JK Healthcare Limited

Weald Hall Residential Home

Inspection report

Weald Hall Lane
Thornwood
Epping
Essex
CM16 6ND
Tel: 01992 572427
Website: www.sohalhealthcare.co.uk

Date of inspection visit: 28 and 29 July 2015
Date of publication: 01/10/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

The inspection took place on 28 and 29 of July 2015 and was unannounced. Weald Hall Residential Home is registered to provide accommodation and personal care for up to 39 older people. The service mainly provides care to people living with dementia. There were a total of 38 people using the service at the time of the inspection.

We last inspected the service in January 2015 and we rated the service as inadequate as the provider was not meeting the legal requirements. Following the inspection the provider wrote to us to say what actions they intended to take.

The service has a registered manager, although they were not present during the inspection as they were on holiday. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

At this inspection we found that the provider had made some improvements but had not met all the requirements made at the previous inspection.

At the last inspection we found that the environment was not being properly maintained and equipment was not safe. We found that the provider had undertaken some refurbishment and had developed areas for people with dementia to use, which reflected good practice. However we found that people continued to be at risk of unsafe care as staff were not sure how to use some of the equipment provided. Moving and handling practice placed people at risk of injury. Risks were not always well managed, and there had been insufficient consideration of the least restrictive way of keeping people safe. Bedrails were in regular use but the dangers that they presented had not been fully considered.

Infection control was not well managed and this placed people at risk and the staff were not clear about the procedures to follow to protect people from the spread of infection.

At our last inspection we found that induction training and support provided was not effective as staff were not suitably skilled and knowledgeable. At this inspection we found that some training had been provided, however in areas such as infection control and moving and handling the limited skills and knowledge of staff remained an issue.

At the last inspection we found that the provider did not have appropriate arrangements in place regarding consent. We found that some improvements had been made but staff still had limited knowledge and understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

At the last inspection we found that people were not protected from the risks of inadequate nutrition and hydration. We found that some changes had been made but the support for people with complex needs was not always effective and provided in line with professional advice. People's health needs were not always promoted, and staff were not always clear about how they should support people with specific health conditions such as ulcers or diabetes and reducing risks of deterioration.

At the last inspection we found that people did not always have their dignity, privacy and independence promoted. At this inspection we found that some improvements had been made, but some staff continued to treat people in a way which did not promote a respectful and caring approach.

People had their care needs assessed and we saw that staff had started to compile social history's. These were at an early stage of development and had not yet been incorporated in care plans. Plans were not person centred and did not offer clear guidance to staff about how care should be provided. Our observations were that the plans were not reflective of the care that was provided.

Complaints were not managed in a proactive way or used as a tool to develop care practice.

At the last inspection we found that the provider did not have an effective system in place monitor quality and identify, assess and manage the risks. We saw that the provider had started to develop a system but it was not fully operational and therefore we were unable to make a decision about how effective it could be. The concerns which were identified at this inspection had not been identified by the registered person.

Medicines were appropriately stored but staff were not always administering them safely or in line with how they were prescribed.

At the last inspection we found that there were not adequate arrangements in place that ensured people were engaged in stimulating activities which promoted their wellbeing. We found that improvements had been made in this area and people enjoyed the activities provided.

The Provider had systems in place to ensure that the staff they recruited were properly vetted. Staffing levels were adequate although they were busy and task orientated in their approach. Staff were clear about how they should respond to concerns and safeguarding.

Summary of findings

We found that there were a number of breaches in the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and you can see what action we have told the provider to take at the back of the full version of the report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
This service was not safe.

Staff did not always use equipment safely or follow safe moving and handling procedures.

Risks to people's welfare were not always managed effectively.

Infection control arrangements did not offer people protection

Medicine administration did not always follow professional guidance.

Inadequate

Is the service effective?
This service was not effective.

There were systems in place to access health care support but advice was not always followed or implemented.

People were not consistently supported by staff with the right skills and knowledge.

The principles of the Mental Capacity Act were not well understood

People were positive about the meals provided.

Inadequate

Is the service caring?
The service was not always caring

Some staff were caring but care delivery was task focused, and did not always meet individual needs.

People were not always treated with dignity and respect

Requires improvement

Is the service responsive?
The service was not responsive

Concerns and complaints were not appropriately managed and responded to.

Care delivery was not always personalised and or corresponded with the plan of care

People enjoyed the activities on offer.

Inadequate

Is the service well-led?
This service was not well-led.

Leadership was visible and supportive but poor practices were not being identified and addressed.

Audits did not address the inconsistencies in the approach of staff or promote individualised care.

Inadequate

Weald Hall Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on the 28 and 29 July 2015 and it was unannounced. The inspection team consisted of two inspectors, two Specialist Professional Advisors (SPA) and an Expert–by-Experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care.

Prior to the inspection we reviewed the information we held about the service and safeguarding concerns reported to us. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect.

As a number of people who lived in the service had dementia we used the Short Observational Framework for inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with seven people, five visitors, and three healthcare professionals. We spoke with seven care staff, the deputy manager and the provider. We looked at three staff records; peoples care records, staffing rotas and records relating to how the safety and quality of the service was being monitored.

Inadequate

Is the service safe?

Our findings

At our previous inspection in January 2015 we found that the provider was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from the risks of unsafe care, because the premises and equipment were not suitably maintained. Staff had a limited understanding of hazards that placed people at risk.

At this inspection we continued to have concerns about the use of some equipment. We saw that some items had been replaced or repaired. Call bells were now working and accessible to people in their rooms, and walking frames which were worn had been repaired and frames were clearly labelled with individuals' names. However some of the new equipment was not being correctly used which placed people at risk of injury. We observed staff attempting to move an individual in a moving and handling sling that was not the correct size for them placing the individual at risk of falling. Staff obtained another sling, but they did not know what loops or fittings to use to secure the individual or the sling to the hoist. They had no guidance available to them on the use of the slings. The individual was subsequently moved using a stand aid, despite the staff's knowledge that this was not appropriate as the individual had painful knees. We observed other individuals being moved using stand aids when they were unable to weight bear or follow verbal prompts. This type of equipment is not suitable for people in these circumstances and doing so places individuals at risk of injury and pain.

The registered person had not ensured that the equipment used to deliver care was being properly used. This is a Breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accident reports and body maps were competed, but we did not see evidence of action to reduce the likelihood or the identification of patterns and trends developing. Although staff told us that reports were compiled, they were not clear what was done with the information. The manager subcequently told us that accident reports were submitted to head office. Staff told us that they were not caring for any individuals who currently presented, "any particular risk". However we observed a number of individuals nursed in bed with a chair backed against their bed. Staff told us that the chairs were in place to stop individuals, "falling out."

We saw that a number of individuals had bed rails in place, however we found the risk assessments were all identical and were not person centred. They stated that the individual may wake up disorientated and try and climb out of bed. This was identified as being high risk. The assessments did not show that any consideration had been given to the risks associated with the increased height of the bed rails, the individual's capacity or that they were possibly being used as a restraint. The use of bed rails placed some individuals at an increased risk of injury, and we could see no evidence that alternative or less restrictive options had been considered.

Certificates were available to evidence that equipment such as hoists had been serviced. We saw that personal emergency evaluation plans (PEEPs) were in place and gave instruction to staff about what action they should take in the event of an emergency if people needed to be evacuated.

People were not protected by the arrangements that were in place for the prevention and control of infection. We saw that since the last inspection a number of the carpets had been replaced and chairs had been deep cleaned. One carer said, "I like the changes that have happened since the last CQC visit, the new flooring looks good doesn't it." However we noted that their continued to be a strong smell of urine in some of the corridors and in some bedrooms. One person said to us, "Look at the carpet, it's all stained and smelly." Another person said, "the room can be smelly; they said that they would deep clean it."

We looked at a sample of mattresses, and found a number were stained and smelt strongly of urine. We saw that in one bathroom there was a clinical bin containing bags which was very full and had an offensive odour.

Staff did not have a good understanding of infection control procedures. We observed that two care staff provided personal care to an individual and then moved on to assist another individual without washing their hands. We saw staff giving people biscuits with their fingers without wearing gloves or using tongs, and we witnessed a member of staff using a cloth and basin to wash equipment which was subsequently returned to the kitchen. We were

Is the service safe?

told the cloth was also used for wiping down dining tables. Staff had limited knowledge about infection control. They told us that separate cleaning cloths were not used for cleaning separate areas of the home, and they were unclear about what the system was for dealing with spillages. This presented an increased risk of cross contamination throughout the home.

We also viewed the laundry facilities. Although this was clean and tidy, we noted that clean linen was being stored directly above the soiled linen. Clean and soiled linen should be segregated to reduce the risk of contamination.

The registered person did not always ensure that care was provided in a safe way. This is a Breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not always safely managed. We saw creams and lotions in individual's rooms which were out of date and prescribed for other individuals. One person who was at high risk of a pressure ulcer had been prescribed a cream to protect their skin. This was not available in their room but was signed in the Medication administration records (MAR) as administered. The member of staff who had signed the records was not able to assure us that the cream had been administered as prescribed.

The MAR were not always completed by the member of staff who administered the medicine. This increased the likelihood of errors. We observed a carer administering medicine to an individual. The medicine was left unattended in a pot in the lounge for a short period before being administered. We looked at the MAR and saw that another member of staff had signed them. We asked for confirmation that the member of staff who administered the medicine had undertaken training and whether they had been assessed as competent. We were informed that they had not been trained or assessed but had previously worked as a nurse abroad.

Written plans were not in place to enable staff to make consistent judgements regarding the use of medicine prescribed on an, 'as required basis' (PRN). This increased the likelihood of confusion and error. Staff told us that they usually made a judgement from the individual's appearance or body language as to whether it was required.

We found the arrangements for the administration of medication to be unsatisfactory. This is a Breach of Regulation 12(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

MAR were well maintained and we did not see any unexplained gaps in the records. Medicine trolleys were stored securely in a locked cupboard and were clean and tidy. Controlled drugs were stored in an appropriate locked medicine cabinet that was securely fixed to the wall. The medicine room and fridge temperatures were taken daily and were within the recommended temperatures. Records showed that two staff had signed the records for the administration of controlled drugs. We checked the system in place for the administration of warfarin and saw that this was checked by two members of staff. We were told that some of the staff had completed competency assessments to safely administer medicines.

People gave us conflicting information about staffing levels. Some people spoke positively about the staff availability and care provided. However other people told us, "They are short staffed; there is not enough of them." A visitor said to us, "There doesn't seem to be enough carers on duty here."

Our observations were that staffing levels were adequate. Although care staff were busy, call bells were answered swiftly and did not ring for excessive periods. We observed occasions where staff were not available in the communal areas or able to spend time chatting to individuals. This was because they were engaged in a variety of other tasks such as serving drinks and assisting people with their personal care needs. During these times the activity organiser and housekeeping staff interacted well with individuals, supporting them and seeking assistance for individuals when needed.

Staff told us that there was sufficient number of staff to meet people's needs and that shortfalls were normally covered from within the staff team and without the use of agency. Although the manager was not available on the day of our inspection, we were told that they used a specific tool to assess the numbers of staff required. However this was not available to us on the day of the inspection. We were shown dependency scores for a number of individuals. Staff told us that there were approximately twelve people who were relatively independent with mobility, twelve people who required two staff to assist them, and a further twelve who required

Inadequate

Is the service safe?

the assistance of one staff to mobilise. The home normally operated with five care staff and a senior throughout the working day and one senior and two care staff during the night. One member of staff said, “There is normally enough staff on duty, we normally have five in the morning and afternoon, but sometimes there is only four due to holidays or sickness.” People confirmed that the manager, who was supernumerary, assisted in these circumstances.

We looked at the recruitment of staff and saw that they followed safe practices. We viewed the records for four staff and saw that these detailed that all checks had been completed before the staff had begun work. This included ID checks, two references and a check from the disclosure and barring service to show that they were not barred from working with adults in social care.

People told us that they felt safe. One person said, “I feel safe here and I can speak up for myself.” Staff told us that they had undertaken training on abuse and demonstrated an understanding of what constituted abuse. They told us that would tell the manager or provider if they had any concerns. One member of staff said, “I would tell the Local authority or CQC.” Our observations did not always support what we were being told and the practice observed. For example staff did not recognise some practices such as locking of doors or bed rails as restraint.

Inadequate

Is the service effective?

Our findings

At our previous inspection in January 2015 we found the provider was in breach of regulation, 18, 11 and 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were concerns about how nutrition was managed, staff training and the implementation of the principles of the Deprivation of Liberty Safeguards (DOLS.)

At this inspection we found that some training had been provided and while there were some improvements, there was still evidence that some staff lacked the skills to meet people's needs.

Staff were positive about the training provided to them, and told us that they had attended a virtual dementia course. The training aimed to help carers understand how people with dementia see the world. Staff told us that the training had made a difference in how they cared for people and had, "opened their eyes to dementia." One staff member said that it had, "shocked us." Another said it had given some staff, "the kick" that they needed. Our observations were that some staff had not transferred their learning into their practical care delivery, and the care did not always reflect good practice. We observed an individual becoming distressed and striking out at a member of staff after they spoke with them. Some of the communication we witnessed was very negative and controlling. For example we observed a staff member saying to an individual, "Go to the dining room and have something to eat now." People were described as, "like children." Confrontations between people were not always well managed by staff, who lacked the skills to effectively intervene and de-escalate situations which put people at risk. On one occasion we observed a member of staff shouting across the dining room to an individual telling him to, "stop it." The situation continued to escalate and the two individuals shouted at each other.

There was no system in place to ascertain staff levels of competency or their understanding of a subject following training. We spoke to staff about some of the areas about which we had concerns such as infection control. When we asked questions of three staff about their understanding of procedures and the steps that they should take, they were not clear. One said, "I do not know." Another staff member said, "My English is not very good."

We observed staff moving people in ways which were not in keeping with best practice. This included lifting people under their arms, pulling them up from the chair by their arms and using their trouser belt to lift people up from the chair. These manoeuvres place people at risk of injury and demonstrate that staff were not suitably skilled in moving people who required support. Two staff who had been working at the home for some time did not have any moving and handling training.

We looked at the training records and saw that the majority of staff had received regular training updates; however there were gaps such as infection control which had not been picked up and addressed. The cook did not have food hygiene or training in nutrition.

The registered person had not ensured that staff received suitable training, professional development and supervision that was necessary to enable them to appropriately perform the duties required of their role.

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

At the previous inspection concerns were raised because people's food and fluid intake was not being effectively monitored, and there were no drinks or snacks available outside set meal times. At this inspection we saw that some improvements had been made but concerns remained about how they monitored and managed the nutrition of people with complex needs.

Most people told us that the, "Food was ok." One person said, "The chef looks after me alright, she knows what I like." Another person said, "I like some of the food but not everything."

Efforts were made to make the dining experience a social one. The dining tables were nicely laid and picture menus were available. We observed lunch and two evening meals. We saw a group of individuals sitting together in the dining room and they clearly enjoyed each other's company and there was lots of laughter and banter. The food served looked appetizing and there was enough for people to have second helpings if they wished.

However for those that required assistance their experiences varied. A relative said, "The staff tell me that (my relative) eats breakfast without help, but (my relative) can't hold a spoon or fork so how can they have a proper breakfast." We witnessed one member of staff assisting an

Is the service effective?

individual. They talked to the person and the assistance was well paced. However in contrast we saw another member of staff assisting a person in a rushed manner with little interaction. The person was initially asleep and when the member staff put the food to the person's mouth they jumped back startled, as they had no warning. The member of staff repeatedly said, "can you have your eyes open." And, "open your mouth." There was no napkin available and food ran down the persons chin.

The organisation and delivery of meals however did not safeguard people with dementia. Some people could not recall whether they had eaten or not, and others were not aware of mealtimes without prompting. During the morning we heard one individual tell a member of staff that another individual had not had breakfast. The member of staff went off to check and subsequently came back with a bowl of porridge. The person was not offered a choice but we saw that the individual was hungry and ate the porridge. At lunchtime we saw that one person who was not in the dining room had missed their meal, however on this occasion their relative spoke to staff and a meal was provided.

There were records of food and fluid intake but these were not effective as they were not always completed fully. We looked at a sample of records and saw that no entries had been made for the previous day. We observed a member of staff completing a number of these records late morning from memory and we were unclear about their accuracy. We observed a member of staff giving a person a drink from a cup and a biscuit. It was later recorded that a syringe had been used to deliver 150mls of fluid to this person. This did not accurately reflect the care delivery or the persons consumption. Therefore it was difficult to know how accurate these records were, and how this information was being used.

The home used the Malnourishment Universal Scoring Tool (MUST) to identify people at risk of not eating and drinking enough. We saw that they had given individuals a score based on this tool, and people that were identified as being at risk were being weighed fortnightly. We saw that referrals had been made to the dietician and advice had been provided, however this was not always followed by staff. For example advice had been given, to give one person, 'Complan shakes' twice daily, high calorie snacks and to fortify foods. ' There were no records of this advice being followed and we saw that this individual had continued to lose weight. The care plan was not sufficiently detailed to give staff guidance, and staff we spoke with were not clear about this.

We saw another person had not eaten on the day of our visit, we noted that their lunch and evening meals were left in their room untouched. We saw that they had consistently lost weight over the last four months. The care plan said, 'offer small portions and record diet and food intake.' The MUST documentation stated that food should be fortified, however staff, including the cook, were unclear about this and our observations was that this was not being undertaken for this individual. We did note that a referral had recently been made to dietician.

We spoke to staff about the arrangements in place to support people who had been identified as being at risk. They told us that cream was put into people's porridge and they made milk shakes. We saw some milk shakes were available on the trolley at one of the evening mealtimes.

People were not adequately supported and this is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC is required by law to monitor the operation of the Deprivation of liberty (DoLS) and The Mental Capacity Act (MCA) which provide legal safeguarding for people who may be unable to make decisions about their care. The records and care plans in place showed that the principles of the MCA code of practice had not always been followed.

We saw that some individuals had Mental Capacity Assessments in place and best interest decisions regarding personal hygiene and eating and drinking. We found that some people had bed rails in use on their beds but there was no evidence of best interest decisions regarding this type of restrictive equipment. We also noted that the dining room was locked for the majority of the day and only opened for meal times. We were told that this was to protect people, but we were not clear how these decisions had been made and if they were the least restrictive methods of keeping people safe. We were told that some applications had been made under the deprivation of liberty (DoLS) with regard to people leaving the premises but they were awaiting the outcome.

Inadequate

Is the service effective?

The registered person had not always ensured that they were acting in accordance with the legislation and guidance when people did not have capacity to consent. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported to maintain good health. We were told that the home was caring for two people who had home acquired pressure ulcers; one of these was a grade 3.

There were no records on site to demonstrate the current situation with the wounds but we were told by staff that one of these was, "doing well." We saw that staff completed a Waterlow Risk Assessment for each person. This is a tool used to identify the risk of developing pressure ulcers. However we did not see a clear plan regarding the reduction of risk or the management of the ulcer. We observed one individual who had an ulcer, spent the morning sitting in chair. When we checked their chair w ith a member of staff, we found they were not sitting any pressure relieving equipment. We also noted that they had a pressure mattress on their bed however this was set at the wrong pressure for their weight; There was no system in place for checking the pump. A repositioning chart was in the individual's room but when we checked it mid-morning we noted that his had not been completed since 5am. We spoke to staff about why they were not repositioning and they told us that you, "cannot reposition in a chair."

We saw that the home was caring for people with diabetes and we asked staff about how this was managed. We were told that, "every now and again we do blood sugars." Staff told us that they had no training in this area. We looked at the care plan and saw that diabetes was not referred to. There was no guidance as to how this condition should be managed and how staff could recognise a hyper or hypoglycaemic event.

We saw that the service was caring for person who had a catheter. We spoke to staff about its management and they were unclear. We subsequently spoke to a member of the management team who told us that they changed the legs bags but there were no records maintained of when and how often this was undertaken. We saw that the individual had frequent problems with the catheter site resulting in antibiotics. The service would benefit from accessing training in caring for catheters to try and minimise the number of infections.

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

The internal décor was tired in places but we were told that new carpet had been fitted in some areas. The corridors did not always contain sufficient signposting for people with cognitive impairment to find their way around. There was some dementia friendly signage but some of the signage was too high for people to see from wheelchairs. Corridors with sloping floor had signs above them to warn of this but these may not be sufficient for people with dementia who may not be looking up when mobilising.

However some changes had been made to the design of the environment to help the needs of people with dementia and promote their independence. In the grounds two wooden garden rooms had been developed. One was made up as an old fashioned library area with books for people to look at. The second room had been made up into a sweet shop café area in a 1950 style. The room contained lots of items for people to touch. These changes reflected good practice in the care of people with dementia and we were told that these areas were used regularly except in poor weather. The provider told us that they had planned further works in the garden including raised bed and the development of a sensory area.

Requires improvement

Is the service caring?

Our findings

At the last inspection the provider was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that people were not always treated with kindness and compassion in their day to day care and enabled to make choices about their care. At this inspection we found some improvements but continued to find inconsistent practice in how people were cared for.

The majority of people we spoke with were positive about the home but this was not everyone's experience. One person told us, "I like it here it is lovely, the staff are lovely and kind." Another person said, "I didn't settle at first but now I like it." Another person said, "The care is alright, it could be better. "A visitor told us, "No one is responsible for my relative, there is no one to one care for my relative, there doesn't seem to any one carer who is responsible." Another relative said "It's not good here for my relative."

We observed interactions between staff and individuals. Some were caring and appropriate such as a member of staff putting their arm round an individual who started to cry. Some staff appeared to know the individuals well and were observed being warm and friendly as they went about their duties. However we also observed some staff being very task based and witnessed examples of poor communication. We saw staff moving people in wheelchairs without any communication or warning, and we observed one member of staff walking up to an individual and looking in their mouth without communicating with them. The individual was asleep and woke up startled.

People's dignity was not always promoted. One relative said, "My relative is often wet through when we arrive to visit, and nobody has noticed but it's pretty obvious they are wet…. nobody seems to notice them." Another person told us, "It is upsetting to see my relative without having their hair brushed and even without their teeth in, these are basic things I would expect the carers to do." One person told us that they wore glasses and said, "I wish I had them to see what I was eating."

We observed that some individuals were wearing clothing which was stained and dirty and when the evening meal was served in the lounge there were no napkins available. This meant that people had food debris around their mouths and down their clothing. A member of staff later came round with some toilet roll for people to wipe their faces.

We saw examples of where people's independence was promoted. We heard a member of staff for example encouraging an individual to put on their socks and shoes. The individual had help with his socks but could manage his shoes.

We saw that people were involved in making decisions about their care to varying degrees. We observed a staff member asking an individual if they needed help to stand and when they said no this was respected and the person took their time but moved independently. However we also observed a member of staff providing assistance without talking to the person about what they were going to do, which was contrary to their care plan.

Staff told us that they gave people choices and that people were actively involved in making decisions. We did observe staff offering people choices such as what and where they wished to eat. However this was not always done consistently, for example when the drinks trolley came round with drinks; they were already made up and handed to people.

Inadequate

Is the service responsive?

Our findings

At the last inspection in January 2015 we found that the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service did not have adequate arrangements in place that ensured people were engaged in stimulating and meaningful activities. At this inspection we saw that improvements had been made.

We observed social activities taking place and the people participating were engaged and seemed to enjoy themselves. We observed activities such as exercises, a sing long, and bingo taking place and observed that they were well attended. However we noted that the member of staff who led the exercise class did not have any training in this area. People were encouraged to stand up and stretch, we did not see any understanding of people's individual abilities or consideration of pain from overstretching. This put people at risk of injury.

One person told us that they helped out with gardening and how much they enjoyed it, they proudly showed us the work that they had done and said, and, "The manager has given me a job." The individual told us that he was hoping to go fishing with a member of staff. However we noted that staff were busy and had little opportunity to spend one to one time with people other than assisting people with the task that they needed help with. However we did overhear a member of staff saying to an individual, "You like your nails done, so I'll do them for you this morning."

One of the changes which had been introduced was a "life story book" which detailed people's previous life experience and interests. We saw that one book had been well completed but others were at an early stage of development. The book will enhance a person centred approach if used effectively to inform care plans.

Concerns and complaints were not responded to in a positive way or used to improve the quality of care.

There was a complaints procedure in place and a number of relatives told us that they had raised concerns, but these had not been dealt with satisfactorily and things had not improved. One person said, "My relative has complained to the manager but nothing changes," Another person told us, "My relative made a complaint, they are trying to find another home for me." Despite these comments from people, the homes management told us that no complaints had been received since 2012, and there were no records to show otherwise. We therefore concluded that concerns and complaints were not being appropriately managed and responded to.

The registered person did not have an effective system for the management of complaints. This is a Breach of Regulation 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were assessed on admission but the care delivered was not always personalised or corresponded with the care plan. We saw little evidence that people's needs were formally reviewed when they changed. This placed people at risk of receiving inappropriate care.

We looked at a sample of care plans and we saw that they were consistent in format but they lacked a person centred approach. They were type written and although they mentioned the person by name they did not contain sufficient information to provide person centred care or guide staff. Care plans for personal hygiene and nutrition did not always outline individual preferences and what steps that staff should take to meet people's needs. There was insufficient detail as to the steps that staff should take to meet the specific needs of people such as those with conditions such as diabetes and catheters. When we spoke to staff about individuals needs they were not always clear as to how to support individuals.

We observed one individual who had become distressed during our visit. Their care plan stated that staff should reassure and identify the triggers that cause the behaviour and document. We saw that behaviour charts were partly completed but this was not being undertaken consistently and the information was not used to update the plan and assist staff to reflect on practice. We observed staff attempting to support this individual and they told us that they did not know how to help them or meet their needs. We saw that the individual had been distressed and refusing interventions for some weeks and that the service had requested support from the mental health team on a number of occasions. There was no evidence of a recent review or reassessment of needs, we had concerns regarding this individuals welfare and following our visit made a safeguarding alert to the local authority.

One individual had been assessed by a physiotherapist and it had been recommended that to strengthen their legs they should have daily exercise. These were provided on a

Inadequate

Is the service responsive?

sheet for care staff to follow however we could find no records to evidence that these were being undertaken. We observed the individual being very unsteady and required assistance to stand and transfer. The exercise class we observed did not cover any of the exercise on this individual's guidance sheet.

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

Inadequate

Is the service well-led?

Our findings

At the last inspection we found significant shortfalls in the way that the service was led and a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to good governance as the leadership was not proactive and there were limited processes in place to assess and monitor the quality of the service. Following the inspection the provider sent us a detailed action plan which stated that, 'Robust monitoring of the service had been created.'

At this inspection we found that some changes had been made such as in activity provision and there had been investment in areas such as the environment and training in dementia care. However we found that there continued to be shortfalls in how care was delivered and in the behaviours displayed by staff towards people.

Our findings showed that staff were not always clear about their responsibilities and there was a lack of management oversight and supervision. While some training had been undertaken, the homes management had not developed the staff to ensure they were delivering care in line with good practice.

Poor moving and handling practice and inadequate infection control arrangements were not being picked up and addressed. People told us that concerns were not taken seriously and problems were not being resolved.

The registered manager was not present at the inspection, but the provider attended and outlined his commitment to improve the care. The provider told us that the service was in the process of changing its quality assurance processes and was planning to introduce a new system which was tied in with the key lines of enquiry. We were shown documentation which the provider was planning to use. Some sections of the documentation had been partly completed but the records were not sufficient to demonstrate that robust audits were being undertaken and the home was well led. Prior to this the last audits were dated 2014.

The registered person did not yet have an effective system or process to assess and monitor the quality of the service and manage risks. This is a Breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite our findings the staff spoke positively about the changes that had taken place and the homes management. One member of staff said, "I feel part of the team here and I can suggest anything to the manager. She makes me feel empowered to make improvements and changes."

The homes manager was described as, "Good, approachable and fair." Another member of staff said, "The manager is good, she asks you for your views on how we can improve the service."

Staff told us that the manager was visible around the home and they had regular monthly team meetings. They told us that they felt supported. One member of staff said, "We are able to speak to her about anything, she is always around and checking up on staff."

We were told that residents meetings were taking place and there had been a meeting three months previously. The administrator told us that invites were sent to families before the meeting and they receive copies of the minutes. The next meeting was due to take place in the week following the inspection. The home has started a Facebook page where pictures are posted and families could comment.

The action plan provided by the provider stated that, "Feedback surveys of residents and their families will be carried out every six months and the lessons learnt implemented and recorded appropriately." We were told that surveys had gone out the previous month but that the results were not yet collated.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment We found that the registered person had not ensured that the equipment used to deliver care was being properly used.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that the registered person had not ensured that staff received suitable training, professional development and supervision that is necessary to enable them to appropriately perform the duties required of their role.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs We found that the registered person had not ensured that people were protected from the risks of inadequate nutrition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person did not always ensure that care was provided in a safe way.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent We found that the registered person had not always ensured that they were acting in accordance with the legislation and guidance when people did not have capacity to consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints We found that the registered person did not have an effective system for the management of complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person did not yet have an effective system or process to assess and monitor the quality of the service and manage risks.

This section is primarily information for the provider

Enforcement actions

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