Trust Care Ltd

Holly Tree Lodge EMI Care Home

Inspection report

Sceptone Grove
Shafton
Barnsley
South Yorkshire
S72 8NP

Tel: 01226712399

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 6 and 7 March 2018 and was unannounced.

At our last inspection on 1 August 2016 we rated the service as 'Requires Improvement' and identified three breaches which related to staff training, safe care and treatment and recruitment. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions in Safe and Effective to at least good.

Holly Tree Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home provides nursing and personal care for up to 41 older people who may have mental health needs and/or be living with dementia. Accommodation is provided on two floors in single rooms with lift access between floors. There are communal areas on both floors, including a lounge and dining room. There were 38 people in the home when we inspected.

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

Staff had received training in safeguarding and understood the reporting systems, however we found safeguarding incidents were not always recognised or reported to the local authority safeguarding team. We found risks to people were not properly assessed or managed well, particularly in relation to nutrition, falls and behaviour which may challenge others.

Relatives told us they felt people were safe in the home. However, some relatives raised concerns about staffing levels. Duty rotas showed staffing levels the registered manager said were in place were not being maintained. However, following the inspection the provider told us staffing levels quoted by the registered manager were incorrect. The provider said they were reviewing the staffing levels. Staff recruitment procedures ensured staff were suitable to work in the care service.

Staff completed induction and were up to date with most of their training. However, they lacked the skills and knowledge in how to manage challenging behaviour which put people who used the service and staff at risk of harm and injury. Staff said they felt supported, although they were not receiving regular supervision.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice.

People's care records were not personalised and did not reflect people's needs or preferences. There was

not enough detail to guide staff about the care and support people required. People's nutritional needs were not always met, particularly those people who were low weight or had lost weight. People had access to healthcare services and systems were in place to manage complaints.

Medicines management was not always safe which meant people were at risk of not receiving their medicines when they needed them.

Relatives told us there were few activities which our observations confirmed. This had been raised in feedback from surveys people had completed in 2017 but not addressed. Relatives told us staff were friendly and caring. We saw some caring interactions but also practices which showed a lack of respect for people and compromised their dignity.

The provider's systems and processes did not enable them to effectively assess, monitor and improve the service. They did not monitor and mitigate risk effectively. The provider had failed to notify CQC of incidents which are legally required to be reported.

We found shortfalls in the care and service provided to people. We identified seven breaches in regulations – staffing, safe care and treatment, safeguarding, dignity and respect, person-centred care, consent and good governance. The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. 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.

Medicines management was not safe and effective, which meant we could not be assured people received their medicines as prescribed.

Some people felt there were not enough staff. The provider is reviewing the staffing levels. Staff recruitment checks were completed before new staff started work to ensure their suitability to work in the care service.

Risks to people's health, safety and welfare were not assessed and mitigated. Safeguarding incidents were not always recognised, dealt with and reported appropriately.

Is the service effective?

Inadequate

The service was not effective.

Staff received induction and training, however they lacked the skills and knowledge to manage behaviour that challenged. Supervision was not provided in accordance with the provider's policy.

The service was not meeting the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were met. People's healthcare needs were assessed and staff supported people in accessing a range of health professionals.

Is the service caring?

Inadequate

The service was not always caring.

People told us the staff were friendly and caring and we saw this in some of our observations. However, we also found people were not always treated with respect and their dignity was not maintained.

Is the service responsive?

Inadequate

The service was not responsive.

Care records were not accurate or up to date and did not reflect people's preferences.

Activities were limited and there was little to interest or occupy people.

Complaints were recorded and dealt with in accordance with the provider's complaints procedure.

Is the service well-led?

Inadequate

The service was not well-led.

There were significant shortfalls in the leadership and management of the service.

The provider did not have effective systems and processes in place to assess, monitor and improve the service or assess, monitor and mitigate risk.

Holly Tree Lodge EMI 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 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 6 and 7 March 2018. The first day of the inspection was unannounced and two inspectors, an inspection manager and an expert by experience with experience of services for older people attended. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The provider knew we were returning on the second day and two inspectors attended.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioning and safeguarding teams and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made judgements in this report.

We observed how care and support was provided to people. We spoke with four people who were using the service, eight relatives, two nurses, four care staff, the cook and the registered manager.

We looked at eight people's care records, five staff files, medicine records and the training matrix as well as

records relating to the management of the service. We looked round the building and saw people's bedrooms and communal areas.

Inadequate

Is the service safe?

Our findings

At our previous inspection we identified breaches in relation to safe care and treatment and staff recruitment. At this inspection we found a continued breach with safe care and treatment. Recruitment processes had improved, although robust checks of identity were not always carried out.

We found risks to people were not well managed. Risk assessments were in place for areas such as nutrition, tissue viability, mobility and falls. However, we found some had not been completed correctly and did not accurately reflect the level of risk. For example, one person had sustained four falls in December 2017, yet this was not reflected in their falls risk assessment which meant the overall risk level was lower than it should have been. Nutritional assessments were not accurate. For example, one person's weight records showed they had been a low weight in October 2017 with a body mass index (BMI) of 17. By February 2018 they had lost a further 4kgs though no BMI was recorded. We calculated their BMI was 15, which using the malnutrition universal screening tool (MUST) showed the person was at high risk of malnutrition. Yet the provider's nutritional assessment tool reflected a low level of risk. Another person's weight records showed they had lost over 7kgs in five months. Their nutritional risk assessment had not been updated and showed a 'safe nutritional state'. There were no risk assessments in place for some people who had bed rails or sensor alarms in place. The failure to properly assess, manage and mitigate risks placed people at risk of harm and jeopardised their safety.

Accident and incident reports were poorly completed with gaps in information and not all sections completed. It was often difficult to determine what action had been taken in response. The registered manager audited the reports monthly, however we found the analysis was limited. The analysis did not consider themes or trends such as times and location or look at lessons learned. At the time of our inspection accident reports for January and February 2018 had not been analysed.

Medicines systems were not always safe. Although most medicines were stored safely and securely we found prescribed nutritional supplements, thickening agents and some pain relief medicines were not. We saw nutritional supplements stored in the kitchen and pain relief tablets stored in an unlocked cupboard in an unlocked office. The nurse told us thickening agents were kept in the kitchenette which we saw was not always locked. The registered manager and staff took action to address this when we raised it with them. We found handwritten entries on medicine administration records (MARs) had been signed by only one staff member and not checked or signed by another staff member to ensure they were accurate. One person's care records showed staff were regularly applying creams to their body yet no creams were prescribed on the MAR. The nurse did not know what creams staff had been applying. One person's MAR showed they were prescribed a medicine to be given weekly. The MAR showed this had been administered as prescribed yet when we checked the stock with the nurse there was an extra tablet which suggested a dose had been signed for but not given. We checked another person's boxed medicine and found the stock did not tally with the balance recorded on the MAR. We saw protocols were in place for most 'as required' medicines, however, we found no protocols for two people. When 'as required' medicines had been administered the back of the MAR had not been completed by staff to show the reason for administration. The nurse told us they did not have time to fill this in.

The registered manager told us competency assessments were not available for all the staff who administered medicines. The registered manager confirmed competency assessments had not been carried out with one nurse and the last competency assessment for one of the senior care staff was dated June 2012. The registered manager could not locate competency assessments for two other nurses. We asked one of these nurses if they had completed any medicine competency assessment in the two years they had been working at the service as a nurse and they said no. Later the registered manager showed us competency assessments that they said had been completed by the regional manager in 2017, neither had been signed by the nurse. The examples stated above demonstrate a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with understood how to report safeguarding concerns and confirmed they had received safeguarding training. They told us they would report any concerns to the registered manager who they were confident would deal with any issues promptly and appropriately. Staff were also aware they could report concerns to other relevant agencies. The registered manager told us there had been approximately four safeguarding incidents in the last five years and showed us records of three safeguarding referrals they had made since October 2017. However, we found safeguarding incidents were not always recognised or reported in accordance with the provider's safeguarding policy. Records we reviewed showed a further six incidents of abuse involving people who used the service, none of which had been identified as safeguarding incidents or referred to the local authority safeguarding team. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives we spoke with told us they felt people were safe in the home. Comments included; "(Family member) is safer here than at home" and "Since (family member) came in here it's been a load off my shoulders. I know (they're) safe."

However, concerns were raised that there was not always enough staff, particularly at weekends. Comments included; "There's a lack of staff to do anything"; "(Family member) went out at the other home (they were in), but never here, not in all the years (family member's) been here. There doesn't appear to be enough staff for that"; and "They are always short of staff so I help out. My only gripe is that they don't get staff in if any staff are off sick so no one to help me with (family member)."

The registered manager told us staffing levels were calculated according to people's dependencies and were increased as and when needed. However, they were not able to show us any records to evidence this. They told us the usual staffing levels were one nurse and one senior care assistant throughout the day and night, plus six care staff in the morning, five in the afternoon/evening and two overnight. They said they had recently put an extra care assistant on duty to work a twilight shift between 4pm and 10pm. We looked at the duty rotas for the four weeks leading up to the inspection and found these levels were not being maintained. Following the inspection the provider told us the information provided by the registered manager about staffing levels was incorrect. The provider stated the staffing levels they had been working to were one nurse and one senior care assistant throughout the day and night, plus five care staff in the morning, four care staff in the evening and one care staff at night. The provider stated they would be reviewing the staffing levels.

We looked round the home and found a marked contrast in the standard of décor and furnishings provided. A new extension had been added to the home a year ago and this area was clean, well maintained and decorated and furnished to a good standard. Communal areas including the lounges, dining rooms, bathrooms and toilets were also well maintained. However, many of the bedrooms we viewed were not to this standard. The registered manager told us there was an ongoing redecoration and refurbishment plan to upgrade these bedrooms.

The registered manager provided us with a spreadsheet which showed all required maintenance checks and certificates for the premises and equipment were up to date.

Systems were in place to ensure infection control practices were followed. We observed staff wore personal protective equipment such as gloves and aprons appropriately. Facilities were available to ensure good hand hygiene, including hand sanitiser. An infection control audit had been carried out by the local authority in April 2017 and identified some recommendations. These had been addressed by the provider.

We looked at recruitment records for five staff which showed staff had attended an interview and checks such as references, employment history and criminal records were carried out before they were employed. However, the identity of one staff member had not been carefully checked which meant the provider could not be sure they were suitable. The staff member had provided documentation for proof of identify and address but the names on the documents did not match. The registered manager acknowledged they had not picked up the discrepancy during the recruitment process and agreed to follow this up straight away.

Inadequate

Is the service effective?

Our findings

At our previous inspection we identified a breach in relation to staff training in fire safety and moving and handling. At this inspection we found although training had been provided in these two areas there were other shortfalls with staff training and supervision.

The training matrix showed the majority of staff had received updates in fire training and moving and handling since the last inspection. Staff told us they completed good quality training and refreshed this as appropriate. They said training was done face to face and helped them understand how to do their job well. Staff who commenced employment completed an induction programme and those who had no previous care experience completed the Care Certificate.

The training matrix demonstrated the majority of staff were up to date with their training and identified those who still required refresher training. However, we saw records which showed people who used the service and staff had been physically assaulted by other people who used the service. Although the training matrix showed 18 out of 31 staff listed had received training in behaviour which may challenge others; 11 had received it in 2011, five in 2014 and two in 2016. The provider had determined that this training was to be provided only once with no updates. The registered manager confirmed this training did not provided staff with the knowledge and skills to know how to keep themselves and others safe when managing unpredictable behaviour and potentially dangerous situations. This was also evident from our discussions with staff, three of whom confirmed they had not received any training in managing behaviours that challenged.

Staff felt well supported but did not receive supervision as often as the provider stated was required to maintain quality standards. Staff said they received good support from their colleagues and the registered manager. One staff member said, "Teamwork is really good." They said they had opportunities to discuss their role and responsibilities and received feedback about their performance. We reviewed the staff supervision and appraisal matrix which showed staff who had worked at Holly Tree Lodge for over a year had received two supervisions and one appraisal in 2017. Staff who had worked at the service for less than a year had received at least one supervision session. In 2018 only two staff had received a supervision session and one staff had received an appraisal. This meant 37 staff had not received formal supervision in 2018.

The registered manager gave us a supervision policy which stated supervision included maintaining and developing quality standards, staff development, clarifying roles and responsibilities, and promoting the homes aims and objectives, a caring environment and effective communication. The policy stated it was the supervisor's responsibility to ensure that a session was carried out with each care worker every two months. Following the inspection the provider told us the supervision policy provided by the registered manager was incorrect as it was an old policy. They said the current policy stated staff received supervision four times a year. However, our evidence shows this frequency was not being met. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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.

The registered manager provided us with a list which showed 18 people had DoLS authorisations in place. The registered manager told us only two people had conditions on their DoLS which they said were being met. However, we found another person's DoLS also had conditions. We found the conditions on two people's DoLS were not being met.

The registered manager said they did not have consent records for care and treatment. They said the only mental capacity assessments they had in place related to people locking the bedroom doors when they were not present. This was confirmed in the care records we reviewed. This meant the provider was not following the principles of the MCA.

Staff told us four people received their medicines covertly (hidden in food or drink). We saw one person had a mental capacity assessment and best interest decision recorded in 2016 which had involved the person's relatives, GP and pharmacist. The plan said this decision was to be reviewed formally after 6 months under the MCA. There was no evidence to show this review had taken place. There was nothing on or with the MAR for another person to show they received their medicines covertly. There was evidence of a best interest decision in 2016 but this form was not dated or signed and there had been no formal review since then. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The training matrix showed staff had received training in the MCA and DoLS. Staff we spoke with had an understanding of the MCA and DoLS.

One the first day of the inspection we observed breakfasts were available throughout the morning and most people were given porridge. We did not hear staff offering people any other options and saw the porridge was just placed in front of people. On the second day there was a slight improvement as we heard staff offering people cereals and toast as well as porridge. One person told us, "I like porridge. It's a good job I do as that's all we get, you have to laugh here. I'm not asked what I want it just comes. I'm slow but don't get any help It takes me a long time."

At lunchtime on the first day of the inspection we observed most people were given the same meal. Again no choice was offered, even though different items were displayed on the pictorial menu in the downstairs dining room. There was no menu on display in the dining room upstairs. We saw people were provided with plate guards and staff asked people if they wanted their food cutting up and if they would like an apron to protect their clothes. People were provided with drinks during the meal.

The service had a three week rolling menu which was varied and stated salad options, jacket potatoes, omelettes and variations to the main meal should be offered as an alternative. The teatime menu stated a buffet tea was offered daily with a choice of assorted sandwiches, pizzas, soup, meatballs, spaghetti

bolognaise, quiches, and jacket potatoes. There was no breakfast menu.

The cook told us they provided blended meals for some people, which were served before other meals. They said they fortified meals by adding extra nutrients, such as butter and cream. They gave examples of adding full fat milk, double cream and sugar to porridge. They also told us milk shakes with additional milk powder and ice cream were provided twice daily. We saw these being served during the day.

At the last inspection we found the environment was not dementia friendly and the provider told us this would be addressed through their refurbishment programme. At this inspection we found some improvements had been made. For example, in the new extension there was a small seating area with two comfortable chairs and we saw people enjoyed sitting there and listening to music playing on an old fashioned radio. Doors to bedrooms, bathrooms and toilets were different colours and had signs with pictures and words to help people orientate themselves. In the bathrooms and toilets, there were coloured toilet seats and grab aids to help people identify these areas more easily. However, the improvements were limited. There were no items of interest to occupy people or promote conversation such as rummage boxes, books, games or artworks. This had been identified at the previous inspection.

Care records we reviewed showed people were supported to access healthcare services such as GPs, district nurses, opticians and social workers

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Inadequate

Is the service caring?

Our findings

We saw staff routinely showed a lack of respect for people who used the service. They often used terms such as 'feeders' or 'softs' (meaning their type of diet) to describe the person rather than using people's names. They spoke about people when they were present rather than including the person in the conversation. For example, one staff member talked about people being reluctant to shower and said, "It's their disease, it's something that happens with water they get a dislike." The reference to 'their disease' related to dementia. One care worker was trying to sit a person up in their chair and was attempting to put a cushion at their back. Another staff member said, "She won't let you go near her."

We also observed conversations that were directed at people but lacked respect. For example, one person was eating porridge and member of staff said to them, "You are making a mess." We observed staff placed a bowl of porridge on a small table in front of this person. The person received no help from staff and proceeded to pour the porridge down on to their lap, although staff were present no one assisted. When we brought it to the attention of one of the staff they took the porridge away, wiped the person down with a cloth and left. We saw the same scenario occurred at lunch time with the same outcome. The person's clothing was not changed and neither were they offered any alternative food.

We saw another person asked for a biscuit with their cup of tea. The biscuits were on the tea trolley in front of the person. The care worker said they had to finish serving drinks for all of the people before they could be given a biscuit and proceeded to give other people biscuits, leaving the person to wait until last.

Although some bedrooms were personalised, many others were stark and bare with basic furniture and few, if any, personal belongings. Several rooms had picture hooks on the walls, but no pictures. Some had furniture which was broken, where doors or shelves had been removed. In many rooms there was nothing to reflect the person whose bedroom it was or their likes and interests. One person's room contained only one piece of furniture and no other furnishings or fittings. The registered manager told us this was as the result of a best interest decision. However, we found there was a condition on the person's DoLS which stated this decision was to be reviewed and the room was to be deep cleaned and decorated to ensure it was hygienic and as welcoming as possible. This had not been done.

Some people had no toiletries in their rooms. The registered manager told us this was because it was not safe for some people as they may ingest the products so the toiletries were kept elsewhere. One person had a note in their room which said their toiletries were kept in the sluice, yet when we looked in the sluice there were none there. The registered manager acknowledged the sluice room was not an appropriate place to store people's toiletries. The registered manager said another person's toiletries were stored in the laundry. When we went with the registered manager to check the only toiletries found for this person were some razors and steradent which were underneath a pile of the person's clothing in a basket in the laundry.

People had life story books which had sections such as childhood, adulthood, family detail, current information, communication and beliefs. These did not always contain very much detail about the person. For example, one person's communication section stated 'due to hearing and sight difficulties cannot join in

any activities'. There was no information about suggested activities or what the person enjoyed. We reviewed the care plan of a person who was registered blind. Staff had recorded 'she is able to see figures and aware when someone is next to her'. There was no information about any equipment that was used or had been considered to help aid the person.

Staff were aware of some people's cultural and spiritual needs. However, the information in one person's care plan about their religion was not always person centred. The care plan contained a guidance document which referred to the person not being permitted to 'Go to the school prom or school dance' or 'Contribute to the Presidential Campaign Fund on their tax return'. We concluded people were not treated with dignity and respect and staff demonstrated a lack of compassion. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives spoke positively about the staff. Comments included; "I like the staff here they are very friendly and very caring. They treat me and my (relative) like family"; "Staff are great' and "Staff here are very good with (my relative)."

We saw some examples where staff interaction was friendly and caring. One member of staff asked people if they wanted a drink and offered tea or coffee. The member of staff used people's names and spoke to them at eye level. People responded positively and four people requested tea. They had good eye contact and two people smiled at the member of staff. We saw another staff member was patient and kind with a person who was sleeping in a chair. We saw they gently roused the person and asked if they would like a drink and some breakfast. When the person said no, they left them to go back to sleep returning when the person awoke to make them a drink and breakfast.

Inadequate

Is the service responsive?

Our findings

Staff said the people they supported displayed behaviours that challenged and people were often reluctant to have their clothes changed or receive personal care. They said they used calm approaches and asked different colleagues to assist which was sometimes successful. Although the registered manager told us physical restraint was not used, it was evident from our discussions with staff that they were dealing with incidents on a frequent basis and physically restraining people. One staff member said about the people they supported, "The majority tend to be aggressive." Another staff member said, "They hate interventions full stop." Another staff member told us they 'very often' held people's hands while another staff member changed the person's continence pads or clothing. They said, "We duck and move away." This was also confirmed in incident reports we reviewed. For example, one report from December 2017 described how two care staff were attempting to change a person's continence pad and one of staff had to restrain the person who was hitting the other care staff member.

We looked at care plans and found insufficient guidance on how to support people with behaviours that challenged. For example, one person's daily notes in February 2018 described occasions when the person was resistive, agitated and verbally and physically aggressive towards staff when they were supporting the person with their care. A behaviour chart was put in place but this was not completed consistently and did not reflect all the incidents reported in the daily notes. The care plan made no reference to behaviour charts and there was insufficient guidance for staff. For example, staff were guided 'to give reassurance' and 'another member of staff to take over if agitation is still present'. There was no information about how staff should carry out personal care when the person continued to refuse even though it was evident from discussions and reviewing the records this was a regular event.

Three people's care records we reviewed showed they were diabetic, however there was no information in their care plans about their dietary requirements in relation to their diabetes. One person's care plan stated their blood sugar levels should be monitored weekly. We saw this was not happening.

Care plans we reviewed made no references to bathing or showering. Staff told us they recorded in the daily notes when people had a bath or a shower. We reviewed two people's daily notes and found one person had received one bath/shower over a nine week period; there was no evidence to show the other person had received any bath or shower over a five week period.

There was no information in the care records we reviewed about people's oral care. It was not clear whether people had their own teeth or wore dentures or the support they required from staff in maintaining good oral hygiene. When we looked round the home with the registered manager we found some people had no oral care products. For example, one person had some toothpaste but no toothbrush, three other people had no toothpaste or toothbrush or denture products. When we asked the registered manager if these people had their own teeth or no teeth or dentures they did not know and were not able to explain how staff supported them with oral hygiene.

Care records did not always evidence whether appropriate care had been delivered. For example, food and

fluid charts did not evidence people had sufficient to eat and drink because the daily fluid intake was not totalled and food eaten was not always accurately recorded. For example, there was no entry to show one person had eaten an evening meal on 28 February and 2 March 2018. On the first day of the inspection we looked at another person's chart at 11.30am and no food or drink had been recorded since tea time the previous day. Care staff confirmed the person had not had anything to eat or drink as they were sleeping.

People and relatives told us there were very few activities, no opportunities to go out and the main entertainment was the television. Comments included; "There is no interaction here, no activities, nothing for (family member) to do, so (family member) becomes disruptive. (Family member) has nothing to entertain (them) or keep (them) busy. (Family member) needs more stimulation not less" and "I would like (family member) to have things to play with because (they) pull at (themselves) and the tables and there is nothing for them. Nothing much happens here but they do have fireworks on bonfire night and things at Christmas." One person said, "I'm ok, I don't move from my chair once they put me here."

People were not supported to take part in social activities. We saw people were sat for long periods with very little stimulation. For example, one person was sat in a chair when we arrived in the lounge at 8.30am and they remained in the same chair until we left the unit at 1.10pm. They were not offered any activity and had no stimulation apart from staff occasionally asking if they were okay. During this period they received two cups of tea and a bowl of porridge which they ate independently. We saw other people continually walking round the corridors and trying to open doors. There was very little to interest or occupy people as they walked around and few places for them to pause and sit for a while other than the communal areas.

The service employed two activity workers who also worked as care workers. We saw from the staffing rotas they had both only worked three 'activity' shifts over the last four weeks so six days in total. On the first day of the inspection there was no activity worker on shift. On the second day of the inspection an activity worker was on shift and we spoke with them after lunch about the activity programme. They told us they provided one to one activities rather than group sessions, and had spent time with two people looking at the 'Queen's Coronation' newspaper that morning. They said they had not provided any other activities but did hope to offer more one to one support before they finished their shift. They said they had been asked to supervise the lounge in one unit because the nurse was busy and had also taken the drinks trolley to people. They told us some external entertainers visited, and every two weeks there was a sing-a-long and musical instrument session. The activity worker told us people had recently enjoyed a therapy session with dogs and a guitarist. We saw photographs which confirmed this. Both sessions had been held in December 2017. We concluded people did not receive care that was personalised or responsive to their needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us they had recently purchased a building next to the home which had formerly been a GP surgery. They planned to develop this into an activity centre for people who used the service and also to provide a dedicated training room.

The complaints procedure was displayed. Relatives told us if they had any concerns they would speak with the registered manager or provider. We reviewed the complaints and compliments file and saw a 'concern' had been raised by a relative regarding the condition of their relative's feet in July 2017. The registered manager had responded to the concern and recorded actions they had taken to resolve the issue. The registered manager told us they had not received any formal complaints in the last 12 months.

We saw the service had received several compliments. These included, 'We all want to say a big thank you for all the care you gave to [name of person]. You made a difficult time for us so much easier. [Name of person's] last few days were made more dignified by the support and care you gave to [name of person] and

us', 'I would like to thank you for all your loving care over the last few months of [name of person]'s life. It made all the difference' and 'You have all been wonderful and did your upmost to make [name of person] happy and comfortable'.

Inadequate

Is the service well-led?

Our findings

At this inspection we found significant shortfalls in the delivery of care as evidenced by the regulatory breaches cited in this report. Governance systems were not effective as issues had not been identified or addressed through quality audits. We concluded the service was not well-led.

We found audit systems were not effective in identifying and managing risks or issues. For example, care plan audits showed one care plan was reviewed per month. The audit form was basic comprising of tick boxes and it was not always clear whose care plan had been audited. No issues were identified in any of the care plans reviewed in December 2017, January or February 2018. Yet in the care records we reviewed we found risk assessments had not been completed correctly, care plans were not personalised and contained insufficient detail. Monthly medicine audits had been carried out, however, no issues had been identified in the most recent audit on 23 February 2018. There was no overall weight analysis or monitoring carried out by the registered manager, who was not aware of the issues we raised in relation to people's nutritional needs. Following the inspection we asked the registered manager to audit everyone's weight and BMI and inform us of the action taken to mitigate the risks. This was provided.

Environmental issues had not been identified and addressed until we brought them to the attention of the registered manager. For example, broken radiator guards where the hot surface of the radiator was exposed placing people at risk of burns, broken furniture and a missing bed head. The registered manager told us there was a refurbishment plan to bring all the bedrooms to the same standard as those in the new extension. The plan given to us by the registered manager did not reflect this. The only works identified for this year were decorating the ground floor bedrooms, painting the kitchen ceiling, replacing floors in two bedrooms, converting the training room into a bedroom and to convert the recently acquired GP surgery into a training room and dementia diner.

We found the menu was not being followed. There was a record of the meals served but this was not monitored. There was no formal process for checking meals were varied and nutritionally balanced. The cook said apart from blended meals only one person had any special dietary requirements. They said one person sometimes had curries to meet their cultural needs but acknowledged this had not been provided for a long time. They told us they did not provide any low sugar or diabetic dishes, although three people's care records we reviewed showed they were diabetic. The registered manager said the menu plan should have been followed and agreed to review this with the catering team. This demonstrated there was no system in place to ensure the menus were being followed and that people's nutritional needs, choice and preferences were met.

The registered manager submitted a monthly pressure damage report to the Clinical Commission Group (CCG) to report any pressure damage to people who were receiving nursing care. The report submitted on 26 February 2018 reported there were no people with pressure damage, yet staff told us and care records confirmed one person had pressure damage at the time the report was submitted.

Accident and incident analysis was not effective as themes and trends were not identified and safeguarding

incidents were not recognised.

The provider shared results from a survey carried out in 2017 which had involved relatives and friends. The results had been analysed by head office and shared with the home on 27 February 2018. Everyone said they considered the home excellent or good, and 95% stated it was clean. Only 66% considered the activities to be good and the provider had commented as part of the results they were very aware social activities in the home were important. However, we saw from the PIR the provider had completed in July 2017 that activities had scored the lowest in a quality assurance audit in January 2017. The PIR stated as a result of this the home had concentrated more on one-to-one interactions and had increased group activities. It was evident from the recent survey results and our inspection findings that the activity provision had not improved. We found the level of activity was not person centred and there was a lack of stimulation.

The registered manager told us the provider visited and audited the home monthly. We saw the last visit report dated 13 February 2018. Areas reviewed were finance, human resources, marketing, quality, health and safety and a tour of the home. No concerns or issues were identified in the report. We concluded the provider did not have effective systems and processes in place to enable the registered person to assess, monitor and improve the service or assess, monitor and mitigate risk. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider is required to notify CQC of certain events that occur in the service. We found no safeguarding notifications had been submitted in 2016, 2017 or 2018, although we saw three safeguarding referrals had been made to the local authority safeguarding team since October 2017. We also found incident and accident records we reviewed at the inspection described events that should have been notified to CQC. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The home had a registered manager who had been in post for six years. Staff we spoke with told us the registered manager was approachable and accessible. Relatives made the following comments; "I think it is well led I can talk to the staff any time"; "I can talk to the manager no problem" and "When it's my time I'd come in here."

On the second day of the inspection we attended the staff handover. Staff were given information about people's well-being. Details were shared about health concerns, issues with behaviours, and food and fluid intake. This ensured staff had relevant information at the start of their shift. Staff we spoke with said they did not attend regular staff meetings but did feel important information was shared at handovers and on an informal basis. We reviewed minutes from two staff meetings held in July and October 2017. They had discussed catering arrangements for Bonfire night and Christmas, use of communal areas, changes of meals and staffing changes. No other staff meeting minutes were available.

A relative and friends support meetings had been held in November 2017. Information was shared about plans to develop a dementia café and a 1950s style seating area, bedroom refurbishment and communication with relatives. The seating area had been developed and we observed people using this. We saw the rating from the last inspection was displayed in the home and on the provider's website as required.