager about the effectiveness of completing training in a busy environment as we were concerned staff could not concentrate on the learning.

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

The manager told us staff would have supervision every two months, and we saw supervision had started for some staff and had been booked in for others. This was being planned based on the needs of individual staff. Supervision should be an opportunity for staff to discuss any training and development needs, any concerns they have about the people they support, and for their manager to give feedback on their practice.

At the last inspection we found Mental Capacity Act assessments were not detailed. Where people were unable to give consent we did not see any best interest decisions were recorded, this meant care staff were not following the principles of the mental capacity act when planning and delivering care to people. We also saw evidence of care being delivered without staff seeking permission or explaining what they were doing. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act (MCA) 2005 provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make specific decisions for themselves. The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards are in place to protect the rights of people who use services, by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm.

We looked at three people's mental capacity assessments. These had been completed following our last inspection. They contained detailed information about how the assessment of capacity to make a specific decision had been made. Where people were unable to make a decision we could see a record of a best interest decision taken on the person's behalf.

Inadequate

Is the service effective?

Staff were able to tell us about importance of seeking consent. One member of care staff gave us an example of supporting someone to choose their clothes in the morning. We saw staff offering explanation to people about what they intended to do and seeking their permission.

At this inspection we found that the provider had followed the action plan they had sent us to meet the shortfalls in relation to the requirements of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The chef worked from 8.30 am until 1 pm five days a week, outside of these times care staff were expected to prepare meals. An additional member of staff worked on the chef's days off. Everyone had their main meal at lunchtime. People did not have the option to eat a main meal at teatime because of the hours the provider employed a chef. The manager contacted us after the inspection to say people could have the lunchtime meal reheated if they wanted to eat later in the day. People's care plans did not contain a record of their preferences in relation to food. This was an institutionalised approach to delivering care.

However, people and their relatives told us they were generally satisfied with the amount and quality of the food provided. One person said, "The food is hot and the right amount."

A new breakfast menu which had been developed by the manager, this contained pictures to help people choose what they would like to eat. However, we did not see staff using this to help people make choices. If people got up before 8.30 am they were offered cereal or toast and drinks which was provided by care staff. If people wanted a cooked breakfast they had to wait for the chef to arrive. The manager contacted us after the inspection to say people could have a cooked breakfast and this would be made by care staff before the chef arrived. However, we did not see this being offered during our inspection. We saw some people ate breakfast late, and because the hot meal was served at 12 pm there were only a couple of hours between each meal.

We were given a copy of the lunch time menu. The menu plan did not correspond with what people were given to eat. The manager explained staff were not following the menu plan and told us they were in the process of developing a new lunch time menu. They said this would be in place soon and staff would adhere to this. At the time of our inspection the service did not have effective system in place for planning and providing varied meals.

At lunchtime we heard someone ask for a ham sandwich as an alternative to the two cooked meals. The chef said they had run out of ham, but the person could have an egg mayonnaise sandwich, a member of care staff asked what other sandwich fillers were available and was told, "none." People were asked whether they wanted tinned fruit and ice cream for dessert. However, people were given tinned fruit. The chef told care staff they had run out of ice cream. There was no explanation given to people about why there wasn't any ice cream. The lack of explanation, or apology, showed a lack of respect.

We spoke with the chef about the food ordering system. They told us they were not responsible for ordering the food. They said a shopping list was kept in the kitchen and then a member of care staff ordered the shopping which was delivered from the supermarket once a week. They told us the reason they had run out of some food was because they were due a food delivery the following day.

The chef was not aware of a budget for food. The manager told us the provider advised there was no set budget. They checked with the provider how much had been spent on food over the last four weeks. The average spend per person, per day was £2.85. The provider could not be assured this was a sufficient amount of money to provide nutritious meals as there was no evidence of the service planning or evaluating the meals provided to people. The approach appeared to be based on a shopping list of food rather than a plan of healthy and varied meals.

The evening meal consisted of snack food, on the first day of our inspection people had spaghetti or tinned tomatoes on toast. Care staff told us they made sandwiches or snacks for people. This was because there were only two members of care staff on duty and they were responsible for supporting people, giving medication and making the evening meal. This resulted in a lack of choice for people who used the service.

We saw people were given drinks and biscuits throughout the day. On the first day of our inspection we saw people had ice lollies and choc ices in the afternoon which they enjoyed. We were told three people were on fluid

monitoring charts, two of these people spent the majority of time in their bedrooms and needed prompting by staff to remember to eat and drink. We visited two people in their bedrooms and saw they had drinks.

We observed lunch on the first day of our inspection. Tables were covered with clean tablecloths and there were knives and forks on the table, but there were no serviettes or condiments. A large vase of artificial flowers dominated the centre of the tables and obstructed the view across the tables. There was no menu on display. The room was very quiet. There was no background music or talking between people who used the service. Interactions staff had with people were task based.

The lunch time meal options were homemade meat and potato pie or fish fingers with vegetables and mash potato. A member of care staff offered people either 'red' or 'orange' to drink and brought squash for everyone. People were not asked about whether they would like to wear clothes protectors. This meant staff did not recognise the need to protect people's dignity by offering them something to help keep their clothes clean.

There were times when people were left alone to eat. One person started eating, the other sat for quite a long time before picking up their fork, they appeared unsure what to do with it and then put it down again. They then picked up the knife and pushed a knife full of potato straight into their mouth. A member of care staff, who was in the other lounge, was called by the inspector to make sure the person was supported to eat safely. Once they arrived they were kind and patient. They helped the person to use a spoon and fork to eat effectively, and they took the knife away. However, they then went to assist someone else this meant the person was left to eat without support or encouragement despite staff being aware the person was finding it difficult to eat independently.

People had been weighed each month. However, the weight records in August reported the weighing scales were not working. People had not been weighed since then. We discussed this with the manager, who then contacted the provider. They told us they would ensure the scales were fixed or replaced.

Although we did not see any evidence of significant weight loss, the diet offered to people was not varied or planned effectively. People's preferences had not been taken into account. People were not supported to choose when to have their main meal; this appeared to be based on staffing levels within the service. Overall, The lunch time experience was a missed opportunity for people to have an enjoyable experience.

Requires improvement

Is the service caring?

Our findings

At the last inspection on 28 and 29 April 2015 we found people did not receive warm, compassionate care. We saw examples of care being 'done to' people, without explanation or reassurance from staff. People were distressed and agitated and not all staff knew how to respond to this.

Care plans were not person centred or up to date and were not consistently followed. They contained minimal information about people's life history or preferences about care routines and daily life. This meant the provider could not be sure care and support was being provided in line with a person's previous wishes and lifestyle choices.

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

The provider sent us an action plan telling us what they would do to put this right. At this inspection we saw some improvements to how care was delivered. However, there was evidence of institutional care practices, confidentiality was not consistently respected and care was not planned or reviewed based on people's preferences. On this visit we arrived at 7am and everyone was in bed. We spoke with the night staff who told us they had previously been under pressure to get people out of bed before the day staff arrived. They told us this had now changed and they gave people a choice about what time they got up. They said this varied from day to day, depending on how people felt.

Staff respected people's privacy and dignity. A member of care staff asked someone if they wanted to get up, "Morning. Are you ready to get up? Okay, I'll come back in a bit." They spoke in a calm and kind tone to the person. People were given cups of tea in bed and staff went back at regular intervals to check whether they were ready to get up.

The atmosphere was calmer than on our last inspection visit. People's personal care needs had been met, they looked well cared for. We saw less distress from people. A member of staff told us they felt able to support people who were upset or agitated because of their dementia. They said, "I talk her down, walk her around or if necessary gently move her away." A relative told us, "I've seen carer's take a wandering lady by the hand and gently encourage her to do something else."

Throughout our inspection staff spoke kindly to people. They made sure they had eye contact with people and got down to their level when talking with them. We saw one resident became quietly tearful, sitting at the table after lunch. A member of care staff observed this. They crouched down to the person's eye level and asked, "Are you going to talk to me? Look at me; I don't like to see you upset. What's the matter?" The person became more settled, less tearful and interacted with them. They went and got the person some tissues and helped them wipe their face. They then checked the person was happy to move from the table and assisted them into a more comfortable seat.

Relatives we spoke with told us they were able to visit anytime and were always made to feel welcome by staff. One relative said, "The first time I visited I thought, I don't like this, it felt sparse and cheap but the caring has always been caring and compassionate. I've never witnessed anything to the contrary."

Although we saw some examples of compassionate care from individual members of staff, the majority of interaction we observed was task orientated. There was evidence that the service operated elements of care practice which were institutional.

There were set routines for people who used the service. People ate lunch at midday, once lunch was finished we observed people being taken, one by one, to the toilet and then being given a drink. This was a task based approach to care and was not based on people's preference.

People were only able to eat their hot meal at lunch time; this was because of the hours worked by the chef. We did not see any documentation to suggest this was people's preference. There was no hot main meal from 1pm until the next morning at 8.30 am. This was because of the staff available within the service.

People's privacy and confidentiality was not consistently respected. The staff handover took place in the main lounge, people were sitting in the lounge, and staff discussed everyone's needs. There did not appear to be an understanding of the need to respect people's confidentiality. The main office desk was in the lounge and discussions took place with health and social care professionals whilst people, their relatives and visitors were around.

Staff could tell us about people's care needs and preferences and one person said, "The carers know my

Requires improvement

Is the service caring?

[relative] very well and she seems to be happy." However, we did not see records of people's preferences being taken into account when planning care. Care plans contained minimal information about people's likes and dislikes. This meant care and support might not be provided in line with a person's previous wishes and lifestyle choices.

The service had a 'bath book', this record had each person's name and the day they would be supported to have a bath. A member of care staff told us people were supported to have a bath whenever they wanted but this record was a guide for staff. This approach to care was based on routines developed by the service, rather than a person centred approach which would have taken into account when people wanted to bathe and planned for this within their individual care plans. This showed a lack of dignity and respect to people.

The manager explained to us the service had started to complete life story books with people and their families. This was to help staff understand people's life experiences and what was important to them when receiving care. Out of the four life story books we looked at; one was empty, two contained brief information about the person. Only one was completed fully, it contained photographs and important information about the person's life. We were told this person's family had completed the life story book. This meant staff did not have the understanding of what was important to people and how they might want to live their life.

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

Inadequate

Is the service responsive?

Our findings

At the last inspection on 28 and 29 April 2015 we found care was not assessed, planned or delivered in a person centred way. Care plans were difficult to follow and did not contain detailed information to enable members of care staff to know how the person should be supported. We found limited information about people's preferences, and life histories. In addition to this care plans were not being followed by care staff and we did not see any evidence of people or their families being involved in the development of people's care plans or reviews. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan to tell us what they would do to put this right. However, at this inspection the manager told us significant gaps remained in the quality of care planning and risk assessments. They told us this was a priority area of work, but we did not see evidence this had started.

We looked at care plans and associated documentation for five people. We did not see improvements in care planning. We found care was not assessed, planned or delivered in a person centred way. Care plans remained difficult to follow and key information was recorded in multiple places which sometimes gave staff different guidance about how to support the person.

People and their families were not involved in planning or reviewing care. We continued to see care plans had been reviewed each month with records such as, 'no change in needs' or 'remains the same at present.' Although relatives told us they were not involved in care planning, they did think they were kept informed by care staff about any changes to their relative's needs.

The manager told us she had requested an occupational therapy assessment for one person because their transfers were unsafe. Care staff were taking some of the person's weight when they were assisting them to move from their bed to a chair, we were told their ability to weight bear varied. The occupational therapist visited on the first day of our inspection, their advice was that the person should remain in bed at all times because the current technique being used was unsafe. The manager explained the person was being re-assessed, by the local authority for nursing care.

We looked at the person's care plan and found this was out of date. It referred to the person being able to walk short distances. This had been completed by the registered manager in May 2015 and had been reviewed monthly. Each month the record indicated 'no change'. However, the manager told us staff had indicated that this person had been unable to reliably weight bear for some time.

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

There was a lack of meaningful stimulation for people. During the inspection we found people were sedentary, drowsy and difficult to engage with. The lack of activity, other than care orientated tasks, resulted in people being disengaged from what was going on around them.

However, in the afternoon of the first day of our inspection we saw people become animated for a short time. A member of staff had put music on which people connected with, and they also handed out ice lollies. People smiled and looked much more engaged with what was happening around them. This showed people's mood lifted when they had music and activity which they could connect with.

Staff and relatives told us more stimulation and meaningful activity was needed for people. Relatives told us, "Since the last manager has gone the place is more sociable. It needed to happen," however, they went on to say, "Some days there's enough stimulation and not others. My [relative] wants to go to sleep after 15 or 20 minutes."

Other comments from relatives included, "My [relative] used to be more engaged with activities but it's not so easy now. This is down to [their] deterioration. Last year [my relative] was in the garden a lot and it made them happy. Now it's difficult for [my relative] to focus," and, "I don't know what they can do regarding stimulation. There was painting the other day. Only two or three residents are interested usually."

We spoke with the manager about activity being meaningful to the person involved. Group activity not always suitable for people living with dementia. The one person who had a completed life story book had a lot of information about what they enjoyed doing. However, we did not see this translated into planned activity for them.

Inadequate

Is the service responsive?

The service had started to record activities. We looked at the activity records for September and they contained the following; visits from family, chatting to staff, baking, dough crafting, DVD, chair exercises.

We were told activity took place in the afternoon. This was because it was arranged by care staff and they had more available time in the afternoon. Activity and occupation needs to be something people can engage with throughout the day rather than at set time. This is particularly important for people living with dementia, as there may be periods throughout the day when they are more settled.

People who remained in their bedrooms were more isolated, although we saw staff check on people throughout the day this was task based. For example they checked they were okay, or attended to their personal care or gave them a drink. There was no evidence of one to one interaction.

The service had recently held a welcome party for the new manager. Relatives and visitors had been invited to meet the manager. Feedback from a relative had been recorded by the manager, "[The service] has improved over the last weeks. Today has been a day to enjoy and I think everyone would say the same thing. [Name] has enjoyed herself, plenty of things on the wall to look at."

From 24 August to 1 September 2015 five compliments had been received. Comments were made in relation to improvements to the environment, cleanliness and staffing. The manager had shared these with the staff which showed they were committed to sharing positive practice and recognising the need to get feedback about the service.

Relatives told us they would know how to make a complaint if they needed to. They told us they would feel comfortable in raising issues. One relative said, "If I had a complaint I would tell them. I make sure I'm listened to." Another said, "Now I know it's the new manager to go to with concerns."

Inadequate

Is the service well-led?

Our findings

At the last inspection on 28 and 29 April 2015 we found record keeping was poor and audits were not effective. There was no evidence of good practice being used to support people who were living with dementia. The service did not have effective leadership in place.

This was a breach of Regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan telling us what they would do to correct the issues. However, we did not see any improvement in record keeping, audits or good governance.

Since the last inspection the registered manager had left the service. A new manager had been recruited and started three weeks before our inspection. The manager was supported by a deputy manager, care and ancillary staff.

Despite the challenges within the service staff morale was high. All of the staff we spoke with told us there had been improvements since we last inspected and expressed feeling confident the new manager would be able to make the improvements required to ensure people received a good standard of care.

We saw evidence of detailed staff meeting minutes which showed a staff meeting had taken place since new manager started in post. The minutes contained clear information about what they expected from staff. All of the relatives we spoke with were aware of the new manager being in post. They had been invited to a welcome tea party to meet them and discuss any concerns.

We found the manager to be open and honest during the inspection. They were able to give us a good account of the service, and identified areas they thought needed improvement. Despite this information which related to the management of the service was disorganised and difficult to follow.

Record keeping was poor. This was in relation to records relating to individuals and the service as a whole. Key information was recorded in multiple places which resulted in staff spending a significant amount of time completing paperwork. Records were difficult to find and follow. For example body maps, which are used to record injuries people have sustained and the action the service had taken to address them, were used for one person multiple times so it was difficult to follow the information recorded. The action taken contained a lack of detail. This meant we could not be certain the service had taken the action required to keep people safe.

We looked at three fluid monitoring records. Staff had recorded 'sleeping' from 8 pm until 7 am which indicated people had not been given a drink. However, staff told us they had. In addition to this the record was completed at the end of the care shift. It was not a reliable contemporaneous record. We saw people had access to drinks but records meant we could not be sure people had been supported to drink an adequate amount of fluid.

We could not find any evidence of audits. We asked the manager who shared with us a cleaning and mattress audit which they had introduced. We were not provided with any other audit documentation so we could not see what issues the provider and manager had identified or how they planned to resolve these.

Policies were out of date and as a result of this staff did not have access to up to date guidance and practice. So they could not be sure they were delivering the best care and support to people who used the service.

At the last inspection on 28 and 29 April we reported that there was no evidence of consistent good practice at this service, particularly in relation to the care of people living with dementia. Despite reporting the concerns to the provider we found this remained the same at our recent inspection. There was no evidence to suggest that the service was using NICE guidelines or other relevant guidance in their care of people with dementia.

There was no overall action plan in place, other than an environmental action plan. Therefore, we could not be assured action was taking place to address the wide ranging concerns we reported on at our last inspection. This meant we could not be confident the issues would be resolved. There was nothing to assure CQC changes would be implemented and people would receive a good standard of care.

The new manager was 'fire fighting' issues as they arose. They told us they felt well supported by the provider, however, there was no record of any discussions which had taken place to support the new manager to prioritise the significant amount of work required to improve the service.

Inadequate

Is the service well-led?

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