Lifestyle Care Management Ltd

Derwent Lodge Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 17, 18 and 19 January 2017 and the first day was unannounced. At our last comprehensive inspection of this service on 26 and 27 January 2016 we found breaches relating to good governance in respect of record keeping. We carried out a focussed inspection of the service on 17, 18 and 21 October 2016 and found breaches relating to safeguarding service users from abuse and improper treatment and safe care and treatment. At this inspection we found improvements had been made in respect of the previous requirements but further improvement was still required with record keeping.

Derwent Lodge Care Centre provides nursing care for up to 62 people. There are three floors and the units offer nursing care for older people including those with dementia care needs and people with physical disability needs. At the time of inspection there were 44 people using the service.

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was due to leave the service the week after the inspection and an interim manager had been appointed and was already working at the service.

People were not always protected against the risks associated with the inappropriate management of medicines.

Staff recruitment procedures were in place but were not always being followed to ensure only suitable staff were employed by the service.

Although the majority of staff responded well to people's needs, activities were limited and care and treatment was not always provided in a way that met people's individual preferences.

Processes for auditing and monitoring had not been effective in identifying all shortfalls within the service.

Processes for auditing accidents and incidents were not being followed so any themes and trends were not being identified.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA). DoLS are in place to ensure that people's freedom is not unduly restricted. Improvements had been made with related care records, however further improvements were required to ensure information relating to people's mental capacity and DoLS authorisation conditions was identified in the care plans.

Improvements had been made with the care records and the majority were comprehensive and information

was clear. Further work was needed to ensure care records were kept up to date.

The environment had not been reviewed to encompass the sensory needs of people with dementia. We have made a recommendation in respect of this.

Staff demonstrated a caring attitude towards people and took the time to make people feel valued and communicate effectively to meet their individual needs. Some care seen on the first floor was task driven and did not meet people's emotional care needs.

Procedures were in place to safeguard people against the risk of abuse and staff understood the importance of keeping people safe and reporting concerns. Accidents and incidents were being recorded and reported and related documentation completed accurately.

Equipment was being used safely and correct procedures were being followed when moving and handling people.

Systems and equipment were being serviced and maintained. Policies for infection control were in place and were being followed to maintain a clean environment and protect people from the risk of infection.

Staff received training to provide them with the skills and knowledge to care for people effectively.

People's dietary needs and preferences were being identified and met.

People's healthcare needs were identified and they received the input they needed from health and social care professionals.

A complaints procedure was in place and people and relatives said they would express any concerns so they could be addressed.

The interim manager was proactive and approachable and was aware of the areas of improvement required within the service.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

People were not always protected against the risks associated with the inappropriate management of medicines.

Staff recruitment procedures were in place but were not always being followed to ensure only suitable staff were employed by the service.

Procedures were in place to safeguard people against the risk of abuse and staff understood the importance of keeping people safe and reporting concerns.

Equipment was being used safely and correct procedures were being used when moving and handling people.

Systems and equipment were being serviced and maintained. Policies for infection control were in place and were being followed to maintain a clean environment and protect people from the risk of infection.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The environment had not been reviewed to encompass the sensory needs of people with dementia. We have made a recommendation in respect of this.

Staff received training to provide them with the skills and knowledge to care for people effectively.

People's dietary needs and preferences were being identified and met.

People's healthcare needs were identified and they received the input they needed from health and social care professionals.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Staff demonstrated a caring attitude towards people and took the time to make people feel valued and communicate effectively to meet their individual needs. However, some care observed on the first floor was task driven and did not meet people's emotional care needs.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Activities were limited and care and treatment was not always provided in a way that met people's individual preferences.

Improvements had been made with the care records and the majority were comprehensive and information was clear. Further work was needed to ensure care records were kept up to date.

A complaints procedure was in place and people and relatives said they would express any concerns so they could be addressed.

Is the service well-led?

Requires Improvement

The service was not well-led.

Processes for auditing and monitoring had not been effective in identifying all shortfalls within the service.

Processes for reporting and recording accidents and incidents were being followed, however processes for auditing accidents and incidents were not being followed so any themes and trends were not being identified.

The interim manager was proactive and approachable and was aware of the areas of improvement required within the service.

Derwent Lodge Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 17, 18 and 19 January 2017 and the first day was unannounced. Before the inspection we reviewed the information we held about the service including information received from the local authority and notifications. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about.

The first day of inspection was carried out by two inspectors, a pharmacist inspector, a specialist advisor and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. They had experience with older people with dementia care needs and of care services for older people. One inspector attended for the other two days of inspection.

During the inspection we viewed a variety of records including risk assessments and associated care documents for eight people, daily care records for six people, medicine administration records for 35 people and a selection of other records including staff training records, safeguarding records, incident records, audit and monitoring reports and policies and procedures. We used the Short Observational Framework for Inspection (SOFI) on the first floor. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed interaction between people using the service and staff on all floors.

We spoke with nine people using the service, nine relatives/visitors, a GP for the service, two managers from a care agency, the clinical and operations director who was also the nominated individual for the provider, the registered manager, the interim manager, a peripatetic manager, four permanent registered nurses, one agency registered nurse, eleven permanent care staff, four agency care staff, the chef, a kitchen assistant, the maintenance person, the housekeeper and two domestic staff. We attended two relatives' meetings that were held on the first day of inspection.

Inadequate

Is the service safe?

Our findings

Medicines were not always being managed safely and this had placed people at risk. We looked at medicines administration and storage on all three floors of the service. They were using manufacturers' original packs of medicines as the pharmacist was unable to dispense into the usual monitored dosage system because prescriptions had not been received from the GP in time. Two floors of the service managed this change safely, organising supplies, and the medicines administration records viewed correlated with the supplies. When records and supplies were audited we could see that people were receiving their medicines as prescribed. Records were made of receipts, administration and disposal of medicines and allergies were recorded for all people living in the service.

On the first floor there was a substantial amount of stock in the medicine trolley and it was difficult to find people's medicines. We observed that it took approximately three hours to give medicines to the people on this floor on the first morning of the inspection. The nurse had difficulty locating individual medicines. We looked at a sample of the medicines administration records. It was only day two of the medicines cycle and we observed gaps in recording the administration of medicine for four people. When we tried to reconcile supplies with records of administration we found discrepancies for five people. The peripatetic manager carried out an audit of supplies with records of administration for all of the people on the first floor on the second day of inspection and found discrepancies for 11 people. This meant people were not receiving their medicines as prescribed and this had placed them at risk. On the first floor the clinical room was very untidy with empty medicine packs not discarded and gaps in the recording of fridge temperatures. The interim manager delegated two nurses to re-organise the medicines trolley and supplies on the first floor.

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

We observed medicines being administered to four people. All had swallowing difficulties. We saw these people had their medicines administered covertly and/or crushed. They had individualised protocols and appropriate authorisations from the GP, pharmacist and relative, in line with the Mental Capacity Act 2005. Several people in the home were prescribed medicines 'as required' for pain relief, agitation or as a laxative. There were appropriate up to date protocols in place to cover the reasons for giving the medicine and what to do if there was no benefit. We looked at storage of medicines and all were secure in locked trolleys or a locked clinical room.

We were told the GP visited weekly and that they reviewed people's medicines when they saw them rather than on a planned rolling review programme. We saw for some people with swallowing difficulties they were prescribed paracetamol tablets which nurses were crushing and other medicines where there were more appropriate formulations available. All people on the first floor had individual crushers for use when giving their medicines. We discussed this with the GP who said they would review this and where appropriate prescribe liquid or dispersible forms of medicines for people that required them. On the second day of inspection we spoke with a nurse who had administered the morning medicines on the first floor and they told us they had only crushed medicines for one person that morning, however the medicine round had

taken over three hours to complete and some people had refused their medicines. During the inspection the interim manager carried out an audit of the authorisations for people to have their medicines given covertly/crushed and identified some medicines where crushing was contraindicated or alternative forms such as liquids were available. The interim manager arranged meetings with the GP and pharmacist to discuss the issues identified in respect of medicines management.

Recruitment procedures were in place but were not always followed to ensure only suitable staff were employed by the service. Application forms had been completed, however for two staff there were gaps in employment and no explanation recorded. We saw this had been identified at interview for one new member of staff and the interim manager said they had discussed it and the staff member had agreed to supply updated information, however this had not yet been received. Two references were available on each file, however for one member of staff the references did not tally with the employment history and there was no explanation for this recorded. We asked the registered manager about this and she told us she had interviewed the member of staff and then went on holiday, so she did not have an explanation.

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

Criminal record checks such as Disclosure and Barring Service (DBS) checks, photographs, proof of identity documents including passports and information regarding staff members' right to work in the UK were available. For nurses information about their qualifications and evidence that they were currently registered to practice with the Nursing and Midwifery Council and expiry dates of their personal identification numbers (PIN) was available. Information regarding the fitness of staff to work at the service was not contained in the records viewed. The nominated individual told us health questionnaires were sent out by and screened at head office and any relevant issues were passed onto the home managers. This information was not included in the recruitment policy and the peripatetic manager confirmed this had already been flagged up with the provider and they were awaiting an updated policy to cover this. The service was using a high number of agency nursing and care staff, especially on the first floor, and they were recruiting permanent staff to these positions. For agency staff the managers confirmed they obtained profiles of each member of staff prior to them working at the service.

We asked people if they felt safe and comments included, "I feel safe.", "I have no worries at all about my safety" and "I know the staff care for me and want me to be ok." One person was very firm about how "safe the staff make me feel." One person said, "the staff are so nice and kind". However another told us, "Although some staff rush me sometimes I have learnt to adapt but they are not nasty or unkind. I know they are busy sometimes."

The service had a dependency chart to determine each person's dependency level to assist with calculating staffing levels. The majority of staff said that they felt there were enough staff on duty to meet people's needs. Staff on the second floor said that although most people required the assistance of two members of staff to move them, there were enough staff to meet everyone's needs and people did not have to wait for care. Staff on the first floor said there were enough staff and we observed that there were always staff around and people did not have to wait for care. Due to the issues identified on the first day of inspection with the first floor medicines, the interim manager arranged for a second nurse to be on duty in the mornings on this floor in order to provide additional nursing cover, as the morning medicine round was taking a long time to complete. She said this would be in place for this 28 day cycle of medicines to ensure medicines were properly managed on the floor and the medicine rounds completed in a timely manner.

Staff on the ground floor said that they could meet everyone's needs but that they had to run a 'tight ship'

and there was no flexibility. For example, on the first morning of the inspection someone required urgent help in the lounge. The four carers were assisting people with getting up and one had to leave to attend to the person in the lounge. The person they had been attending to required the support of two members of staff so they had to wait until the second member of staff came back to assist. Staff also said there could be delays with breakfasts due to staff providing personal care and not being available to help. We saw staff were present in the lounges so they could observe and speak with people and help maintain their safety. Although staff were often busy the atmosphere was calm.

At one relatives' meeting two concerns were raised regarding the night time and someone not always having their call bell in reach or a delay in staff attending when a call bell was rung. The interim manager reassured relatives that she would look into the matter. She also explained that she was living at the service during the week and walked about during the night to ensure people were safe and being well cared for. We saw records that recorded staff checked people each hour so that if they were unable to use a call bell the staff were available to see if they were safe and required any assistance. We discussed the concerns regarding the ground floor staffing and the interim manager said staffing levels would be kept under review to ensure people's needs were being met.

Staff had received safeguarding training and were able to demonstrate a good understanding of this topic. They described what they would do if they were concerned about someone's safety and felt confident speaking with the senior staff or manager. One member of staff said, "If I had any concerns I feel I could speak to the person in charge or with managers. It would not be easy because it is so important and serious, but that would not stop me." Incidents of unexplained bruising and injuries were being reported to the local authority and the majority of these involved people living on the first floor. Care staff knew to check people's skin for any changes and said they always reported changes in condition or any injuries to the nurse.

At our inspection on 17, 18 and 21 October 2016 we identified discrepancies in documentation relating to bruising which had not been followed up. At this inspection we saw that for two incidents of unexplained injuries, these had been recorded and staff had provided statements following the finding. The information provided tallied with that on the incident form. The interim manager had issued each department with a memo reminding all staff of the importance of reporting any concerns without delay and staff had signed to confirm they had read it. We asked staff about whistle blowing procedures and they were clear about contacting outside agencies such as the local authority, the Care Quality Commission and the police to report the concerns. Agency care staff told us they would report any concerns to the nurse or the manager and would also inform the senior staff at their agency, in line with the agency's policy.

Prior to the inspection a concern had been raised in relation to non-nursing staff being involved with secondary administration of medicines when a medicine error had been reported to the interim manager. Action had been taken by the service and the matter had been reported to the local authority. A concern regarding this practice was also raised with the interim manager during the inspection and they reported this to the local authority. As part of our inspection we asked some non-nursing staff if they ever gave medicines to people and they told us they did not. Two care staff said that they had been asked to do this in the past, however in a meeting a few months ago it had been made clear to them that this practice was unacceptable and must not occur. We asked non-nursing staff what they would do if a nurse asked them to assist in this way and they said they would refuse and would report the matter to a manager so it could be addressed.

At our inspection on 17, 18 and 21 October 2016 we saw that equipment was not always used safely and people were at risk of injury. At this inspection moving and handling techniques used by staff were safe and staff offered reassurance to people about what they were doing. Staff supporting people in wheelchairs did

so safely ensuring their feet were on foot plates and lap belts secured.

Policies for infection control were in place and were being followed. The environment was clean and tidy. Hoists and other equipment were clean and stored away from communal areas. Living spaces and bedrooms were spacious and clear of obstructions. There were handrails throughout and corridors were unobstructed. We noted a walking frame that required some maintenance and the interim manager took action to arrange to get it repaired.

Risks had been identified and action put in place to minimise them. We saw people's assessments including those for falls risk, use of bedrails, pressure sore risk, risk of bruising and nutritional risk. Incidents of bruising were recorded and incident reports and body maps completed. Photographs were taken and for any unexplained bruising or injuries staff statements were also obtained. Incidents of bruising were reported to the GP and to the local authority. We saw that incidents of bruising had been investigated and where a cause was found this was recorded, for example, for one person bruising had been found to be as a result of them scratching. A care plan had been drawn up for this. For another person a medical condition had been identified as contributing to a higher risk of bruising and this had been recorded. Bruises observed on people had corresponding records, including dated reports, body maps and reports sent to the GP with photographs. There was an incident and accident file in the manager's office and copies of the reports and related documents were kept there so they could be kept up to date.

Risk assessments for systems, equipment and safe working practices were not initially available to view. Those from the previous provider were found and the peripatetic manager obtained the current providers' documents and completed them. They involved the housekeeper and the chef with those relevant to their departments so the information was shared. The nominated individual confirmed all the documents had been available electronically and were accessible to the service.

Records for the servicing and maintenance of equipment were available, including gas appliances, portable appliance testing, passenger lifts, servicing of hoists and legionella testing. Records for periodic checks such as flushing of little used water outlets, exterior lighting, the nurse call system, first aid boxes, the fire alarm and temperature checks of hot water outlets to ensure these were maintained within safe range were seen, demonstrating that systems and equipment were being checked and maintained. A fire risk assessment had been completed in September 2016 and where issues had been identified, dates for action were included and the action plan had been reviewed in December 2016 and identified what action was to be taken and by whom. All actions to be completed were still within the projected timescales. A list of the personal emergency evacuation plans for each person was in the fire file Fire drills had been carried out regularly and staff had received fire training updates to keep their knowledge current.

Requires Improvement

Is the service effective?

Our findings

People were positive about the staff and the care they received from them. Comments included, "The staff are very kind and really look after me.", "I do not want for anything" and "I have a good relationship with the staff and they are so easy to talk to." A relative said, "The staff are really caring and I think they are well trained. It makes me cry when I think of just how well [family member] is treated and just how kind people are to her. The staff have made such a difference to her."

The staff said they had received an induction into the service which including shadowing experienced members of staff and reading policies and records. The staff said they had lots of opportunities for training and that training had been refreshed regularly. They said they had practical/class room based training for fire safety, moving and handling and customer care. Most training was now on line, including dementia awareness and staff felt this was not as useful as classroom based training, as they could not talk about different examples with the trainers and found it more challenging and less useful. However, they all felt they could speak with the nurses or managers if they had any queries. The agency staff told us they had received training in all key areas and that they were involved in team meetings, information sharing and handovers with the permanent staff. They said they had enough information to work at the service. The employment profiles we saw for the agency staff identified the trainings they had undertaken, however these were not dated so it was not possible to ascertain if all the training for agency staff was up to date. There had been communication between the interim manager and the agency provider regarding staff training in moving and handling and refresher training had been carried out for the agency staff to ensure their skills and knowledge were up to date. We saw two agency care staff have on-site supervision from the agency managers, reviewing care interventions and record keeping.

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). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

At our inspection on 26 and 27 January 2016 we found shortfalls in the completion of capacity assessments and consent documents plus DoLS authorisations were not available in people's care records. At this inspection we saw mental capacity and best interest assessments had been carried out and were in people's care records. Do not attempt cardio pulmonary resuscitation (DNACPR) documents were in place and were kept at the front of the care records so they could be easily accessed if needed. These were appropriately completed with GP signatures. Consent forms for a variety of activities including having photographs taken were completed and people with the capacity to do so had signed these.

Where people had been identified as lacking capacity and where it was felt people may be being deprived of their liberty, DoLS applications had been completed and submitted to the placing authorities. Copies of DoLS documentation including authorisations were kept in a file in the managers' office. There were eight DoLS applications that had not yet been responded to and the registered manager confirmed that they had followed these up with the placing authorities and were awaiting assessments to be carried out. DoLS documentation was seen in the majority of care records viewed on the first floor. For one person for whom there was a DoLS authorisation contained in their care records, a mental state and cognition assessment had been carried out, however there was no care plan to reflect the findings of the assessment or that a DoLS authorisation with conditions was in place. Although improvements had been made in this area, further work was required to ensure information relating to people's mental capacity and DoLS authorisation conditions was identified in the care plans for staff to follow.

23 permanent staff had completed training in MCA and DoLS since the inspection on 26 and 27 January 2016. We heard people being offered choices and staff listened to them and encouraged people to make decisions for themselves. One person we spoke with was in bed with bed rails in place. These had an associated risk assessment and capacity assessment. We saw bedrail assessments had been carried out and where they were identified as appropriate for use there were signed consents to the use of bedrails also in place, with one being completed at the time of inspection. Where they were not suitable for use people had beds set at the lowest level and a mattress beside the bed in case they should roll out. This was identified in care records and if people rolled out of bed this was recorded and the person assisted back to bed. For one person we saw they had on one occasion chosen to stay on the mattress by their bed. Staff had recorded and respected this and increased their observations until the person was ready to return to bed.

We looked at the environment on the first floor in conjunction with providing a suitable environment for people living with dementia. Apart from one mirror and toilet doors painted yellow, which was in line with research, we did not see anything that was dementia friendly, no tactile surfaces or interactive items to occupy people or for them to look at. There were several cabinets containing small ornaments and photographs, but these were not accessible or appropriate for the needs of people at the service. In one lounge the television was left on but no-one seemed to be watching it. The environment looked dated and, whilst it was clean and safe, it was in need of redecoration throughout, with particular attention to providing a suitable environment on the first floor for people living with dementia. Following the inspection the nominated individual informed us that the provider had approved a redecoration programme for the service.

We recommend that the service reviews the National Institute for Health and Care Excellence (NICE) guidance about environments for people with dementia to enhance positive stimulation to enable people living with dementia to see, touch, hear and smell items or objects (such as sensory and tactile surfaces and walls, attractive artwork, soothing music, and planting) that give them indicators about where they are and what they can do.

We asked people about the food provision at the service. Comments included, "There is always a choice and I am a vegetarian and I always have enough to eat.", "I don't always want what is being offered but the girls always find something I like……..they definitely would not let you starve.", "The meals are always lovely and you get a choice" and "If it is something I do not like I can always have something else like sandwiches". One person told us, "The food is good but there is always too much on my plate…..a big meal puts me off. I can always have sandwiches though." We fed this back to the interim manager who said she would look into it. One person was being assisted by their visitor and they told us, "I think the care has improved recently, I come regularly and my friend is always well dressed, clean and the skin on her hands is now so soft – they really care for her." The person did not want to eat their lunch and a member of staff said to the visitor, "Do

not worry I believe her [relative] is coming to see her later and we will try again to get her to eat something – we will definitely monitor things." This comment reassured the visitor because they were concerned that the person was not eating.

The kitchen was being well managed with good stock ordering and rotation. Food was stored and prepared safely and temperatures taken. The chef was flexible and knew people's dietary needs, choices and likes. Food was freshly prepared and home cooked and the kitchen staff had received training in food textures and special diets. The chef visited the floors at lunchtime to see how food was served and received. A choice of fruit was available for people throughout the day and there were home cooked cakes with afternoon tea. The chef sought feedback on meals and this was positive. Lunchtimes were calm, organised and staff worked methodically as a team. People were asked what they would like before being served and we saw meals were eaten well. There were soft and pureed options for people with chewing or swallowing difficulties. People were served with hot food and staff were available to provide the support and assistance people required. Use of adapted plates and utensils were in evidence, enhancing and promoting independence.

We asked people if their health was cared for. Comments included, "I can see a doctor if I want to without any problem.", "The doctor comes in regularly I think" and "My health has definitely got better since I have been in here and that is down to the way the staff look after me." There was information in people's care records about visits from health and social care professionals, including social workers, GPs, tissue viability nurse, continence assessor, podiatrist and speech and language therapist. Influenza vaccines had been recorded as given in October 2016 and batch labels placed in the care records to evidence these had been administered. We spoke with the GP who said people were referred for medical input and that people were reviewed every three months.

Requires Improvement

Is the service caring?

Our findings

We asked people if they felt they were treated with respect and their comments included, "The staff are always polite.", "The staff are always nice to me" and "I am treated very kindly – it is perfect here." We asked people if they were able to make choices about their lives. One person said, "I like to stay in bed and the staff bring me a paper and a magazine but they do ask me if I would like to get up and go to the lounge." We confirmed this with a member of staff who told us, "We always ask if we can take her to the lounge but she prefers to stay in bed so we respect this as it is about what the resident wants." We asked people if friends and family could visit freely and their comments included, "I can have friends or relatives here whenever I want to.", "My family come and go as they please and I go out most weekends with them" and "My family come in whenever they like." A relative said "I never worry about leaving [family member] because I know she is well cared for."

We asked staff about caring for people and their comments included, "The teamwork is the best thing about working here. It helps us provide good care to residents. We would prefer all permanent staff but the current agency staff do fit into the team and we get on well.", "I trust my colleagues. When I am busy elsewhere I know they are not far away working the same as me looking after residents in a caring way." and "If I could improve something I think we could be less task driven but there is a lot of work to get through in the day." During the relatives meetings the interim manager asked relatives for their input to provide background information including people's likes and wishes, so that care records could be reviewed to ensure this information was included.

We used the Short Observational Framework for Inspection (SOFI) on the first morning of inspection for 75 minutes in one of the lounges on the first floor. The staff were calm and allowed people to take their time, however, the work was very task based. At mid-morning fruit was served to people who could eat independently but it was not offered to those who could not. Tea was served for everyone. One person requested coffee which a member of staff got for them, but people had not been offered a choice. One person appeared upset. A staff member said, ''Are you alright [person's name]?'' without looking up from the records they were writing. Later another member of staff approached the person and stroked their hand but the interaction did not last long and the staff member walked away. In another instance a staff member went to support a person with a drink. They placed a paper apron on the person without asking them. They supported the person with their drink but did not speak with them. They had a conversation with another person who was sitting behind them, turning to speak with them and not giving their attention to the person they were assisting. For another person staff did ask them if they wanted a paper apron and respected their choice when they said they wanted to keep it after they had finished their drink. We saw that some people's clothing was not clean.

We also spent time observing care and support in the first floor second lounge and in the ground and second floor communal areas and had a different experience. We observed a staff member supporting one person with their lunch. The staff member explained what they were doing all the time, ensuring the person had understood and waited for their response. We saw staff worked calmly and were continually engaging with people. Drinks were available throughout the day and refreshment rounds were well organised and

socially inclusive. There was good staff interaction with people and encouragement to have something as a snack. There was a choice of fresh fruit as an alternative to cake or biscuits, and those who required support were given assistance in an unhurried manner.

With the exception of our observations in one of the first floor lounges, we saw staff worked as a team and had a flexible attitude when people required help. An example of this was when someone required immediate assistance with personal care and staff attended to this. We saw staff knocking on doors and waiting to be granted access to the person's room. We witnessed conversations between people and staff which were comfortable and informal but at the same time demonstrated the respect the staff had for the people. Conversations were initiated by staff and kept appropriate according to the understanding of the person they were speaking with. We heard a conversation where staff asked people if they were comfortable and warm enough. Bedrooms were personalised and the majority of people looked well cared for and their clothing was clean.

We saw people were given a choice of meals at the point of service so they could make a decision at the time. People were addressed by their correct names and staff smiled and spoke in a calm and friendly way. Staff were present in the lounges and combined their observations and interactions with other duties, for example updating daily care records. On the first floor bedroom doors were mainly open, unless personal care was underway. Observation and interactions by passing staff was regular and part of the routine. There were two people cared for mainly in their bedrooms and staff were available to provide the supervision and support they required. People were able to walk along the corridors if they so wished and staff greeted them and encouraged them with their walking. Care records included information about people's preferences including times of sleeping and food and drink preferences.

At lunchtime, one person presented with some behaviour that challenged and threw their drink across the room. A member of staff instantly came and reassured them and another mopped the floor. While they were cleaning up the staff were reassuring the person and offered them a cup of tea and biscuits which was accepted. When the tea and biscuits arrived the person became aggressive again and refused them. The staff showed patience and kindness and dealt with the person respectfully.

Requires Improvement

Is the service responsive?

Our findings

On the first morning of inspection one inspector carried out an observation in one lounge on the first floor. The television was on but no one was watching this. There was nothing offered to occupy people's time. There were no games, dolls, soft toys or activities available for people to use and hold. With one person staff kept referring to taking them shopping, telling them that they would get a taxi and all go shopping after the person had drunk their drink. At no point did the person say they wanted to go shopping except once in response to something a staff member said. The person was not supported to go to the shops. Staff spoke with each other but their only interactions with the people present were functional about the task they were performing, for example, offering them drinks. The staff did not give people the opportunity to respond and apart from one occasion when a member of staff bent down to speak with a person, staff did not get down to eye level or sit with people to converse. The staff members spent most of their time looking at or updating records.

Care plans for personal care indicated how often people should be offered a bath or shower but the daily care records indicated people usually had a bed bath or wash. Some people were resistive to personal care, however it was not clear from the daily care records if they had been offered a bath or shower and had refused. We discussed our findings with the interim manager. She had done some work alongside staff to observe practice and had identified shortfalls in person-centred care. This was part of an action plan for the service to make improvements.

The home had an activities coordinator but they were not on duty at the time of the inspection. There was a board on each floor of the home outlining the activities on offer during the week and these seemed varied, however there was no-one allocated to lead the activities in the absence of the activities coordinator. There were no activities taking place on the first day of inspection. When we spoke with the staff about activities they said that this was the role of the activities coordinator. When we asked them what happened when the activities coordinator was not around they were not able to answer this.

At the relatives meetings taking place on the first day of inspection, areas discussed included the laundry and items not being checked to see if they required laundering before being put in the laundry basket or wrong items ending up in people's rooms. Another area covered was the provision of baths for people, with relatives feeling these were mainly carried out at the weekends and did not allow for people's individual choices.

Relatives asked about the provision of duvets as the service only provided sheets and blankets. The registered manager said these were not available on the order system. We asked the nominated individual who ascertained duvets could be ordered, however the online ordering system did not list them as items that could be routinely ordered. We discussed the importance of providing bedding that met people's individual needs and preferences, rather than the somewhat institutional approach of sheets and blankets for all.

These findings were in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

The interim manager said she would look into all the points raised at the meetings. For example, in respect of timings of telephone calls to relatives to pass on non-urgent information, she said, "The choice of what times relatives would like to be called depending on what information they were being given could be encompassed in the residents care plans." She explained that she wanted people and their relatives to be more involved with the care planning process in order to ensure people's individual needs and wishes and, where appropriate, those of their relatives were clearly identified and could be met. With the exception of one of the first floor lounges, we observed good interaction and staff were responsive to people's needs in other areas of the service and the interim manager was aware that work was needed to improve people's experiences on the first floor.

We asked people about activities and their comments included, "Someone comes in to sing sometimes and that is always lovely.", "There are things to do if I want to.", "I would like it if we went out more on trips – perhaps there could be a mini bus" and "The staff make sure I am ready to go out with my family at weekends." There were two musical entertainments that took place during the inspection and we saw some people doing colouring. There was an edition of the 'Daily Sparkle' which contained stories of what happened in this week in history, including brief biographies of notable people and facts about new inventions and quizzes. The administrator said she distributed the 'Daily Sparkle' to each floor. There were also some folders in one of the lounges with headline newspaper articles from the past.

During the relatives meetings it was announced that there would be some school students coming in to visit once a week as part of their Duke of Edinburgh award and this was seen as a positive occurrence because it would give people new individuals to talk with. It was also announced that a medical student would be volunteering at the service on Wednesday afternoons.

At our inspection on 26 and 27 January 2016 we had identified that care records were disorganised, difficult to follow and updates had not always been included. At this inspection we found care records had improved. The content of some seen on the first floor was long and needed to be condensed to clearly identify the headline care needs, for example, for personal care. The content of the care plans on the ground and second floors was clear and provided staff with the information they required to meet people's needs. Care records had been reviewed monthly. The service had introduced the 'resident of the day' and this meant that the person for each day had additional attention given to them to review each area of their care and support needs and this was reflected in the care records. Care records for wound care were in place and recorded each dressing change and the progress of the wound. Photographs were taken to evidence this. The interim manager had obtained the GP patient summaries for all the people on the first floor in order to ensure people's diagnoses were correctly recorded and to inform the care plans so that diagnosis and treatment information was accurate.

We found some assessment documents for one person that appeared to have been completed for several months together. One nurse explained that it was possible that staff had copied the information from previous paperwork in order to have the full year on the current provider's documentation. We saw that for one person with a wound this had not been accurately reflected on the pressure sore assessment document, although there was a wound treatment plan being followed and the wound was improving. The assessment was updated at the time of inspection. We also found some folders needed to have documentation archived as the folders were quite full. We brought this to the attention of the interim manager who had already identified care records as an area for further improvement. She had obtained blank care documents so new records could be drawn up where required.

The daily care records completed by care staff were kept in people's rooms or brought into the lounges, depending on where people were situated. These contained regular updates of the care being provided. Details included hourly checks, daily skin assessments, food and drink intake including volume and times, elimination records, personal care support given and topical cream applications. Those viewed were up to date. We saw staff updating these at regular intervals throughout the days of our inspection. Daily carer progress notes were also completed and where people required a higher level of supervision and intervention this was reflected in the frequency of entries. There were clear records of incidents of behaviour that challenged, with behavioural charts being completed to cover this and to record the action taken to respond to, manage and review such incidents.

Care plans had evidence of personalised information in the social profiles and life history sections. These referred to people's preferences including diet, music, TV and radio, favourite people and significant life events. We saw pictures of family members were included in some of these. There was also a one page summary page giving detail of information such as, 'my preferred time to nap', 'what my room should be like', 'what I like watching on TV', 'my favourite reading material' and food and drink favourites. Hobbies, interests and culture were also included in the care plans. We were told that no-one currently living at the service had any specific religious or cultural dietary needs, however that these would be taken into account and met if required. The service had input from representatives from the Church of England and the Roman Catholic Church and there was a monthly Christian church service held.

Where staff provided close supervision for someone we saw that they alternated at least two hourly and sometimes sooner to give a colleague a break, especially if the person was becoming agitated or restless and staff responded to their needs and behaviours appropriately. Staff providing close supervision did so in a caring way. On several occasions we saw the cooperation of people was gained by staff using clear, reassuring tones. Handover of care meetings took place twice a day between the day and night staff and we saw handover sheets had been compiled for each floor. These were clear and provided staff with headline information about each person and comments were added if any issues were identified during the handovers.

We asked people what they would do if they wished to raise any concerns and complaints and comments included, "I know who to talk to if I needed to complain and I think they would listen to me.", "I would speak to one of the staff" and "I would try and speak to the manager but I do not really know who she is." A copy of the complaints procedure was displayed in the front lobby area. At the relatives meetings the interim manager encouraged relatives to raise any issues they might have so these could be addressed. The service had received one complaint since the last inspection and this had been investigated and responded to.

Requires Improvement

Is the service well-led?

Our findings

The provider had systems in place for monitoring the service, however these were not effective. During our inspection we identified shortfalls in several areas. These included medicines management, staff recruitment, provision of a dementia friendly environment and person-centred care giving. The auditing and monitoring processes were not robust and so shortfalls were not always being identified and addressed, which placed people at risk.

The provider had an in-house process for auditing a variety of areas monthly including accidents and incidents to look for any themes or trends. These were seen for September 2016, but records were not available to show if a review had been carried out since. Records for the last skin tear and falls management audits were dated August 2016. In-house audits of medicines were scheduled to be done monthly, however audits for December 2016 were not available at the time of our inspection. This meant that the provider's monitoring processes were not being followed and consequently people were being placed at risk.

These findings were in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accidents and incidents were not being monitored. There had been 28 accidents and incidents recorded for December 2016. Although accidents and incidents had been recorded and reported, the last in-house monthly analysis seen in the files to look for themes or trends was for September 2016 and there was no evidence that action had been taken to look for themes or trends for accidents since this date.

These findings were further evidence of a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Quality monitoring visits on behalf of the provider had been carried out in September 2016 and January 2017, the latter being the week before our inspection. In the latest report the quality monitoring officer had identified several shortfalls including care records, medicine management (this did not include those around the crushing of medicines), a lack of in-house monthly audits and a lack of meaningful activities for people to occupy their time. It had also identified some of the servicing and maintenance certificates for the service were not available on file and we saw action had been taken to get copies or to ensure services that were due were scheduled to be carried out. The report from this visit was received on the first day of our inspection and therefore had not yet been added to the action plan for the service. The registered manager said there were weekly conference calls with the provider to go through the action plans and discuss progress and areas for improvement. She said this had now been taken on by the interim manager who was working on improving the service.

The registered manager was finishing at the service the week after our inspection. The interim manager had been employed on a year's contract and was a registered nurse who had worked for many years in a variety of settings including hospitals, care homes and the community. One member of staff said, "Both managers are very good. Whenever I want to talk to them I can always do so."

The interim manager was regarded by staff as a positive influence. She was seen around the service during the inspection and interacted with people and staff in a cheerful and informed way. Staff commented that they were "expecting improvements to come about this year." Staff said that the interim manager had worked alongside them on the floor, listened to their feedback and seemed to really try to understand their concerns. They were happy and impressed that she had put on a uniform and worked with them. One of the staff said, "[Interim manager] is very supportive, open and will listen to your views. She gives respect and will speak to you privately if anything is wrong." Another said, "[Interim manager] is very good, very supportive and she helps."

The staff, housekeepers and chef all said if they asked for any resources these were provided and they felt supported by this. We were also told that there had been a four month delay in the provision of some non-breakable crockery for the first floor, which could be related to budgetary constraints.

All the staff felt able to speak with other staff or the interim manager. The staff said that they worked well as a team and had good communication. One said, "We are like a family." Some of the things the staff liked about the job were, "Getting to know all the residents and the stories of their past.", "Working with the families" and "Helping people and doing the best for them." Several of the permanent staff we spoke with had worked at the service for a long time and said they were happy. They said the recent changes were for the better and they felt things were improving.

Two relatives meetings were timetabled on the first day of inspection and one relative welcomed the addition of the afternoon time, which the interim manager had introduced following discussion and identifying that some relatives preferred daytime meetings. We attended the meetings and relatives were forthcoming with their comments and conversations were open. Minutes of the meetings were taken, the interim manager listened to the points raised and said she would take action to address them.

We saw minutes for the previous relatives meeting in October 2016 and there was a 'next steps' action plan to address the issues raised. At that meeting as well as at the meetings held on the first day of our inspection the managers were open about the fact there had been safeguarding issues raised. Relatives were encouraged to raise any concerns they might have so action could be taken to address them. The last survey for relatives had five responses and comments received were shared and discussed. The need for redecoration had been identified in this and also the new furniture in the lounges was appreciated. A food survey was given out at the relatives meetings for relatives to complete with their family members or, where appropriate, on their behalf.

The service had an action plan that had been put in place to address shortfalls identified by previous CQC inspections, the provider's monitoring visits and also by the local authority, who had raised very significant concerns over several months and were currently not placing at the service. Shortly after our inspection we received a whistle-blowing alert which raised significant concerns about this service. These allegations were passed to the local authority. The evidence we collected during this inspection indicated that people receiving care on the first floor of the service had been placed at significant risk of harm, as also evidenced in the Safe domain of this report.

The interim manager assisted by the peripatetic manager took steps during the inspection to identify the scale of some the issues identified, for example the medicines management shortfalls on the first floor, so she could start taking action to address them. The service had daily 'flash meetings' and an inspector attended one on our third day of inspection. This included the heads of department and lead nurses on each floor. The meeting covered each aspect of the service and got feedback from the managers, chef, housekeeper and nurses. They discussed a variety of topics such as safeguarding, arrangements for deep

cleaning a bedroom, provision of nutritional milkshakes, vacant shifts and holidays to be covered and maintenance areas such as the planned replacement of two radiators on the second floor. Care issues identified included checking daily records were being completed accurately and medicines management, particularly on the first floor. Staff said they found these meetings were good and we saw issues could be flagged up with the management to be addressed.

The service had a Business Continuity Plan in case of emergencies including failure of amenities and action to take in the event of evacuation of the service and contingency arrangements were in place. Notifications were being sent to Care Quality Commission (CQC) for any notifiable events, so we were being kept informed of the information we required.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not: 1. Design care or treatment with a view to achieving service users' preferences and ensuring their needs are met Regulation 9(1) and 9(3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not protect service users against the risks associated with the safe and proper management of medicines. Regulation 12(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person did not operate recruitment procedures effectively to ensure the required information was obtained for people employed at the service Regulation 19(2)(3)(a) and Schedule 3

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered person did not assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). Regulation 17(1)

The enforcement action we took:

We have issued a warning notice telling the provider they must make the required improvements by 18 April 2017