Four Seasons (No 10) Limited

Summerdale Court Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Summerdale Court Care Home was inspected on 8, 9 and 15 February 2017. The first day of the inspection was unannounced.

Summerdale Court Care Home is a large care home with nursing registered to provide care to up to 116 people. At the time of our inspection 87 people were living in the home. The home provides care for older people, people who have a physical disability and people living with dementia. There are four units within the home. Two of these units provide residential care for people living with dementia. The other two units provide nursing care, one of which specialises in providing nursing care for people living with dementia. The home is fully accessible and located on two floors. There are a variety of communal areas including gardens for people who lived in the home.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The last inspection took place in April 2016 when we rated the service as requires improvement and made four recommendations to drive improvement. Although one of these recommendations had been followed, the others had not and we found the quality of care had deteriorated since our last inspection.

People were not supported to be safe as needs assessments, care plans and risk assessments were poorly completed. Measures to mitigate risk, particularly risks around behaviour which challenged the service, were not robust and did not incorporate advice and guidance from healthcare professionals. People's preferences were not consistently recorded, and where they were recorded records did not show they had been respected. People were not involved in writing or reviewing their care plans.

Medicines were administered by trained staff and were stored and managed in a safe way. However, where people were given medicines covertly there was insufficient information in care plans to ensure this was done safely.

People gave us mixed feedback about the staffing levels at the home. Records showed that the home did not always deploy the number of staff their staffing assessment tool showed they needed. Records showed the home did not consistently follow safe recruitment practice as gaps in employment and professional qualification checks were not performed in a timely manner. We have made a recommendation about safe recruitment.

Healthcare assistants received the training they required to perform their role. However, it was not clear that senior staff performing assessments and line management tasks had received appropriate training in these aspects of their role.

The home had made appropriate applications to the local authority where people were being deprived of their liberty. However, it was not clear if people were actively consenting to their care, and relatives had provided consent without clear records they had the legal authority to do so. Staff understanding of the Mental Capacity Act 2005 and its application was poor.

Some people told us they liked the food, but others found it was not to their taste. The menu was varied and people were able to choose food that was not on the menu if they wished. The dining experience was not positive for people who lived in the home.

People told us the staff were caring, and staff demonstrated they treated people with dignity and respect. The home had not addressed our previous concerns about supporting people who identified as lesbian, gay, bisexual or transgender. Information about people's pasts, relationships and interests remained inconsistent.

People told us the activities were limited and it was not clear people were supported with activities in line with their preferences. The home provided a daily schedule of activities but did not maintain records of who attended or levels of engagement with activities provided.

The home had a robust complaints policy and records showed complaints were responded to in line with it. Relatives told us they knew how to make complaints.

Quality assurance and audits were ineffective as they had not identified issues with the quality and content of care plans and risk assessments, and actions in place to make improvements had not worked. The staff team was divided in its opinion of the management of the home and the culture among staff was not positive or person centred.

We found breaches of seven regulations. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as

inadequate for any of the five key questions it will no longer be in special measures.

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 who presented with behaviour that challenged staff and the service were not supported in a positive way to manage their behaviour.

Risk assessments were inconsistently completed and were not clear about what measures staff should take to mitigate risks.

People who received their medicines covertly did not have this managed in a safe way.

Incidents and allegations of abuse were not consistently responded to in an appropriate way.

There were not always the number of staff required on duty.

Staff had not consistently been recruited in a safe way.

Is the service effective?

Requires Improvement

The service was not always effective. Consent was not always sought in line with legislation and guidance. Staff understanding and application of the Mental Capacity Act 2005 was poor.

People gave us mixed feedback about the food. Some people liked it, but others found it unappetizing. The dining experience was not pleasurable for people.

People's healthcare needs were recorded and people were supported to access healthcare services where required. Updates by healthcare professionals were not always included in care plans.

Staff gave us mixed feedback about their experience of supervision. Records did not show all staff had received the training they needed to perform their roles.

Is the service caring?

Requires Improvement

The service was not always caring. People's sexual identity and needs in relation to their sexuality were not captured by care plans so were not supported.

People told us they were not always supported in a way that ensured their religious obligations were met.

People told us the staff were caring.

Staff treated people with respect and promoted their dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans were not personalised and the level of detail about people's preferences varied across the home.

Activities were facilitated, but records were not maintained. People told us they did not have much to do.

People were not involved in reviewing and updating their care plans.

The home had a robust complaints policy and records showed this was followed.

Is the service well-led?

Inadequate

The service was not well led. The home did not have a positive, person centred culture.

Some staff were intimidated by the management team and found them unapproachable. Other staff told us managers were firm but fair.

Audits had not been effective as they had not identified issues with the quality of care delivered at the home.

Summerdale Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. The service was last inspected in April 2016 when it was given an overall rating of Requires Improvement.

The inspection took place on 8, 9, and 15 February 2017. The first day of the inspection was unannounced.

The inspection team consisted of three inspectors, a specialist advisor with expertise in nursing and dementia care 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. This expert-by-experience had expertise in caring for older people living with dementia.

Before the inspection we reviewed all the information we held about the service, including notifications the provider had sent to us. We sought feedback from the local authority commissioning and safeguarding teams and the local healthwatch. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 15 people who lived in the home and six relatives. We spoke with 25 members of staff including the registered manager, the regional manager, the deputy manager, the chef, the maintenance man, an administrator, two activities workers, three unit managers, two nurses, three senior health care assistants, two care home advanced practitioners (chaps) and seven health care assistants. We reviewed 13 people's care records including care plans, risk assessments, and records of care delivered. We reviewed 21 people's medicine administration records and medicines plans. We reviewed the staff files, including recruitment, training and supervision records for eight staff. We reviewed a variety of other records

including policies and procedures, safety and quality audits, accident and incident records, complaints records, maintenance logs, meeting minutes and other documents related to the management of the service.

Inadequate

Is the service safe?

Our findings

When the service was last inspected in April 2016, we made two recommendations regarding the safety of the service. The first recommendation related to the administration of medicines prescribed on an 'as required' basis. The home had followed this recommendation and there were now clear instructions regarding the administration of medicines prescribed on an 'as needed' basis. The second recommendation related to providing support to people living with dementia who present with behaviours that may challenge the service. The home had not followed this recommendation.

Care files for people who presented with behaviours which challenged the service were reviewed. Instructions for staff regarding how to support people with such behaviours were vague and unclear. Staff were instructed to, "Work around it [behaviour which challenged them] with patience, respect and dignity." This was not a clear instruction to inform staff how to respond to behaviours. In another care file staff were instructed, "Be careful during restraining [person] during personal care as they can cause [person] to bruise." There were no guidelines in place to describe appropriate use of restraint and staff told us they did not use restraint. The conflicting information about use of restraint meant this person was at risk of being restrained in an unsafe way. A third person's file showed extensive involvement from healthcare professionals had not been incorporated into their care plan in a timely manner. Staff from the multi-disciplinary team involved with the service told us they did not feel their recommendations were followed consistently and the home did not demonstrate they had exhausted ways of supporting people who presented with behaviour that challenged the service.

Incidents of behaviour that challenged the service, including incidents of violence and aggression to staff were recorded by staff on forms called "Distressed Reaction Monitor Form". These included a section where staff could record any precursors to behaviour and any actions that might prevent future occurrences of behaviour. These were poorly completed and stated there was nothing that could be done to prevent recurrence. For example, two forms described that a person had scratched and kicked staff. One form stated the person had calmed down but had still refused personal care, the other form said the person had calmed down. One form stated, "We tried to calm him down, but no results, so we just changed his pad because he was too challenging."

Records showed staff had been hit, kicked, scratched, punched and throttled by people living in the home. Staff were asked if they were provided with any support after incidents, particularly regarding whether they were able to continue working with people who had been violent towards them. Although staff in one unit told us their line manager would check they were OK, other staff told us this was not provided. One member of staff said, "There is no welfare check after you've been hit. I think that would be a really good idea. It's horrible when it happens. You can't give your best care after you've been hit." After the inspection the registered manager told us staff would be reminded of the availability of the employee assistance programme following incidents of violence and aggression towards them.

Care plans and records of incidents showed that staff were advised to leave people to calm down and return to support them later. This was discussed with the registered manager as being an inadequate response to

people with dementia presenting with behaviour which challenged the service. As a dementia specialist service staff should have been taking a more pro-active approach to supporting people with behaviour that challenged the service. Records showed these approaches had been outlined by the specialist healthcare teams involved with the service. The registered manager told us, "All we can do is walk away" with regard to one person's behaviour. Regarding a second person they said, "We don't feel there is anything more we can do." This meant there was a risk people were not receiving the pro-active support they required to manage their behaviour and were at risk of harming themselves or others during incidents.

Care files contained a range of risk assessments to address areas where people were at risk during their care, such as during moving and handling, mobility, skin viability and risks to people's nutrition. The quality of these risk assessments varied across the different units in the home. Some risk assessments were robust, with clear instructions for staff to follow in order to mitigate risks. For example, a risk assessment relating to one person's risk of developing pressure wounds included clear instructions regarding ensuring the person stayed hydrated, was encouraged to move their position and maintain their personal hygiene. Another person's risk assessment in relation to their mobility and moving and handling included clear instructions regarding where healthcare assistants should position themselves when supporting the person to use their walking aid.

However, other risk assessments were not clear or detailed. For example, one person was identified as being at medium risk of choking in October 2016. Their December review stated they were low risk and updated staff that, "[Person] prefers to eat in his room and can feed himself independently." The January 2017 review stated, "Carers help feed [person] at meal times. Sometimes he refuses." In addition, the initial risk assessment had not been completed properly and the scores used to calculate the level of risk were not correct. This meant people's risks were not being consistently managed in a way that ensured they received support in a safe way.

Medicines were not always managed safely. When people refuse to take their medicines and appropriate assessments have been made, they can be administered covertly. However, specific processes must be followed to ensure this is done safely. Records showed staff were not given clear instructions on how to administer medicines covertly. For example, one person's instructions simply read, "Crush in a drink." This included a medicine that should not be crushed as it can cause damage to the throat. At a previous inspection, in October 2015 the home had been informed this medicine was not suitable to be crushed. The home secured an alternative form of this medicine after we brought this issue to their attention.

Two nurses told us capsule medicines were opened and put into a drink. Medicines are dispensed as capsules for the specific properties of the capsule and removing them from the capsule may make them less effective. Another person receiving medicines covertly had a care plan for covert medicines but this did not list their medicines or explain how each medicine was to be given. There was no specific information from a pharmacist on how to give each medicine. The unit lead told us the medicine was given in porridge or soup. However, there should be clear guidance in place regarding the temperature of the food or drink used to disguise medicines as they can affect their efficiency. The registered manager told us they struggled to get clear instructions from the prescriber of medicines regarding covert administration. However, the home should not be administering medicines covertly without clear guidance about how to do so safely. The lack of clear information regarding how to administer covert medicines safely meant there was a risk that people did not receive their medicines in a safe way that ensured they acted in the way the prescriber had intended.

Medicines were administered by staff who had completed training on administering medicines safely. Records showed two out of 23 staff who administered medicines had not completed the required training. Annual checks of staff competency were carried out to ensure they were administering medicines safely.

However, competency checks were poorly completed and people had been signed off as competent without completing the required steps. Three staff told us their competency had been assessed during September and December 2016 but there were no records available during the inspection to support this. The registered manager told us staff had taken their recorded assessments home as it was part of their assessment for the newly created role of Care Home Advanced Practitioner. This meant the systems in place to ensure staff were competent to administer medicines safely were ineffective as records were incomplete or unavailable.

Observations showed that medicines cups were being washed and re-used. In one of the nursing units medicines pots were being dried on a dusty radiator which was a potential infection control hazard. Single use medicine pots were being re-used. This meant there was a risk that people were exposed to infection control hazards during medicines administration.

The above issues regarding risk assessments, challenging behaviour and management of medicines are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records of medicines administered were reviewed. Each unit had shortfalls in the recording of topical medicines and powders prescribed to thicken fluids for people with swallowing difficulties. Medicine administration records (MAR) were coded with the letter F but there was no explanation of what code F meant. Seven staff told us that code F meant a health care assistant had administered the medicine. However, this was not recorded on the MAR to clarify who had administered the creams or the times thickeners had been added to drinks. Records showed there were weekly audits of MAR charts. Medicines stocks and storage facilities were checked. 20 people's medicines stocks were checked and all were correct. The temperatures of medicines storage rooms and fridges were checked daily and staff were aware of the procedures to follow should temperatures go above or below the stipulated range.

Observations of medicines administration showed staff administered medicines safely. Staff checked and verified the medicines were correct and waited until people had taken their medicines before recording them as administered on the MAR. Staff were able to explain the medicines ordering process and the process for returning unused or spoiled medicines. Medicines trolleys were kept locked in locked treatment rooms when not in use. People living with diabetes and on anti-coagulation treatment were monitored appropriately and had their medicines reviewed regularly in order to safely manage their symptoms.

People told us they felt safe in the home. One person said, "Of course I feel safe." Another person said, "I do feel safe, having these people help me." A relative told us, "As a family we are happy." The home had a robust policy for safeguarding adults from harm. Training records showed there were 15 staff who had not completed training in safeguarding adults.

Health care assistants told us they would report any concerns they had that people were being abused to their unit managers. One healthcare assistant told us, "I'd inform the nurse in charge, if you see something or are concerned you should tell them." However, when asked how they would respond to an allegation made against a healthcare assistant, all the staff we spoke with who had line management responsibility described investigating and responding to the concern without referring it to the local safeguarding authority. Records showed a relative had raised a concern that their relative had been handled roughly and not supported in a dignified manner. The registered manager had investigated and responded to this issue as a complaint and had not identified it as a potential abuse issue or raised it with the local safeguarding authority. When asked about this, the registered manager said, "The family said it was a complaint." This meant the home was not responding appropriately to allegations of abuse which meant people were at risk of allegations not being appropriately responded to.

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

People gave us mixed feedback about staffing levels in the home. Six people told us they thought the home had enough staff. One person said, "It's enough." Another person said, "There is enough staff here." However, five people told us they did not think the home had enough staff. One person said, "They could do with a bit more staff." Another person was asked if they thought the home had enough staff and told us, "No, not really." Staff with line management responsibility told us they thought the home had enough staff. However, all the healthcare assistants we spoke with told us they did not think the home had enough staff and they had to rush to support people. One member of staff said, "It [staffing levels] depends. Sometimes we work short, sometimes absence is covered. We have to rush. I think people feel rushed. On a dementia unit people feel it." Another member of staff said, "The rota is fine, but if staff cancel we work short. Then it's just task, task task. You have to have eyes everywhere because people are all walking around and might fall. They [management] don't arrange cover. It's not safe and it's stressful."

The registered manager sent us information about the staffing levels and grade of staff for the home. Analysis of the staffing information provided showed the home was operating with fewer staff that calculated as being required on five of the days considered and on six out of 14 nights reviewed. On four nights records showed there were only three staff working at senior grades. This meant one unit did not have a dedicated unit lead on these nights and the service was not providing the staff they had calculated as being required to provide safe care. After the inspection the provider submitted staffing needs calculations based on the providers staffing tool. This produced a lower staffing need than the information used by the registered manager in the service. The service had deployed fewer staff than the registered manager had calculated as being required.

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

Observations showed the home was clean, and there were no malodours present. However, the bathrooms of the home were in a poor state of repair. The tiling and flooring was dirty and grouting was cracked which presented an infection control risk. The home was undertaking refurbishment of the bathrooms during the inspection. In addition, people told us, and temperature checks confirmed, the hot water in baths and showers was not hot enough. The registered manager told us they had on-going issues with their boiler which was being replaced during our inspection. People told us they had not been able to regularly have hot baths and showers over a period of months. Records showed the home had escalated these concerns with the provider's maintenance contractors appropriately.

Recruitment records for five staff who had been recruited to the service since our last inspection were reviewed. These showed the service had not consistently followed its recruitment processes. Two of the staff were returning former employees. There were no records to show these staff had been re-interviewed for their posts and references or explanations for the time spent not working for the service was not in the files. Records showed the service had not checked one nurse's registration with the Nursing and Midwifery Council until over two months after they had started working at the service. Another staff file showed the staff member had been interviewed for a role 13 days before the date of their application form. In two staff files the references in the file were not from the staff members most recent employer and there was no explanation as to why that was the case. This meant it was not clear the service had ensured staff were suitable to work in the service, as gaps in employment history and professional validation checks had not been carried out in a timely way. The service had performed checks on staff members identities to ensure they had the right to work in the UK.

We recommend the service seeks and follows best practice guidance on safer recruitment practice.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decision 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 interest 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.

Records showed that where people were deprived of their liberty appropriate applications had been made to the local authority. Staff understanding of the MCA and its application was poor. We asked staff if they had heard of the MCA and what it meant. Only three out of the 17 staff asked about the MCA were able to explain that it was about people being able to make their own decisions and that there were processes to follow if people were unable to do so. One member of staff told us the MCA meant, "Treating people with dignity and respect." A second member of staff said, "It's regarding if someone has mental problems." Staff with management responsibility had not understood that the MCA means that others cannot consent on a person's behalf without having the appropriate legal authority. One staff member told us, "If anyone is next-of-kin they can decide." Another member of staff said, "Next of kin can make decisions." Being someone's next of kin is not the same as having the legal authority to make decisions on their behalf. The lack of staff understanding of the MCA meant there was a risk people's relatives were asked for consent when it was not appropriate or lawful to do so.

Records showed that relatives had signed consent forms in relation to procedures such as vaccinations as well as overall consent to care plans without corresponding records showing they had the legal authority to provide this consent. Every care file contained a care plan relating to capacity and consent. However, these were poorly completed and did not contain information for staff on how to support people with decision making. For example, one person's plan stated they lacked capacity and all decisions were made in their best interests. The plan continued, "[Person] is able to make non-complex decisions therefore all complex decisions are made by the family." A second person's care plan stated they lacked capacity for complex decisions but could make decisions including meal choices. Their care plan stated, "[Person's] wife makes on his behalf." There was no record to show the wife had legal authority to make decisions. Another person's care plan stated they had "full capacity." However, they had not signed their care plan so it was not clear they had consented to their care and treatment.

The registered manager told us they requested information from families and social workers regarding who had legal authority to make decisions but did not receive it. They also told us the local GP had sought consent from relatives regarding vaccinations. However, the records associated with these vaccinations were held in the home's care files and showed consent had been sought from relatives without corresponding records showing they had legal authority to provide consent.

The above issues are a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in April 2016 we made a recommendation about re-visiting the induction for some staff. This was because some staff had missed out on having a comprehensive induction. Records showed the service offered staff a range of e-learning and classroom based training sessions. Face to face training sessions were offered at different times of the day, with day time and evening sessions to facilitate night staff attendance. During the inspection the provider identified an issue with their records which meant some training courses, including those relating to safeguarding adults, allergen awareness, infection control and the Mental Capacity Act 2005 had not indicated their renewal dates as the provider's policy required. This meant the services records had showed that staff had completed the training at some point since they joined the service, but had not indicated when it was due to be renewed. The provider was taking action to ensure that staff completed this training in a timely manner.

Records showed staff received supervision and appraisal in line with the provider's policy. Staff received a minimum of three supervisions and an appraisal every year. Staff received supervision more often if they or their line manager requested. Feedback from staff regarding supervision was mixed. Some staff told us they found supervision was only used to tell them when they had done something wrong, and they did not find it supportive. One staff member said, "It's only bad supervisions, they [line manager] don't help." Another member of staff said, "If something happens you get a supervision. If there's new paperwork we have a group supervision. If we're not following the instructions we get supervision." This member of staff was asked if they ever discussed career development or support in their supervisions. They told us, "No, that's appraisals." Other staff told us they found supervision useful and supportive. One member of staff said, "They ask if we are happy, getting the support we need, do we need more training that kind of thing." This meant staff were having a varied experience of support and supervision, and the inconsistencies identified in April 2016 had not been fully addressed.

Records showed healthcare assistants received training in equality and diversity, first aid, food hygiene, infection control, dementia, moving and handling and pressure ulcer prevention. Staff who administered medicines received appropriate training. However, the training matrix did not include training in completing needs assessments, or the various tools such as pain scales, pressure wound risk assessments, and wellbeing assessments contained within people's care files. Although some staff told us they had received training in using these tools, other staff told us they had not. Likewise, the training records did not include training related to line management skills and tasks. The registered manager told us this training was included as part of the special training package for 'chaps' and these staff had requested to hold their own training records rather than the home hold the records. This meant it was not clear whether all staff had received the training they needed to perform all aspects of their roles.

People's health conditions were recorded in their care plans and records showed people were supported to access healthcare services. The GP visited the home twice a week. The home would contact the local rapid response team if people could not wait for the next GP visit. Records of health input were recorded, however, records showed the advice of health professionals was not consistently incorporated into care plans. In some units, care plans were updated in response to feedback from health professionals. For example, one person's skin and tissue viability care plan had been updated to reflect they had been prescribed a moisturising cream and anti-biotics following the development of a wound. The plan was further updated to show progress and ongoing measures after the wound had healed. However, other health professionals' advice, particularly the input from mental health professionals, had not been routinely incorporated into care plans.

People gave us mixed feedback about the food in the home. One person said, "The food is really good, and they know what I like or dislike." Another person said, "I like the food here." However, another person said, "It's not really my cup of tea, not the sort of food I like." The chef told us they had a diverse range of tastes in the home which reflected the cultural diversity of the local area. This meant that meeting all people's preferences was challenging as they had found where culturally specific food was served as the main menu option many people did not eat it. The chef made culturally specific meals available for people "off-menu." Records showed the chef provided multiple different meals for people with different tastes on a daily basis. The chef devised a 4 weekly rolling menu which was changed in line with the seasons. The chef attended residents and relatives meeting and incorporated their feedback along with observations of what meals were well eaten and which were returned to the kitchen uneaten when devising menus.

Records showed people were supported to make a choice for their meals by healthcare assistants and this was sent to the kitchen as a guide for preparation. Observations showed people were offered a choice at each meal time in addition in recognition that people may change their minds, or may not remember the choice they made several hours earlier. Healthcare assistants completed "dietary preference sheets" for people and copies were held in the kitchen. This ensured the kitchen had up to date information on people's needs and preferences, such as whether they required halal meat, or a soft or pureed diet. Records showed appropriate checks on the temperatures of foods and storage facilities, including fridges and freezers were carried out as required and food was stored and served at appropriate temperatures.

Mealtimes in all the units were observed during the inspection. Observations showed that mealtimes were not consistently a pleasant or shared experience. For example, although dining rooms were dressed with place settings, napkins and tablecloths, these were not used by people eating in the dining rooms. Staff cleared the crockery and napkins to another table and people were not supported to have or use napkins during their meals. People who needed support to eat their meals had to wait for staff to be available to eat and this meant their food was not kept hot until they were able to eat it. Staff did re-heat some people's food, but not everyone's. In addition, in one unit, observations showed staff talking about people and their needs with other staff. One person had their plate cleared away while they still had food in their mouth. Another person had clearly indicated they did not wish to eat one part of their meal, but staff repeatedly questioned them about this until the person shouted and left the room. This meant that the dining experience for people was not positive.

We recommend the service seeks and follows best practice guidance about mealtime experiences for people living in care homes.

Requires Improvement

Is the service caring?

Our findings

At the last two inspections in April 2016 and September 2015 we made the same recommendation about supporting people who identified as lesbian, gay, bisexual and transgender (LGBT) in care homes. The registered manager told us they had completed a lot of work with staff around this area, and although no one who lived in the home had disclosed they identified LGBT they were confident we would find improvements in records and staff attitude.

Information about people's sexual identity and sexual needs was recorded in a document called "My Choices." Records showed these remained poorly completed with regard to sexuality and sexual needs. One person's plan stated, "I like to wear dresses or trousers." This was recorded in the section called "My sexuality." Another person's stated, "Wants to be dressed and groomed as a man. I have been married." A third person's plan stated, "[Person] likes to be shaved." A healthcare assistant confirmed this was in relation to their face. Healthcare assistants told us one person did have sexual needs and they were given private time to ensure they were able to meet them, however, this information was not recorded in their care plan.

Healthcare assistants were asked if they supported anyone who identified as LGBT. They told us they did not know this information. One healthcare assistant said, "I don't really know. It's not come to my knowledge." A senior healthcare assistant said, "We don't really go into sexuality. We have a man who has sexual needs, he is given private time." Another healthcare assistant said, "I don't know if it [sexuality] would be in the care plans." This meant there was a risk that people who identified as LGBT or who had needs in relation to their sexuality were not having these needs identified or met.

Care plans contained details of people's personal histories and cultural background. The quality of this information varied. While some people's care plans contained a high level of information about people's past interests and relationships, other people's plans contained limited or no information. For example, one person's plan said their relationship with their family was important, but gave no details of their family members' names or relationships. Another person's plan stated, "[Person] refuses to talk to [staff] despite several attempts asking him what his interests are." There was no further information about this person or key events in their life that might be used by care staff to build a relationship with them. This meant there was a risk that people did not build strong relationships with staff as the foundation information staff needed to start conversations needed to build these relationships was not there.

People told us they thought staff had a caring attitude. One person said, "They [staff] are caring and very polite." Another person said, "They are very caring, kind and compassionate towards me." Relatives also told us staff were caring. One relative said, "I'm sure my mum thinks the staff caring, it matters to me." Another relative said, "From what I have seen they are caring." Staff demonstrated a caring attitude towards the people they supported. One healthcare assistant said, "Residents become like family, we worry about them." Staff also told us how they treated people with respect. One healthcare assistant said, "I show them that this is their home, I'm their guest and they are welcoming me." Another healthcare assistant told us they showed respect by asking people about their choices, they said, "I am always asking what they want, you ask

them and respect that choice." Observations during the inspection showed staff closed doors when supporting people with personal care, and knocked on closed doors before entering bedrooms.

Where people followed a religious faith this was captured in their care plan. Staff told us that representatives of various faiths would visit the home and spend time with people as they wished. Staff told us they respected how people's religious faith affected their care choices, for example, one person liked to receive personal care before they practiced their faith. However, one person told us that staff did not always manage to support them in line with their religious needs. They said, "I often miss my prayers because the staff are late in assisting me with my personal care and shower." This meant that the service was not consistently supporting people in a way that ensured their religious needs and preferences were respected.

Requires Improvement

Is the service responsive?

Our findings

At our last inspections in September 2015 and April 2016 we had not been able to review the assessments the service completed when people moved into the home as they had not been taking new admissions. At this inspection records of the assessments completed when people moved into the home were reviewed. Records showed these were poorly completed and did not contain the information required to form the basis of a care plan that would meet their needs and reflect their preferences. For example, one person had recently moved to the home. Their care plan and assessment contained conflicting information about the level of support they required with their mobility. In addition, the tone of how the plan was completed was not person-centred. Regarding their personal care it stated, "I like having a wash down every morning." There were no details about the products the person liked to use, and whether they liked to have a wash in their bedroom or in a bathroom.

Another person had moved into a different unit of the home in December 2016. Their plan and assessment was similarly completed with a lack of detail. This person's plan contained incorrect information about the person's cultural background. A member of the inspection team asked the person to confirm where they were from and they were able to clearly state a different place from that stated on their care plan. This person's plan contained limited information about their preferences for personal care. It stated the person needed "assistance and supervision" with personal care and that they "Need staff to facilitate shower gels and shaving foam by speaking to the administrator." There was no information about how the person liked to be supported to have a shower or what type of products they liked to use. This meant there was a risk that people were not supported in line with their preferences as these were not clearly or consistently recorded.

The registered manager told us the assessments relied on information from referring agencies and previous placements including hospitals and other care homes. They said they did not always receive sufficient information to complete a robust assessment of need. However, they were still accepting and admitting people without receiving sufficient information to ensure they were able to meet people's needs and preferences.

Needs assessments included a range of technical assessments of skin integrity, pain and wellbeing. It was not clear that the pain and wellbeing assessments had been completed appropriately. For example, one person's pain assessment had been repeated monthly and indicated they had no pain. However, there was correspondence from healthcare professionals recommending the person be prescribed and administered pain relief medicine as they had been expressing pain. Another person's wellbeing assessment had not identified that the activity of repeatedly packing their clothes into suitcases might be an indication of mental distress. This meant there was a risk that people's pain and distress were not being appropriately identified and supported.

At the last inspection in April 2016 we identified that monthly reviews of care plans and risk assessments were completed by senior staff and it was not clear that people and their relatives were involved in the review process. The registered manager had showed us a plan to improve people's involvement in the review process. However, at this inspection we found that people's involvement in the review of their plans

had not improved. Although plans were reviewed monthly, it was not clear that people were involved in this process. During the inspection observations showed staff completing updates on people's plans without people being there or involved in the process. The level of personalisation of care plans had not improved, and care plans written since our last inspection contained less detailed information about people's preferences than those completed prior to April 2016.

Staff told us it would be helpful if care plans all contained the same level of detail. One member of staff said, "Some care plans do [contain detailed information]. It might say they need one member of staff with assistance, but not if they can do their own face and so on. Others go to into the details about what they can do and what they need help with. More detail is better." Another member of staff said, "Information about things like water temperature, whether they use a sponge or a flannel, that's not in there. The care plans are basic, they aren't in detail." A third member of staff told us, "We did have that much information, but then we were told it was too much and had to re-write them as summaries."

Care files contained information about people's interests and activities, but it was not clear that these were followed when planning activities for individuals. For example, several care files told us people liked arts and crafts, knitting, and one person liked playing chess. However, there were no corresponding records to show people had been supported to engage in these activities. The home employed two activities coordinators who facilitated a range of in house and community activities and told us they also spent time with people in their rooms. There was a full timetable of daily activities, including a sensory session, textiles, bingo and cake baking. However, the activities staff did not record which people had attended sessions and did not have time to write in individual records when people had attended activities sessions. This meant it was not clear how many people were able to engage with activities offered in the home.

On one of the units a room had been turned into an indoor garden, with synthetic grass and two pet budgies and recorded birdsong in the room. This room was by the entrance to the unit and the registered manager told us this was so that people who wandered around the unit would get to the door and find a destination. However, during the inspection observations showed the volume of the birdsong recordings triggered the door closure system. This meant people arriving at that end of the unit could not see that the room was available for them to go into it. We did not see the room being used during the three days of inspection and records of people's care did not show they had been supported to use the room. Observations showed people sat on a sofa in the hallway, but did not sit in the bench in the garden room. This meant there was a risk that people were not being supported to use the resources available to them.

People gave us mixed feedback about the activities in the home. One person said, "I like to read and do sing along. I don't think I get bored here." Another person was involved in buying pet rabbits for one of the units during our inspection. However, other people told us there were not enough activities and they were bored. One person said, "I have to stay in my room, I don't do many things here." A second person said, "There is not much to do." A third person said, "Sometimes we need more activities." A relative said, "From what I have seen, I think they need more." A second relative said, "I think there is a lack of activities here." A third relative told us, "I have seen a few, but nothing that makes you go 'Wow!' if you know what I mean." This meant that despite the improvements in group activities offered, people were still not engaged in activities to keep them stimulated and engaged.

Care files were large, and information was held in different locations. The main care file contained care plans relating to various aspects of care, with a separate file used to record more information about people's preferences and life stories. Healthcare assistants told us they did not have time to read people's care files and relied on verbal handovers to get information on how people wished and needed to be supported. One member of staff said, "Healthcare assistants don't have time to read the care plans. The

residents need our attention all the time." Another member of staff said, "There is no time to read care plans. I make time to read them for new people, and they [senior staff] tell you what's needed if there's a change." A third member of staff said, "There's not really time to read them" A fourth member of staff said, "There's no time to read the files. I looked through them a long time ago. We get feedback in handovers when new people come in. We can ask for the information." This meant there was a risk that people were not receiving support in line with their care preferences as staff did not consistently have time to access this information and relied on informal handover of information.

The above issues are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed the home held regular residents and relatives meetings with the registered manager and chef. These were used to discuss the progress the home was making, menu, activities and to receive feedback from relatives. Records showed the registered manager had informed residents and relatives about the home's values and encouraged people to think about their end of life care wishes. In addition, the home used tablet computers to collect feedback from people and their relatives about the home. Records showed people were positive about their and their relatives' experiences within the home.

The home had a clear policy regarding complaints which included the expected timescale for response and how to escalate concerns if complainants were not satisfied with the response. People told us they would inform the nurses or their family members if they wished to make a complaint. Relatives were confident they could talk to the manager if they wished to make a complaint. Records showed the home had received four formal complaints since our last inspection in April 2016. Records showed these had been investigated by the registered manager and responded to in line with the policy. However, there was no record to indicate whether complainants were satisfied with the response. The provider told us they closed complaints when they sent the response to the complainant, but would re-open them for fresh investigation if they received further correspondence from complainants. Records of unit meetings showed that complaints were discussed so the same issue would not arise again.

Inadequate

Is the service well-led?

Our findings

Records of incidents, accidents and near-misses were recorded on a datix system. The datix information for the last five months was reviewed. This showed there had been a number of incidents which the home should have notified CQC about but had not. For example, one person was found on the floor with "Blood pouring out of his right side eye." The same person fell two months later and was described as "Lying on the floor covered in blood gushing from his mouth with a small laceration on the upper lip." There were no corresponding notifications regarding these injuries. Five people had sustained bruising or injuries of an unknown cause, these were not identified as possible safeguarding concerns and had not been notified to us. There was a report of an incident between staff where the police had been called which had not been reported to us as an incident being investigated by the police. There was a reported safeguarding alert regarding an unexplained injury which had not been reported to us. There was a report of an incident where a person chocked on their food and was subsequently admitted to hospital that had not been reported to us. This meant the home was not consistently identifying incidents and safeguarding alerts and was not keeping us informed as required.

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

At the last inspection in April 2016 the registered manager had used quality assurance and audit tools to identify areas that required improvement. These included the quality and consistency of care plans and risk assessments, and the attitude, behaviour and culture of the staff team. The actions taken by the management team had failed to make the improvements required. For example, the quality of assessments and care plans had deteriorated since the last inspection. According to the data from the monitoring system all care plans were in place, up to date and of the required standard. This meant the audits were ineffective.

Feedback about the management of the home was mixed. People who lived in the home were not sure they could identify the manager. One person said, "I'm not too sure about that [name of manager] actually." Another person said, "I don't know [who the manager is]." Relatives told us they knew who the manager was. One relative said, "Yes, I do know. I have to know." Another relative said, "Yes, we all know who the manager is."

Staff feedback about the manager was also mixed. Some staff told us they thought the manager was fair and approachable. One member of staff said, "She is one very good pillar one can easily approach. They listen and given us time, and provide help to all staff." Another member of staff said, "I'm happy with how [registered manager] is at the moment. She is supporting us, giving us opportunities and training. For me the home is well run and I can see thing have changed."

However, other staff were not happy with the style and approach of the management team. One staff member said, "It seems like they bully people. It feels like they are having digs at me all the time. I was crying every day. Staff who are friends of [registered manager] do very well. The rules aren't applied to everyone." A second member of staff said, "If you question something it's held against you. But if you're a friend of the manager you can get away with it." A third member of staff said, "[Registered manager] is very strict. I think

staff are unhappy. There are certain things I feel I can't say." A fourth member of staff said, "[Management team] have created an atmosphere. It's caused people to leave. I used to love coming in, but I don't feel the same now." A fifth member of staff said, "[Registered manager's] tone is very much 'don't talk to me' and everyone is very withheld. People don't want her to sack them. I cry when I get home."

Some staff explained they believed the home required strong management, describing the management approach as "Tough" and "Firm." One member of staff explained, "[Registered manager] is a tough woman. When things need to be done, it needs to be done. But we still have a culture of staff doing what they want." The historically problematic culture at the home was discussed with the registered manager and deputy manager. They told us they were challenged by staff whenever they attempted to introduce changes or improvements to the home. The deputy manager repeatedly told us that whenever they introduced change they were "Bullied back." The registered manager told us, "We don't allow staff to run the home." They expressed surprise at the tone of feedback about their management as they had expected to be perceived as "firm" but not as bullying.

The provider's human resources team had conducted a staff listening event at the home which had not identified the level of dissatisfaction with the management that was found during the inspection. However, external professionals who worked with the home told us they found the management approach to them very defensive and described them as "explosive." External professionals expressed concern about the impact of the management team's communication on staff and people living in the home.

Records showed each of the units held regular staff meetings. However, the tone of the records showed the meetings were not supportive and they were not used to drive improvements to the quality of care in the home. For example, several meetings across two different units referred to the fact that staff should do specific record keeping tasks to "Ward off" a CQC inspection or threat of local authority embargo on admissions. One record stated staff had raised an issue of risk to a particular person "Which will put the home in danger of an embargo." Another meeting record showed there had been discussions around staff gossip and behaviour. The minutes stated, "CQC are aware of the issues and they have got a key to the front gate, and they can come in and inspect us anytime. The home will close if we have an embargo again." This shows a misunderstanding of CQC's inspection approach. One unit meeting record stated, "Staff mentioned that the registered manager should attend the next meeting or some staff will not attend." Staff meetings were not used to promote a positive, person centred culture or the values of the organisation.

The registered manager told us they no longer held meetings for the whole staff team as they did not find them effective. Records showed they did not routinely attend the unit team meetings. The registered manager was aware of the tone of the meeting minutes but had not attended subsequent meetings to clarify the situation. They had introduced a set agenda to be used in future unit meetings.

The above issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Needs assessments were not robust, and care plans lacked detail and were not personalised. Regulation 9(3)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent had not been obtained in line with legislation and guidance. Regulation 11(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Allegations of abuse had not been identified or investigated appropriately. Regulation 13 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Fewer staff had been deployed on duty than the service's staffing needs calculator required. Regulation 18 (1)

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents Notifications had not been submitted for incidents that require notification. Regulation 18 (2)(a)(b)(e)

The enforcement action we took:

We are considering the appropriate regulatory response to this breach of regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people had not been appropriately assessed and measures to mitigate risk were insufficient. Medicines were not managed in a safe way for people who received them covertly. Regulation 12(1)(2)(a)(b)(g)

The enforcement action we took:

We served a warning notice on the registered manager and the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance and audit systems had not identified or addressed issues with the quality and safety of the service. Regulation 17 (2)(a)(b)

The enforcement action we took:

We served a warning notice on the registered manager and provider.