Aps Care Ltd

Stradbroke Court

Inspection report

Green Drive
Lowestoft
Suffolk
NR33 7JS

Date of inspection visit:
20 April 2017
28 April 2017

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10 July 2017

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

Stradbroke Court provides accommodation and personal care for up to 43 people, some living with dementia. There were 28 people living in the service when we inspected on 20 and 28 April 2017. This was an unannounced inspection on both days.

At our last inspection 8 December 2016 we identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were concerns with safe care and treatment, person centred care, staffing and good governance. We rated Stradbroke Court 'requires improvement' overall. We told the provider to submit an action plan to us to let us know how they intended to address the concerns we raised. At this inspection we found that the provider had not made satisfactory improvements to ensure that they were consistently delivering a high standard of care and that the standards of care had actually declined.

Due to a number of concerns raised about the service we brought forward this scheduled inspection so we could check that people were receiving safe care. At this inspection, we found people's safety and well-being was being compromised in a number of areas.

There have been several changes of manager since our last inspection. Currently there is a manager in place but they are not registered with CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This inspection identified serious concerns regarding the management and leadership of the service, safe management of medicines and infection prevention and control. People were being put at risk of harm and there was insufficient governance and oversight to monitor the service. Due to management changes there had been a lack of effective leadership and management at the service which had led to a significant deterioration in the quality of the service.

We found the home was in breach of six regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Four of these regulations were continued breaches from the last inspection 8 December 2016. You can see what action we told the provider to take at the back of the full version of the report.

Risks to people's health, safety and welfare were not managed effectively which placed people at risk of harm.

The systems in place to monitor the service provided were not robust enough for the service to independently identify shortfalls and address them. The service had received support from health and social care professionals and was working to address the concerns they had identified. To assist in making improvements in the service the provider's nominated individual had recently employed the services of an

external company.

Improvements were needed in the management of medicines. The service were working on addressing shortfalls identified by a health professional. In addition we identified that guidance provided to staff relating to medicines that were prescribed 'as required' PRN did not hold sufficient information to ensure that the risks to inappropriate use of these medicines were minimised. Medicines that were prescribed in variable doses, for example one or two tablets were not always recorded.

Improvements were needed in infection prevention and control systems. The service were working on addressing shortfalls identified by health professionals. Despite this there had been two recent outbreaks of sickness and diarrhoea in the service. In addition we identified areas within the service that were not hygienic and presented a risk to people.

There was a task led culture in the service. Improvements were needed in the deployment and organisation of staff to meet people's needs safely and effectively. Recruitment processes were not robust.

The quality of information in people's care records to guide staff in how people's needs were met varied and these were in the process of being reviewed by the service following guidance from the local authority. Further consideration of how to provide more and consistent guidance to staff would ensure that people were provided with safe and good quality care at all times.

People's nutritional needs were assessed. However, improvements were needed in how staff recorded the amounts that each person had to drink and eat each day, where required and how this is monitored to ensure people receive enough to eat and drink.

Staff supported people in the least restrictive way possible; the policies and systems in the service support this practice. However, improvements were needed in how people's capacity and support to make decisions is included in care records to provide guidance for staff.

An effective complaints procedure was not in place. There were limited systems in place to gain the views of the service provided from people using the service and their representatives. Improvements were needed to ensure people's concerns and complaints were investigated, responded to and used to improve the quality of the service.

Recruitment processes were not always adhered to; appropriate risk assessments were not carried out where there may have been concerns about a person's suitability for the job role.

Despite some people living with dementia there was little in the way of signage and familiar items to help people navigate themselves. We recommend that the provider refers to current guidance from a reputable source about adapting the environment for people living with dementia.

The systems in place for staff to receive training, achieve qualifications in their role and be supported through supervisions needed further improvement.

People were provided with some opportunities to participate in activities but this was limited due to the staffing situation. People were treated with respect and compassion by the staff working in the service although improvements could still be made in this area.

Staff were trained in safeguarding and understood their responsibilities in keeping people safe from abuse.

There were safeguarding investigations being undertaken by the local authority, we will continue to monitor the progress and outcomes of these.

People were supported to see, when needed, health and social care professionals when required.

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."

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 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.

Risks to people's health, safety and welfare were not managed effectively which placed people at risk of harm.

The deployment and organisation of staff was not effective to consistently meet people's needs safely.

Systems for the safe management of medicines were not robust.

Infection prevention and control procedures were not robust.

Recruitment processes were not robust.

Is the service effective?

Requires Improvement

The service was not always effective.

Recording of people's nutritional intake was not consistent to help manage the risks to people's health.

Assessments of people's capacity to make decisions about their care were not always undertaken in line with the Mental Capacity Act 2005.

Improvements were needed to the environment to ensure it meets the needs of people living with dementia.

Staff had received training and were supported in their role through supervisions although improvements were needed to ensure consistency.

People had access to healthcare services.

Is the service caring?

Requires Improvement

The service was not always caring.

Although care staff were caring in their approach people were

not always supported in a way that upheld their dignity and respected their privacy.

People and relatives were positive about the care people received from staff and felt that they could visit at times of their choosing.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans lacked important information to guide staff in how to care for people in ways that were safe.

The delivery of care had, at times, not always met people's individual needs.

The complaints system was not robust.

Is the service well-led?

Inadequate

The service was not well-led.

There were ineffective governance and oversight arrangements within the service.

Management changes had impacted on the consistency within the service

The provider had not established quality assurance and risk management systems to effectively and consistently identify issues or to improve the service.

Stradbroke Court

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 20 and 28 April 2017 and was undertaken by two inspectors.

We reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We spoke with eight people who used the service, four relatives and three visiting health and social care professionals. We observed the interaction between people who used the service and the staff.

We reviewed the care records of 10 people. We spoke with the nominated individual, the manager, the deputy manager and 14 members of staff including housekeeping, maintenance and care staff. We looked at records relating to the management of the service, staff recruitment and training, and systems for monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

At our last inspection 8 December 2016 this key question was rated as requires improvement. This was because we found shortfalls in keeping people safe. This included breaches of Regulation 12 Safe care and treatment and Regulation 18 Staffing of the Health and Social Care Act (Regulated Activities) 2014. Action plans were submitted to CQC on the improvements the service was making to address our concerns. However these were not consistent due to the changes in managers at the service. At this inspection this key question has been rated inadequate. During this inspection we found that significant improvements to address previous shortfalls had not been made. In addition we found additional concerns within the service which did not consistently ensure people's safety and wellbeing.

On the second day of the inspection a visiting health care professional made a safeguard referral when they found one person to be incontinent of urine in their bedroom. The person's mattress and duvet was wet through. Their daily care records showed they had not received any personal care or checks during the hours of 4.45am – 10am despite two hourly checks being in place for the person to reduce the risk of pressure areas. Despite this being brought to the attention of the management team when we checked the person's records later that day there were further gaps in their records. We were not assured of this person's safety and wellbeing.

Some people's care records included risk assessments which provided guidance for staff about how to minimise the risks for people. There were also some systems in place to reduce the risks but these were not robust.

There were records in place for staff to record how often people who were at high risk of pressure ulcers were repositioned. However, these did not all include the frequency for repositioning the person nor did they all include details about how the person was repositioned. This meant that staff were not able to be assured that they were providing the appropriate care for each person.

During the first day of our inspection we found the cover of one person's pressure mattress was ripped and stained. The tears in the cover did not allow for this to be laid smoothly so when the top sheet was in place there would be folds in the plastic cover so increasing the risk of the person developing pressure ulcers. We asked a member of staff about this and they told us that the tear had been reported to the management team five days earlier but no action had been taken. We checked the handover sheets for the day and six days before our visit and there was no mention of this. There was no mention in the person's care records of any action being taken. Later in the inspection we saw the damaged mattress being replaced by staff. On the second day of the inspection we spoke to the deputy manager about our concerns and they told us they had ordered a replacement mattress when it had first been reported damaged. However, they were unable to provide records to reflect this.

Where people required a softer diet to assist them to eat their food their records did not always indicate what they had eaten and entries included, "Soft savoury." Where one person had been provided with soft savoury food their records also showed that they had eaten biscuits and crisps, which were not part of a

softer diet and put them at serious risk of choking.

One person's care records stated that they mobilised with the aid of a stick, they were at risk of falls and that staff should monitor them when mobilising to reduce the risks of falls and that they should use their stick when walking in the service. On the first day of our inspection we saw this person walking in the service alone without a walking stick. In addition they wore only socks on their feet. Which made them at high risk of slipping on the laminate/wooden flooring.

Improvements were needed in the safe management of medicines. The manager was working on addressing shortfalls identified by healthcare professionals. This included staff competency, training, gaps in records, ineffective audits and stock checks. However progress had been hindered by staff, including management and care staff, leaving.

During our inspection we found medicines administration records (MAR) were completed to show that people received their medicines. However, we found inconsistencies in the records. For one person their care records showed that they were allergic to penicillin but their MAR sheet stated allergies 'unknown'. This meant they were at risk of receiving medicine that could cause them potential harm. We brought this to the attention of the deputy manager and when we checked the person's MAR sheet later found this had been amended by the senior on duty. However, a daily form contained in the MAR folder as part of the ongoing improvements which highlighted to staff key information about an individuals' medicine and or changes to be aware of had not been updated. This form is looked at as part of each medicines round. There was no mention in the handover sheet to inform staff at the start of their shift of this change.

Where people were prescribed with variable doses of medicines, for example one or two tablets, it was not always made clear in the MAR how many people had taken. This put people at risk of harm by exceeding the prescribed amount during a set interval. Where people were prescribed medicines to be taken as required (PRN), protocols were not in place for all of these medicines to guide staff at what point they should be considered for administration. Those that were in place did not give detailed guidance for staff. For example one person's PRN protocol stated that the medicine was, "To assist with bowel movement." There was no further guidance for staff on how to assess when the person needed to take this medicine. In another person's PRN protocol the medicine was used for, "Mild to moderate pain," no further information was included as to how the staff could assess this. Another stated that the PRN medicine was to support the person, "For agitation/anxiety," there was no further information about how the person displayed their anxiety. The use of these protocols reduces the risk of inappropriate administration of PRN medicines. In addition there was not a consistent way of recording when PRN medicines had been administered, some entries were left blank and others had the code to show that the medicine had been offered but not needed.

One person's care records stated that they had no difficulty taking their medicines but they, "May spit out or refuse them." There was no guidance in place of the actions staff should take if this happened. With reference to the person's prescribed PRN pain relief their care records stated, "Can usually tell if I am in pain by my body language and facial expressions." The records did not explain what facial expressions and body language the person may display if they were in pain. There was a risk that this person may not receive their medicines when they need them.

Infection prevention and control systems were not robust to minimise the risks to people using the service. The service had received involvement from healthcare professionals regarding the hygiene and cleanliness in the service. They had shared with us their concerns and reports from their visits. This had involved five visits since 17 February 2017. Issues they had identified included concerns over the cleanliness and hygiene

of equipment and within the service. Despite this support there had been two recent outbreaks of sickness in the service and we found areas in the service during the inspection that were not hygienic.

In the Hickling unit we found that the microwave was dirty inside, the kettle had lime scale around the top, there was a fan which was dusty above the toaster, in the bottom drawer of a cupboard there was a hairbrush with hairs in it next to table mats and the radiator cover next to a table was dirty. A cupboard next to the fridge had a missing front panel at the bottom exposing the dust and unidentifiable objects underneath. We reported this to the maintenance person who advised they would address this.

In the kitchen areas in two of the units, Hickling and Trinity the grouting around tiling on the worktops was dirty and coming away which was a risk of the growth of bacteria.

In the communal toilet in Trinity the bin was broken and had not been reported to maintenance to repair. The foot pedal was broken which meant that to dispose of items the lid to the bin needed to be opened by hand. This is not in line with best practice. A tap on the hand basin was broken we spoke with the maintenance person who advised that this had been reported to the management team two weeks ago and a part was on order.

Daily cleaning schedules in people's bedrooms had been brought in as part of ongoing improvements to the cleanliness and hygiene of the service. These were not consistently completed. There was no auditing of these schedules to identify any issues and reflect actions taken. There was a stale smell of urine in one person's bedroom. The records showed this person's bedroom had not been cleaned on a daily basis.

All of these concerns amounted to a continuing breach of Regulation 12: Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Feedback from people's relatives about the staffing levels was mixed. Whilst one relative told us that they were, "Not concerned about staffing levels, can always find someone." This was not the experience for everyone. Another relative told us, "On paper the ratio of staff for residents is brilliant but the layout of the building is inadequate and doesn't help." A third relative comented, "It can be difficult to find someone as they [staff] are usually busy helping someone else."

There was a task led culture within the service. Staff commented that they were very busy and did not have much time to sit and chat with people. This was confirmed in our observations. Whilst staff supported people with their requests for assistance and their daily routines, for example, getting up, their interactions were caring but were focused on the task required. There was no time for these staff to engage with people on a social level which met with their emotional needs.

The manager told us how the service was staffed each day. This was confirmed in records and discussions with staff. However, improvements were needed to consistently deploy and organise staff to meet people's needs. There was no system such as a dependency tool to support the manager in demonstrating that staffing levels and skill mix were being reviewed continuously, and adapted to respond to the changing needs and circumstances of people.

Staffing arrangements were not always effective. Staff roles and responsibilities on shift were not clear. A senior member of the care team spent the first day of the inspection administering people's medicines and was frequently interrupted increasing the risk of a potential error. On the second day of the inspection we saw that two seniors on shift had shared the administration of people's medicines in the service and it took considerably less time to complete. In addition this had freed them up to provide support to the care team

and to take one person to hospital.

There was a lack of staff effectively deployed at the lunch time meal. This meant that not everyone had a positive meal time experience. For example we saw a member of staff supporting two people to eat their meal at the same time. They were unable to focus on both people enough to ensure that they were not rushed and were able to use the time to positively engage and enjoy that time. Staff were put under pressure in providing people with their meals at multiple sites in a timely manner and with the support they required. The meal was served by care staff in the day care centre which doubled as a large dining room. People chose where they had their meals, including in this area or in the units. There was not enough staff to facilitate this in an effective and organised way. Interactions at times with staff and people were rushed as staff hurried to get back to the dining room to collect and deliver the next person's meal. Two members of staff who were providing assistance to people to eat their meal were interrupted by other colleagues checking that people's meals had been served. Staff were also seen trying to adhere to best practice regarding minimising the risk of cross infection by putting on/taking off their aprons. However not all staff were aware of this practice and had to be reminded by their colleagues.

We brought this to the attention of the management team and on the second day of the inspection saw that changes had been made. Kitchen staff served the meals from the main dining room and used a trolley to take the food to the units where people had decided to have their meal. Care staff were then able to stay in designated areas to provide the support required.

Improvements were needed to ensure sufficient numbers of staff were consistently deployed and organised throughout the shift to safely and effectively meet people's needs.

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

Recruitment procedures were not robust. Checks included if prospective staff members were of good character and suitable to work with the people who used the service. However where one disclosure and barring service (DBS) had identified an issue, which had been confirmed by the prospective staff member in their application, there was no follow up discussion or risk assessment or record to show how this had been considered as a potential risk.

We observed part of the morning medicines administration round in the Trinity unit on the second day of our inspection and saw that they were provided to people in a polite and safe manner by staff. However, this was interrupted by visiting professionals and a member of the company supporting the service to improve. They had asked the staff member to locate other staff to assist a person with their personal care needs. We saw that the staff member secured the medicines trolley before they left it unattended. The staff member completed the medicines administration records (MAR) appropriately which identified staff had signed to show that people had been given their medicines at the right time. People were provided with choices if they wanted pain relief and the staff member patiently explained what their medicines were.

The staff member told us that they knew people's routines and arranged the medicines round to ensure that they got their medicines when required and to fit around their usual routines, for example if they preferred to sleep later in the morning. The medicines for the rest of the day were then staggered to ensure that people did not receive their medicines sooner than four hours between. One person refused their pain relief and then requested it later and we saw that this was provided in line with the person's choice. Discussions with this staff member and records showed that staff had received training in medicines and competencies were in place. There was guidance in people's records which identified how people preferred to take their

medicines, such as, "Needs a lot of prompting," and, "Like to see a familiar face for [person's] medication, if refusing please ask other team leader on shift to support."

Medicines audits records were viewed but these consisted of stock checks only. We were not assured that this system enabled the service to identify shortfalls in the overall medicines management. Due to concerns in the service about the safe management of medicines, a healthcare professional had been providing support to staff members. However due to the changes in management and staff leaving there had been issues with continuity and consistency which was impacting the progress. We were concerned that the designated staff member for medicines was part time and this would take longer for the shortfalls identified to be addressed.

Staff had received safeguarding training and were able to identify different types of abuse and what action they needed to take if they suspected someone was being abused. Where a safeguarding concern or incident had happened, the service had taken action to report this to the appropriate organisation who had responsibility for investigating any safeguarding issues. There were safeguarding investigations being undertaken by the local authority, we will continue to monitor the progress and outcomes of these.

Risks to people injuring themselves or others were limited because equipment, including hoists, portable electrical appliances and fire safety equipment, had been serviced and checked so they were fit for purpose and safe to use. Fire safety checks were undertaken and there were personal evacuation plans in place for each person to ensure that staff were aware of the support that people need should the service need evacuating.

At our last inspection concerns were identified with the legionella arrangements in the service. At this inspection we saw that the service had implemented regular checks to reduce the risk of legionella bacteria in the water system and updated their policies and procedures.

Environmental checks were in place which identified what areas in the service required action, for example light bulbs needed replacing. However, there were some issues identified such as window frame needing replacing but there was no further information to show how this was to be addressed. A recent improvement had been made with the development of a maintenance book where staff reported concerns and the maintenance staff reported when this had been addressed.

Requires Improvement

Is the service effective?

Our findings

Daily monitoring records of whether people had enough to eat and drink required improvement. For example food monitoring records recorded if people had eaten a quarter, half or all of their meal but there was no information on the portion size provided. Therefore staff could not be assured that people were eating enough to ensure that the risks of malnutrition were reduced.

We checked the care records of two people who had received a softer diet and found that their food provision was referred to as, "Soft" and "Pureed" it was not clear what consistency they required. We were not assured that these systems were robust to monitor what people had eaten and minimise the risks of not eating enough and of choking.

The systems in place to monitor the amount of drinks people had each day to reduce the risks of dehydration and risks associated with not drinking enough were not robust. Fluid charts did not always have a daily target or total to show what the person had drunk. This could be confusing for staff when trying to ascertain how the person's needs had been met. For example, one person's care records stated that they were at risk of getting urine infections and that they were to be encouraged to drink plenty of fluids and for staff to maintain a fluid chart. However, there was no information about what amounts they were recommended to drink each day.

We reviewed people's fluid and food records and totalled the amount that people had to drink. Some of these varied significantly, for example over four days one person had drank 430mls, 470mls, 570mls and1080mls. Another person had 1450mls, 940mls, 1000mls and 535mls over four days. There was no information as to why the amounts were so different and what actions had been taken by staff to keep them hydrated.

We were not assured that staff understood the importance of good nutrition and hydration in maintaining health and wellbeing for people. We spoke with a senior staff member about how much people should drink and they said it should be in their care plans but could not tell us. They said that the staff had to ensure that people had enough to drink but did not know what was enough or what was too little to cause them to take action. The provider's nominated individual and manager said that the senior staff were required to total the fluid charts and address if people were at risk of not drinking enough. We reviewed ten people's care records and found that none of these indicated how much they were to have to drink. People's fluid intake was not properly assessed and monitored to promote adequate hydration and nutrition.

These concerns amounted to a breach of Regulation 14: Meeting nutritional and hydration needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to quality of care concerns the local authority contract team suspended admissions at the service in February 2017. Commissioners from health and the local authority carried out reviews of people placed in the service and where identified their healthcare needs were not being met and or their needs were too complex these people were moved to alternative services.

We were aware of concerns reported about unsafe moving and handling practices and that health care professionals were providing guidance and training to staff to support their practice. However due to the changes in management and staff leaving there had been issues with continuity and consistency which was impacting the progress. On the second day of the inspection the manager informed us that the designated staff member for moving and handling had left the service and they were considering a suitable replacement.

Some systems were in place to provide staff with training and support and the opportunity to achieve qualifications relevant to their role. Since our last inspection the provider's nominated individual had made changes to the training arrangements following reported concerns over staff practice and suitability of the training to effectively meet people's needs. An in house trainer had been replaced by an external provider who was delivering refresher training to staff. However competency assessments had not been fully implemented to check staff understanding and best practice.

The manager had implemented an induction programme which involved new staff shadowing more experienced staff in the first two weeks. They advised that to support their development staff new to care would be put forward for the Care Certificate. This is a recognised set of standards that staff should be working to.

Staff told us that they were provided with support to develop in their role and improve practice, however, due to the recent changes in management this had not been consistently implemented. Records showed that staff were provided with one to one supervision meetings. The manager advised us there had been some slippage with the frequency of staff supervision due to the management changes but they were addressing this. Conversations with staff and records seen confirmed this. Staff meetings and supervisions provided staff with a forum to discuss the ways that they worked, receive feedback on their work practice and were used to identify ways to improve the service provided to people.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The manager understood when applications should be made and the requirements relating to MCA and DoLS. They understood when applications should be made to ensure that any restrictions on people were lawful. However, there was limited information in the care plans about the arrangements for decision making for those who lacked capacity, best interest decisions, and the decisions that they may be able to make independently. The manager and a staff member told us that the local authority were supporting them in improving in this area.

We saw that staff sought people's consent before they provided any support or care, such as if they needed assistance with their meals and where they wanted to spend their time in the service. Care records included documents which had been signed by people and/or their relatives where appropriate to consent to the

care identified in their care plan. This included disclaimer records for photographs to be taken, the use of terms of endearment, for visual checks to be done during the night, sharing information with other professionals and for staff to assist them with their medicines.

People were provided with a choice of meal. We saw a staff member talking with a person who had refused breakfast, they listed the things that a person could have and highlighted what they usually preferred. When the person had agreed on toast the staff member asked the person what they would like spread on the toast. Another person had asked for ice cream during lunch and made a choice of the flavour they wanted. When they tasted it they said to staff, "I don't like it," the staff member offered them another flavour which was given to them. This showed that staff acted on people's preferences and choices.

Records showed that people had access to healthcare services and receive ongoing healthcare support. One person's relative told us they had been made aware when the GP was visiting and of upcoming reviews. They said, "They [staff] will let me know if the doctor has been and if there is a meeting that I might wish to attend."

At our last inspection on 8 December 2016 the environment required attention. During this inspection, we found that progress had been made in improving the courtyard area making it accessible for people to enjoy gardening and being outside. The work inside to improve the service was ongoing; this included painting and decorating and general maintenance. Despite some people living with dementia there was little in the way of signage and familiar items to help people navigate themselves around their home.

We recommend that the provider refers to current guidance from a reputable source about adapting the environment for people living with dementia.

Requires Improvement

Is the service caring?

Our findings

Improvements were needed in how people's privacy was consistently respected. In Hickling there were booklets which staff recorded people's skin integrity support, food and fluid and personal care. These were on a table in the communal dining area and could be accessed by people and others visiting the service. These included private information about people's personal care needs and did not respect people's privacy. When this was pointed out to staff they told us that they had brought this up previously and the booklets were then placed in a drawer. The provider's nominated individual said that they had been kept in people's bedrooms but staff had not been completing them. When we visited Trinity later in the day the food and fluid booklets were in the kitchen area but the others were in people's bedrooms. On the second day of our inspection following our feedback the records were stored in a box to protect people's privacy.

We spoke with a person in their bedroom who told us that all of the staff were, "Lovely." We noted that they were wearing a hearing aid which was making a noise. We pointed this out to staff who immediately went to speak with the person. Their interactions were caring and they asked the person's permission to look at their hearing aid. They engaged with the person talking about their relative's visit and reported their concerns about the hearing aid to a senior staff member during a visit from the GP. However, during the GP visit the person was sitting in the dining area of the unit where they lived. They were not offered the opportunity to see the GP in private and the consultation was undertaken in the presence of other people.

Language in care records was not always respectful. For example one person's records stated that a person had been, "Rude" to staff. There was no further information about what the actual actions or words that the person had used and the reasons for this. We discussed this with the nominated individual who told us that staff were not always confident in reporting what had actually happened when a person may be displaying behaviours that may be challenging to others and this would be addressed in further training.

People spoken with said that the staff were caring and treated them with respect. One person said, "They [staff] are all very nice." Another person said, "They [staff] are charming all of them, really lovely to me." Relatives felt that they could visit at times of their choosing. One relative said, "Never a problem to pop in. I am here most days. Always made to feel welcome." Another relative commented, "Staff are lovely, very kind people, am here every day I do notice the difference."

There was a relaxed and friendly atmosphere in the service and people and staff clearly shared positive relationships. Interactions between staff and people were caring and respectful. The staff made eye contact with people and were patient when waiting for them to reply. Staff used appropriate touch when communicating with people which responded to people's preferences and needs, for example when a person reached out for the staff member's hand, the staff held it.

Staff talked about people in a caring manner and knew people well. One staff member told us how one person was not feeling well on the day and needed some reassurance when mobilising.

We saw some examples of caring and compassionate interactions from staff which took into account

people's choices. For example, during the administration of medicines the staff member was patient and addressed people's comments. When staff saw people they greeted them in a friendly manner, this included one person who walked purposefully throughout the day, each time they passed staff they checked that the person was alright, needed anything and greeted them warmly. A staff member and a person walked together, they were linking arms and singing.

People's records identified the areas of their care that they could attend to independently and how this should be respected.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection 8 December 2016 this key question was rated as requires improvement and included a breach of Regulation 9: Person Centred Care of the Health and Social Care Act (Regulated Activities) 2014. This was because we found shortfalls in the service with people's care records. These required further development and improvement to ensure they were person centred, accurate, met people's needs and reflected their preferences. Action plans were submitted to CQC on the improvements the service was making to address our concerns. However these were not consistent due to the changes in managers at the service. At this inspection this key question remains rated as requires improvement. Despite ongoing support from the local authority improvements to address previous shortfalls with people's care records had not been made. In addition the complaints system was not robust.

Staff were not always responding in a timely manner to people's needs. For example, meeting their personal care needs. This was identified and reported to the local authority safeguarding team by a visiting healthcare professional on the second day of the inspection.

There were some inconsistencies in records which could be confusing for staff and there was a risk that people could receive inappropriate care. In addition the care plans did not always provide staff with the guidance they needed to meet people's needs. For example, one person's records stated that the person was at risk of developing urinary tract (UTI) infections and staff were to report to team leaders if they had concerns. However, there was no information about what staff should be looking for and the signs and indicators of UTIs developing. Another person's care records stated that they could be anxious when having a bath or shower, there was no information in the care records to guide staff how to best support this person to reduce their anxiety. Another person used an anticoagulant medicine, there was no guidance in their care plan regarding actions staff should take if the person gets injured and the risks associated with their medicine and blood loss.

On the first day of our inspection a senior care staff spent the majority of their shift in the office updating care plans. They had been tasked with updating all 28 people's care records with support from the local authority and had been working on the care plans for several weeks. We were not assured that this was an effective system for one person to be responsible for as despite input from relevant professionals no care plans had been completed and were all a work in progress.

There were records in place which identified the personal care and support provided to people. However, on the first day of the inspection there was a lack of documentation which identified the quality of people's day, wellbeing and how they had spent their time. We received varying information from staff and management about how they monitored people's care and wellbeing. Two staff told us that they no longer completed daily records apart from the booklets of personal care, diet and fluid and pressure ulcer care. They told us that important events were recorded; however the folder in the Hickling unit to record this information had been missing for several days. In another unit we looked at the folder, which was provided to us by the deputy manager and found that there were gaps in the daily recording, for example some days had not been completed for people and they were mainly referring to the task based care provided.

The manager told us that all staff attended a handover meeting and these were recorded. We reviewed the records of handover meetings which were held at each changeover of shift. These listed each person and their wellbeing was discussed. These were not kept in any order and there was no evidence that these were monitored or used to assess any changes required to people's care. Not all people were discussed in the meetings.

All of these inconsistencies amounted to a continuing breach of Regulation 9: Person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The complaints procedure was displayed in the entrance of the service, which advised people and visitors how they could make a complaint and how this would be managed. Despite this information an effective system for managing people's comments and concerns was not in place. Prior to this inspection we had received information that people's concerns and complaints were not being properly looked into. We asked the manager to demonstrate to us how people's concerns and complaints were being recorded, acted on and used to improve the service. They told us there were no records. Therefore we were not assured that people's feedback about their experience was valued by being appropriately investigated and responded to in a timely manner.

This amounted to a breach of Regulation 16: Receiving and acting on complaints of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Activities on offer were identified on an activities programme posted in the service. This included arts and crafts, exercise, biscuit decorating and games. There were no activities identified during weekends. On the first day of our inspection we saw people throwing a ball to each other in the main day centre area. However, in the units where some people chose to spend their time, there were no activities provided, other than watching the television and speaking to visitors. We met with one person in the corridor where they were looking out of the window with a staff member. They showed us the baby chickens in the grounds and told us how they liked to watch the progress.

On the second day of our inspection we saw a person doing some gardening. When they had finished they engaged with staff about what they had done. Another person got bread from the kitchen area and broke it up onto a plate. When we asked what they were doing they said, "I'm feeding the birds, I do it every day." They then went into the garden area and laid the bread out. Discussions with staff identified that this was the people's usual routines and chosen activity. A group of people in the main dining area were encouraged by staff to help to fold the napkins. In the afternoon people watched a film. When a person was being encouraged by staff to watch the film, the staff member said, "I have saved a lovely comfortable chair for you." This made the person smile and join in.

Activities records showed that people participated in both group and individual activities, including learning to knit, chats and looking at birds.

People told us that they could have visitors when they wanted them. We saw people entertaining their visitors on both days of our inspection.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 8 December 2016 this key question was rated as requires improvement and included a breach of Regulation 17: Good Governance of the Health and Social Care Act (Regulated Activities) 2014. This was because robust systems were not in place to effectively monitor and evaluate the safety and quality of the service to drive continual improvements.

At this inspection this key question has been rated as inadequate. We found a significant decline in the standards of care at the service. There were insufficient quality assurance systems in place, ineffective governance and poor oversight at manager and provider level which had failed to fully identify shortfalls in the quality of the service putting people at risk of harm. Improvements were needed in how the service was assessed and monitored to ensure that people were provided with a good service at all times.

Following a significant number of quality of care concerns the local authority contract team suspended new admissions at the service in February 2017. The local authority's provider support team had been working with the manager on developing an action plan in response to concerns identified by CQC and health and social care professionals. Despite agreeing to provide a weekly action plan to CQC and the local authority the changes in management at the service affected the frequency and quality of information provided.

During this inspection, we found there were continuing breaches in respect to safe care and treatment, staffing, person centred care and good governance. In addition we identified shortfalls in the complaints process and a number of safety concerns.

There was a lack of ownership and accountability at all levels in the service. We were not assured that the current structure demonstrated effective leadership to address the concerns and take appropriate action. We asked the manager what systems were in place to assess and monitor the service to ensure that people were provided with a quality safe service at all times. They told us there were no systems.

Despite the support of several health and social care professionals' progress on issues that had been identified had been slow due to the number of managerial changes in the service. Since our last inspection there have been three changes of manager for the service.

Staff told us that they found this unsettling because each manager brought changes and they were unsure of the current systems to ensure people's safety and good quality care. They were not always clear on the reasons for changes, for example people were to be encouraged to eat meals in the main dining area, however, some people preferred to eat their meals in the units. One staff member talked about a high turnover of staff and attributed this to the regular changes of management, they said, "It has been unsettling with managers and the changes, like where people have their meals it should be their choice. Too many different ways of working." There was no information provided to show how people had been consulted.

The provider's nominated individual advised us in February 2017 that they would not be taking any new admissions including respite care whilst they made improvements to the service. However this instruction

was not always followed. We were aware that the previous manager had accepted a person for respite care which the nominated individual then had to cancel once they became aware.

The current manager told us that they had decided to return to their role in another of the provider's services. The provider's nominated individual told us about the actions they were taking to ensure there was effective management in place. This included the appointment of another new manager to run the service. They were due to start the following week. As part of their induction the current manager would be providing support for three months before returning full time to manage another of the provider's services that they were the registered manager for.

People's records were not always detailed or accurate and this placed people at risk from inappropriate care. We found people's medicines were not always managed safely and properly, risks to people health and safety were not always assessed and mitigated. There was not an effective quality assurance system in place to identify these issues and take appropriate action.

There were limited systems in place to gain the views of the service provided from people using the service and their representatives. There were no satisfaction surveys for people and relatives to complete to share their experiences. There were no meetings for people who used the service although a meeting for relatives had taken place and another one was planned for May 2017. The meeting minutes showed that relatives were concerned with the quality of the service, staff leaving and management changes and that communication within the service was a problem.

Records and discussions with the manager showed that incidents, such as falls, complaints and concerns were not analysed to identify possible trends, used to improve the service and reduce the risks of incidents re-occurring. This would help to make sure that people were safe and protected as far as possible form the risk of harm.

Providers are required to send the CQC statutory notifications to inform us of certain incidents, events and changes that happen within the service. So that where needed, CQC can take follow-up action. Due to the changes in management we had not always received the relevant statutory notifications.

All of these concerns amounted to a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's nominated individual had made some changes since our last inspection. This included improvements to the garden and outside area making it safe, accessible and decorative including raised beds for people to enjoy gardening. They had been actively recruiting staff recognising a need for more qualified and experienced senior care staff and told us two people were due to start in this role the week commencing 1 May 2017. They had recently employed an external company to assist them to make improvements to the service. However at the time of this inspection it was too early to assess their impact.

During our inspection the housekeeping staff shared with us a positive change they were making to improve the recording and monitoring of their work. Such as introducing housekeeping books on the units so that staff could record any issues and link up with maintenance where appropriate. At the start of each shift these would be reviewed and updated reflecting what actions had been taken and what was outstanding and needed to be escalated.

We found that staff understood and were confident about using the provider's whistleblowing procedure. A whistleblowing policy was in place and staff were aware of it. Whistleblowing is where a member of staff can

report concerns to a senior manager in the organisation, or directly to external organisations. They can do this anonymously if they choose to.

We saw that the current manager had been keeping staff updated with changes in the service and people's needs. The most recent staff meeting minutes in 5 April 2017 identified that staff were advised to check mattresses, all injuries to be reported, how to report sickness and diarrhoea outbreaks, food and fluid charts not being completed. The meeting minutes 22 February 2017 discussed the rating from last CQC inspection, infection control requirements, recruiting more staff and new maintenance staff.

People, relatives and staff spoke positively about the current manager and said they were approachable and visible in the service. One relative said, "Seems a better home, feel like the [current] manager has listened to me. Last manager, didn't like. [Another] resident kept walking into [relative's] [bed] room. Frightened [them]. Previous manager didn't stop it." A member of staff said, "[Manager] is a calming influence, always around; has helped to boost morale amongst the staff."

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care Due to inconsistencies in records staff were not always provided with the information they needed to meet people's needs. Regulation 9 (1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Systems in place to monitor the amount of drinks people had each day to reduce the risks of dehydration and risks associated with not drinking enough were not robust. Regulation 14 (1) (a) (b) (4) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints An effective system for managing people's comments, concerns and complaints was not in place. Regulation 16 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Improvements were needed to ensure sufficient numbers of staff were consistently deployed

and organised throughout the shift to safely and effectively meet people's needs.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service did not always receive care provided in a safe way. Systems for the safe management of medicines and infection prevention and control procedures were not robust. Regulation 12 (1) (2) (a) (b) (d) (e) (g) (h)

The enforcement action we took:

Notice of proposal to impose positive conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were insufficient quality assurance systems in place, ineffective governance and poor oversight at manager and provider level which had failed to fully identify shortfalls in the quality of the service. Regulation 17 (1) (2) (a) (b) (c) (f)

The enforcement action we took:

Notice of proposal to impose positive conditions.