Windsar Care Limited

Salt Hill Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Salt Hill Care Centre is a care home with nursing registered to provide the regulated activity of accommodation for persons who require nursing or personal care, diagnostic and screening procedures and treatment of disease, disorder or injury for older people. It provides care and support to people living with dementia and learning and physical disabilities. At the time of our visit there were 53 people living in the home.

The most recent comprehensive inspection of the service was on 4 and 5 February 2016. The inspection resulted in an overall rating of 'good', with a 'requires improvement' in the key question is the service well-led. We found a breach in Regulation 18 CQC (Registration) Regulations 2009 (Notification of other incidents). A requirement notice was issued and we requested an action plan to be submitted by the provider on 13 April 2016. The provider failed to submit an action plan by the required date.

People and their relatives said the service was safe. Comments from people included, "Oh yes, quite safe" and "Yes, I'm safe here." This was supported by relatives whose comments included, "Yes, she's (family member) safe and well looked after, I can guarantee that she'll be safe here."

We found various work practices that placed people at risk of receiving unsafe care. This ranged from staff not having relevant training; people's dependency levels not being regularly assessed to ensure appropriate staffing levels are in place; unsafe handling and administration of medicines to concerns about health and safety of the premises.

People and their relatives gave mixed feedback concerning how skilled and competent staff were. Comments included, "Seem alright. My laundry gets done; I just leave it on the bed" and "No. There needs to be more staff and better trained staff. I see them go to a resident in a chair and pull her up by her hands. I know they should put their arms under her arm and lift her."

We found staff did not receive appropriate induction and training. The service did not always act in accordance with the Mental Capacity Act 2005. This legislation was put in place to protect people who are not able to make specific decisions. The service ensured people had access to a range of health care professionals to in order to maintain good health.

People felt the service was caring. Comments included, "The caring could not be better, the girls do their utmost to look after them all. They always offer me something to eat or drink, they're very hospitable. I can come any time and I can make a cup of tea" and "They (Staff) look after her (family member) really well, her hair is always brushed, she never smells, she gets showered."

We observed some good care practices. For instance staff were cheerful; attentive and encouraged people to eat. However, on other occasions we observed care was impersonal. We found people's choices about end of life care was not reviewed regularly or discussed with appropriate others, to determine whether

changes were needed.

Pre-admission assessments undertaken to establish peoples' care needs were not designed to capture all the relevant information. We have recommended the service consider relevant nationally recognised evidenced –based guidance on the completion of assessments. People did not always receive care that was responsive to their specific needs. This was evident when reviewing the care of people who were diabetic; at risk of developing pressure ulcers and who were socially active.

People and their relatives gave a mixed response in regards how complaints were handled. Comments included, "I don't have anything to complain about. It's okay here", and "There's a resident who swears a lot, using really unpleasant words and I didn't want my wife exposed to it. I told the (Registered) manager but he didn't do anything about it so I said not to bring my wife into the lounge anymore. I don't see why any of us should have to put up with it. I would prefer for her to come to the lounge and her daughter would too. I sent the (Registered) manager an email about it but he never responded to it. Why should we suffer?" We looked at how the service responded to complaints.

Relatives gave mixed views about the leadership of the service. We addressed how complaints about the registered manager are handled with a director. We found complaints were not always responded to appropriately.

Quality assurance systems did not operate effectively to ensure the welfare and safety of people who used the service. Information requested by the Care Quality Commission (CQC) was not submitted by the required deadline. Staff spoke positively about the support they received from the registered manager however; we found unsatisfactory management support placed people's welfare and safety at risk. Records relating to care and the management of the service were not fit for purpose and the service failed to seek the views of people. People and their relatives were not given the opportunity to provide feedback about the service delivered.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff did not always receive the relevant safeguarding training.

People's dependency levels not being regularly assessed to ensure appropriate staffing levels are in place.

Unsafe handling and administration of medicines to concerns about health and safety of the premises.

People and their relatives felt the service was safe.

Is the service effective?

Requires Improvement

The service was not always effective.

People and their relatives gave mixed feedback concerning how skilled and competent staff were.

Staff were not appropriately inducted and trained.

The service did not always act in accordance with the Mental Capacity Act 2005.

The service ensured people had access to a range of health care professionals to in order to maintain good health.

Is the service caring?

Requires Improvement

The service was not always caring.

People felt the service was caring.

We observed some good care practices. However, on other occasions we observed care was impersonal.

We found people's choices about end of life care was not reviewed regularly or discussed with appropriate others, to determine whether changes were needed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Pre-admission assessments undertaken to establish peoples' care needs were not designed to capture all the relevant information.

People did not always receive care that was responsive to their specific needs.

People and their relatives gave a mixed response in regards how complaints were handled. We found complaints were not always responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not well-led.

Quality assurance systems did not operate effectively to ensure the welfare and safety of people who used the service.

Information requested by the Care Quality Commission (CQC) was not submitted by the required deadline.

Staff spoke positively about the support they received from the registered manager however; we found unsatisfactory management support placed people's welfare and safety at risk.

Records relating to care and the management of the service were not fit for purpose and the service failed to seek the views of people.

People and their relatives were not given the opportunity to provide feedback about the service delivered.

Salt Hill Care Centre

Detailed findings

Background to this inspection

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

This was an unannounced inspection which took place on 4 & 5 May 2017 and was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed all the information we held about the service. We looked at notifications the provider was legally required to send us. Notifications are information about certain incidents, events and changes that affect a service or the people using it.

We did not request a provider information return (PIR) for this visit. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before our visit we received feedback from a staff member from Buckinghamshire County Council's contract team.

Where people were unable to speak at length due to their capacity to understand, 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 to us.

We spoke with five people, four relatives of people who used the service; the chef; four registered nurses; four care staff; the registered manager and a director. We looked at 10 care records, six staff records; six medicine administration records and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People and their relatives said the service was safe. Comments from people included, "Oh yes, quite safe" and "Yes, I'm safe here." This was supported by relatives whose comments included, "Yes, she's (family member) safe and well looked after, I can guarantee that she'll be safe here", "I suppose 100% really", "I'm sure he's (family member) safe here" and "Completely safe."

People were not always protected from abuse because systems and processes in place did not effectively prevent abuse. For instance, we viewed the training records for six members of staff. We found five members of staff had not undertaken safeguarding adults from abuse training since their respective employment with the service in February; May; August; September 2016 and January 2017. One staff member had received safeguarding training from their previous employer in August 2015 but since commencing their employment at the service (February 2016), there were no records to show the relevant training had been updated. A review of the service's staff training matrix confirmed what we had found. This meant people received care from staff who were not appropriately trained to respond to allegations or suspected abuse.

Staff said they would report any concerns about suspected or alleged abuse to the registered manager. The registered manager confirmed this and stated, "If staff suspect abuse they will notify me and I will raise the alert. If I am unavailable I will nominate someone staff can refer to in my absence." The service had a copy of the 'Berkshire Safeguarding Adults Policy and Procedures dated April 2016'. This is a set of steps implemented by the six local authorities located within Berkshire for consistently dealing with allegations of abuse or neglect. However, we saw there was a potential for staff not to be aware of changes in safeguarding arrangements because the service's local safeguarding abuse policy was last updated on 16 May 2014.

People and their relatives gave mixed feedback about staffing levels. Comments included, "Yes, it's all the same people (Staff)", "Yes I know the staff here", "Oh yes, I know their faces", "Yes, all the same staff. They seem to have been here a while", "It's the same staff mostly, the carer that fed her (family member) today is quite new. There seems to have been a reduction in staff since last autumn. A lot (staff) left all in one go, so people must be suffering" and "Yes, it's pretty much the same staff now. There was a haemorrhage of staff around November."

We observed there were sufficient numbers of staff during our visit; this was supported by the staff rosters viewed. However, staff members said there were occasions when more staff were required. We heard comments such as, "I think we need an extra person because people's needs are changing" and "There are occasions when people present behaviour that challenge and this can impact staffing." We viewed the 'service user dependency' assessments for the three people. All three people's dependency needs were assessed as high which meant they required two staff members to attend to their care needs. We asked the registered manager to show us how people's dependency levels were regularly assessed to ensure appropriate staffing levels were in place. The registered manager gave us a staff dependency matrix dated 2013 but was unable provide evidence of an up dated one during and after our visit. This meant staffing levels were not continuously reviewed and adapted to respond to the changing needs and circumstances of people using the service.

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

Safe recruitment procedures were in place. This included satisfactory evidence of new workers' employment histories, explanations for gaps in employment and confirmation of why they had left previous roles. Staff criminal history checks were completed via the Disclosure and Barring Service (DBS). Satisfactory proof of new staff's identity was in the personnel files, medical assessments were completed. This ensured that people were supported by staff with the appropriate experience and character.

Health and safety risks from the building and equipment were not always adequately assessed and monitored, in line with relevant legislation. We found some checks were in place. For example, there was a gas safety certificate and a satisfactory report from checks on the building's electrical safety. There was a Legionella risk assessment by an external contractor for the prevention and control of Legionella in the service's water supply. We looked at the content of the risk assessment dated 13 April 2017. We noted a list of remedial actions were required to ensure people's and others' safety from the risks of Legionella. When we asked, the registered manager was unable to provide evidence that these were acted upon or that appropriate interventions were planned to mitigate the risk of Legionella. We also found no recent water sample results to check for the absence of Legionella within Salt Hill Care Centre's water supply. These failings meant people and others were placed at risk of being exposed to Legionella, and the development of a severe form of pneumonia caused by the microorganisms.

We found no recent fire risk assessment was in place at the time of our inspection. We considered this to be a risk anyone's safety within the building and expressed our concern to the registered manager. In response to our concerns the registered manager arranged for a contractor to conduct a fire risk assessment on 6 May 2017. We received a copy of the document. We noted the new fire risk assessment showed a 'moderate' risk to people's lives at the time of the contactor's visit and report. However, we were concerned that there were 25 'significant findings' or 'actions' required in the report; some which required 'immediate attention'. We reported our concerns and findings to the fire safety inspection authority.

We contacted the registered manager after our inspection to request additional evidence about the premises safety. The service sent evidence of an insurance certificate and policy for the passenger lifts, but could not show evidence that routine checks required by the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) were regularly completed prior to this. The service was unable to determine that the passenger lifts were safe for anyone to use, although they were in operation at the time of our inspection. We did receive evidence that LOLER inspections on hoists used to move people were completed and the equipment was safe. The service's failure to ensure all required health and safety checks were conducted meant that people were placed at risk of harm from the premises or equipment.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found a range of unsafe practices regarding medicines management. Various procedures had not be reviewed and updated for reflect current leglisations. For instance, the medicine and ordering reconciliation process and 'homely remedies' (this relates to medicines traditionally purchased over-the-counter at shops or pharmacies) were last updated in June 2012. This meant people were placed at risk of unsafe care as the medicine policy and procedure was out of date.

Medicines were mainly supplied by the pharmacy in blister-packs, but some medicines were liquids, tablets or capsules which were kept in their original box or bottle. This occurred when the medicine was not safe to

put in a blister pack. We observed from records that staff did not keep a running count of medicines which were in bottles or packets. This meant staff would not be readily aware of whether any medicine was missing, whether a medicine was omitted or given more often than prescribed and increased the risk that medicines errors would go undetected.

Topical medicines charts or maps were not always in use to show what medicines (in the form of creams, lotions or ointments) were applied to the body. The failure to have topical medicines charts meant creams may not be applied to the correct part of people's bodies, or applied incorrectly in areas where the cream may create a skin reaction. We pointed this out to the registered manager at our inspection.

When observing the administration of medicines we noted staff members did not always perform hand hygiene between giving each person their medicines. The availability of handwashing sinks was not nearby and there was no alcohol hand gel on or near the trolleys to enable fast hand hygiene.

Medicine administration records (MAR) which were pre-printed by the supplying pharmacy were altered by the service's staff. For example, we saw a prescribed laxative was crossed out and changed from a regular dose each day to 'as required'. It was not clear whether the GP or pharmacist were consulted about changing the person's medicine and what impact this would have on their normal personal hygiene routine.

'As required' medicines are given only occasionally when needed by people. Many of the records we looked at showed the maximum dose to be given in a 24 hour period, was blank. A small portion of the 'as required' protocols were correctly signed by a pharmacist and GP but the majority were never reviewed by the relevant professionals. This meant people were placed at risk of harm because staff who administered 'as required' medicines did not have the guidance or advice about how and when administration should occur or when the medicine should not be given.

Although medicines were stored away safely, guidance used to protect the effectiveness of medicines was not considered. Medicines room and refrigerator temperatures were checked and recorded by staff. However; there was no signage or documents which indicated the safe temperature ranges for the medicines in either storage location. We found the temperature in one room consistently exceeded 25°C for nine days in July 2016. These meant medicines were sometimes stored in conditions which could alter their effectiveness and the ability of the substance to work properly to treat people's conditions altered.

For people prescribed anticoagulant medicines, an appropriate care plan should be in place which details what to do if any type of trauma or bleeding occurs. For example, a person had a medicine prescribed by the GP 'as required'. However, from the MAR we saw staff had consistently given the medicine twice every day. Staff had not consulted the GP or the pharmacist to have the frequency of the medicine verified or the MAR changed. One person's antibiotic order was handwritten onto the MAR by staff. The written entry was not checked or signed by another staff member to ensure what was written was accurate. There was no clear audit trail of when the person had the medicine or failed to take it. These practices meant people were at risk of harm from incorrect administration of medicines or failure to plan for any known side effects.

We looked at the storage of sharps, such as injection needles, within the service. The service had sharps containers. They were not available with medicines trolleys or anywhere else for the safe disposal of sharps. We looked at the administration of insulin to three people with diabetes. We saw staff carried the used needle from the point of the person's injection to the sluice room. This was not safe for the staff member, as there was a risk they could sustain a 'needle stick' injury. Staff disposed of the needle correctly, but were required to bend or reach down to the floor where the sharps containers were situated.

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

We observed a staff member administer medicines to one person with swallowing difficulties. The person required thickened fluid (stage one) using starch-based powder. The staff member knew the correct procedure of making the thickened fluid and how to prepare it using the person's individually-prescribed and dispensed thickening agent. When the staff member administered the person's medicines, they correctly positioned the person upright in their bed and ensured that the person was able to swallow the tablets safely. We also observed a staff member assist a person with their metered-aerosol inhaler (a device to provide medicines into the lungs). This was completed correctly and the staff member encouraged the person to try their best to undertake this for themselves, with prompting.

Requires Improvement

Is the service effective?

Our findings

People said staff were experienced and skilled to provide care and support. Comments included, "Seem alright. My laundry gets done, I just leave it on the bed", "Yes, I think so, the staff are good", "Yes I am sure they are good" and "No. There needs to be more staff and better trained staff. I see them go to a resident in a chair and pull her up by her hands. I know they should put their arms under her arm and lift her."

People were cared for by staff that were not effectively inducted and trained. We viewed the 'Salt Hill Care Centre Induction Programme'. We noted that within two weeks of working for the service, new staff members were to receive training in, the role of the care worker; principles of person centred care; manual handling (one day combining theory and practice) and infection control. Staff were also expected to complete the Care Certificate. This is a recognised set of standards that health and social care workers adhere to in their daily work. It applies to all health and social care staff.

We looked at six staff records and compared what induction and training they had completed with what was recorded on the service's training matrix. We found four out of the six staff members had not completed the required training within the first two weeks or during the course of their employment. Although some staff had been 'assigned' to start the Care Certificate, we found no record to support this had occurred. For instance, one care worker had started their employment with the service on 23 May 2016 and another staff member on 30 August 2016. Both staff had been 'assigned' to start the Care Certificate, but there was no evidence to confirm this had occurred. Where staff had started the Care Certificate there were no time limits for completion. For instance, one staff member had worked for the service for approximately seven months but had only completed one of the standards. There were no records to show how this was being addressed by management. We spoke with the registered manager who was unable to provide us with an explanation and documents during or after our inspection to confirm the relevant training had been undertaken. This meant people received care from staff who were not competently trained to meet their care needs.

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

Staff were regularly supervised. Staff said they had the opportunity to discuss how they were progressing in their jobs. We noted supervision meetings did not clearly show how people were being supported with their induction and training.

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.

We found that the service was not acting in compliance with the requirements for consent, MCA and DoLS and the associated codes of practice. We saw some people were capable of making decisions themselves and therefore were able to consent to care and treatment. Some people at the service had reasons that affected their ability to provide valid consent. For example, some people had dementia and other illnesses that affected the mind. This meant that mental capacity assessments would be required to determine whether the person could legally provide any form of consent.

In the mental capacity assessments we reviewed, the documentation of the process was unsatisfactory. Although the form itself detailed the requirements of the assessment, staff recorded little information in the necessary parts of the form. In some capacity assessments we viewed, parts of the form were missing, incomplete or blank. This meant some mental capacity assessment outcomes were unsatisfactory and questionable. In almost all cases where a person's mental capacity assessment was required and completed, these were undertaken by staff, primarily registered nurses. The records did not indicate how people or relatives were involved in the process and whether the opinion of any relevant healthcare professional was considered. In cases where a consent decision was necessary, the mental capacity assessments were not time or decision-specific, as required. The mental capacity assessments were not repeated or checked over time, in the event that someone had fluctuating ability for consent or regained the ability to provide consent. We saw the mental capacity assessments were used as a single decision that the person was unable to consent or make decisions themselves. This meant some people's ability to consent to care was not always considered, discussed and effectively decisions were made by staff instead.

Best-interest decisions were made about things like whether bed rails should be installed. We did find that decision-making about bed rails was not safety-related but treated as a form of restraint of the person. For example, in one file we saw staff had noted, 'To use bed rails to act in [person's] best interest.' The obligation to examine all possible alternatives and implement the least restrictive form of restraint was not taken into consideration. This meant some people were subject to restrictions that were not supported by valid decision-making.

Where a person required any type of restriction, an application was not always made to the supervisory body (the local authority or commissioner of the care) for a DoLS authorisation. We found more than one example in people's care files where the application was incomplete, lacked information needed by the best interest assessor or was never submitted for consideration. Staff were unable to readily tell us which people were awaiting DoLS outcomes, which people had DoLS authorisations that were current or who had an expired DoLS. Staff also had no knowledge of what conditions, if any, the standard DoLS authorisations placed on the service. The registered manager had failed to keep an accurate record of people's DoLS applications or authorisations, although later produced a list when we requested this.

Some people had an existing enduring power of attorney (EPA) or lasting power of attorney (LPA) before their admission to Salt Hill Care Centre. The documentation in care files regarding this was not always clear, so staff would not know who was able to legally provide consent for important decisions on behalf of the person. When we asked, no master list of people with LPAs or EPAs was readily available. This required the registered manager and receptionist to compile a list for us to review as part of our inspection. When we were provided with the list of people who had attorneys in place, we examined care records to determine whether copies of the documents were available which supported the list. We found the service did not obtain and retain copies of the necessary documents. All EPAs and LPAs in the UK must be registered with

the Office of the Public Guardian. Attorneys or solicitors were not asked by the service to bring relevant registered paperwork to staff to verify they were legally-entitled to provide consent or make choices on behalf of the person. In these cases, the relative or other person who made decisions on behalf of people with an EPA or LPA may not have been recorded by the Court of Protection as attorney. We explained to the management how to check EPA and LPA records with the Court of Protection. Prior to our advice, the management were unaware of how to verify whether a person had a valid EPA or LPA.

On one unit, we noted five people received their medicines covertly. Covert administration is normally reserved for use with people who refuse to take medicines or spit them out. Covert medicines are usually disguised in foods or drinks, which enable people to take them without being aware. The use of covert administration of medicines was high, given the number of people who resided on the unit. When we checked people's records, we could see no documentation about why each person had this method of medicines. It could not be established that peoples' or relevant others' choices were taken into account, and whether the use of covert medicines was the best decision taken for the person.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In communal areas, we saw people were offered drinks and staff asked people if they would like more fluids. In the bedrooms we looked in, we could not see that people had jugs of fluids or cups/beakers to enable them to take fluids if they did not come into communal areas. There was a risk that people would become dehydrated if they did not leave their bedrooms, could not call for help from staff or were unable to communicate with staff to say they were thirsty or wanted a drink.

During breakfast, in one unit we noted four bowls of porridge on a stainless steel trolley, which was not heated. These had been ladled into the bowls much earlier. The bowls had cling film on the top. We noted staff, during breakfast, gave people bowls of porridge which was at the time cold. The staff members made no attempt check the temperature of the porridge or heat the porridge before giving it to people. People were not asked first if they wanted the porridge, but instead an assumption was made this was the people's choice. This resulted in two people not eating the porridge at all. Staff offered one person an alternative, which was toast. The staff member served the toast to the person by carrying two triangles of toast to the person and handed this to them. They did not use a plate or provide a napkin to the person.

Menus were clearly displayed in communal dining rooms with words and pictures that were easy to interpret. There was also clearly an alternative menu for people from culturally diverse backgrounds. The alternative menu primarily consisted of curries, but people were able to choose any of the available meals on offer. We noted that vegetarian meals were available 'on request'. When we spoke with the kitchen staff, they showed us the menu rotated on a four week cycle and explained that the entire menu was changed about every six months. They were aware of food allergens and people's individual likes and dislikes.

People's weights were routinely recorded and monitored. The service used a nationally-recognised tool (MUST) to determine people's risks of malnutrition, and track weight loss or gain over time. Appropriate guidance was available to staff in people's care files to assist with the determination of the MUST score. We found the assessments were routinely carried out and that staff did detect when weight loss occurred that may result in a person being malnourished. In one person's file we examined, we found the MUST score decreased over time, which meant the person's weight was successfully increasing. We saw staff had consulted a GP and dietitian and the person was given liquid supplements to help improve their calorie intake and weight gain. This was an example of good practice in preventing a poor health outcome for the person.

When we looked in people's care documentation, we saw appropriate access to a range of healthcare professionals in order to support people's good health. For example, we noted visits by GPs, dietitians, speech and language therapists and opticians. We met one of the company directors, who told us about an oral health project the service was involved in. The project aim was to ensure people who used residential care facilities had every opportunity possible to good healthcare of the mouth, gums and teeth. This included onsite visits by a dentist. The company director explained that dental students were also encouraged to complete clinical placements at the service to increase awareness and understanding of older people's oral healthcare needs. The company director told us that people's dentures were able to be created or renewed via visits by dentists to the service. This reduced the need for people to visit dentists within the community. When we looked in care records, there was evidence that people's oral healthcare was well-managed.

Requires Improvement

Is the service caring?

Our findings

People and their relative described the caring nature of staff. We heard various comments such as, "They're (Staff) all alright. They get me my Horlicks every evening at 8pm, and a biscuit. I buy it and they make it for me", "When she (family member) used to come out to the lounge, someone would be sitting with her when I arrive. The staff are absolutely kind and caring. They know her well and said things like "I love you, do you love me? I think they still talk to her sometimes when they are turning her", "The caring could not be better; the girls do their utmost to look after them all. They always offer me something to eat or drink, they're very hospitable. I can come any time and I can make a cup of tea" and "They (Staff) look after her (family member) really well, her hair is always brushed, she never smells, she gets showered."

We noted one person with dementia who walked around continuously on their unit during the inspection. They did not sit down for meals and were disregarded by staff, with little to no interaction from care workers each time we observed their whereabouts. At various times of our observations, the person sat and rolled on the floor in communal areas and in corridors. We noted staff did not pay attention to the person during this behaviour. On more than one occasion, staff were in direct line of sight and either kept doing other tasks or walked past the person, completely ignoring them. The person was dressed inappropriately. They wore trousers that were too long at the feet, and we noted the person attempted to walk with the material from the clothes continually being stepped on throughout our observations. We pointed this out to a staff member, who told us they would adjust the clothing. When we checked on the person twice further during our inspection, we noted their trousers were the same, had not been adjusted in any way and they continued to walk on them each time we saw them. The person did not wear shoes at any point. However, the person had a pair of socks on. The person was placed at high risk of falls-related injuries and received impersonalised care throughout the inspection.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the lunch time period we observed some good examples of care. For instance, whilst supporting a person with their meal, a staff member did this with patience and care and used a small spoon for feeding. We heard staff gently encouraging people to eat and appeared cheerful and attentive during this period.

Relatives said the service sought their views in regards to their family member's end of life preferences. Comments included, "Originally there was a resuscitation order. That was done at the start of her illness. There's a new guy that's started, her carer is called [name of carer] and he raised it. I was a bit shocked at first but she's not getting any better and that's the situation she's at now. So, I discussed it with my step daughter and we agreed and we both signed the forms" and "Yes, we had a discussion about four to five months ago. It was done very sympathetically and we've made our wishes known and signed a form."

We looked at people's advanced decision making choices and preferences about end of life care. The service used appropriate forms (DNACPR) to record whether people were to have resuscitation in the event of a cardiac arrest. Some people did not have a DNACPR form in their care files, and we could not find within

the care records whether any decision about end of life care was discussed with the people. In one example, a person had a form in their file, a relative with an LPA had signed the form and the GP had signed the form as the person who held the discussion with the relative. The decision on the form was at the end of 2016 and appropriate at the time of our inspection. However, the completion of other DNACPR forms was unsatisfactory. We saw an example where one person's decision about resuscitation was documented by a registered nurse. There were no details of consulting the person, any relatives or the GP. Some DNACPR records we viewed lacked details about consultation with the person or their relatives. This meant people's choices about end of life care were not reviewed regularly or discussed with appropriate others, to determine whether changes were needed.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said they were treated with respect and their dignity was preserved. Comments included, "Yes, they do", "When they change her (family member) pads they let me know and I don't stay, I don't want to see any of that" and "They have a room to change people. I think they could avoid saying loudly 'I'll take you to the toilet' I know he(family member) hates it and he gets upset and starts repeating 'please, please, please…' it's because he hates having to be helped. But yes, they always knock on the door… they never come in without knocking." This was supported by a registered nurse who commented, "I will on occasions carry impromptu checks to ensure staff treat people in a dignified way."

Requires Improvement

Is the service responsive?

Our findings

Prior to admission to the service, staff visited people in their home or hospital to complete a pre-admission assessment. We found the purpose was to determine the person's needs and whether Salt Hill Care Centre could provide safe, quality care. The admission assessment form used by the service was an unsatisfactory method of determining a person's care needs and whether the service could provide necessary care or treatment. The form consisted of only two pages. Apart from basic demographic information, there was little information recorded about people's care needs. This simply consisted of 'tick boxes' for mobility, communication, personal care, behaviour and nutrition. The form did not allow sufficient appropriate information to be recorded about the person, and the risks that might be present from their medical conditions, social history or physical state. This process meant people could be admitted, based on brief information, without a satisfactory determination of whether the service could safely provide the care they needed.

We recommend the service consider relevant nationally recognised evidenced –based guidance on the completion of assessments.

People with diabetes did not have specific care plans that were tailored to their individual needs. The care records did not establish what to do in the event of high or low blood glucose levels, what to do if the person was unwell or unable to take their medicines, and when to seek the assistance of a relevant health professional. One relative was so concerned about a person's diabetes management they approached us during the inspection. They explained they felt the service did not plan or manage the person's diabetes well and felt that the person was at risk of harm. They told us they had raised this with staff on multiple occasions and were not kept informed of what action, if any, had occurred. We explained we would review the person's diabetes management within the records and with the staff. When we saw the records, we found the person's blood glucose levels were very high for a sustained period of time. We did find staff had consulted the GP more than once, and the person's medicines were altered in an attempt to better control the diabetes. However, staff had not contacted the GP again for further advice or visits. We found staff had not involved a diabetes specialist nurse to help the service with the management of the unstable blood glucose levels. We asked staff to contact the GP and the specialist nurse so that the person's care plan could be more specific to their individual needs. The staff member we spoke to told us they would make the necessary referrals, and then spoke with the relative to provide confirmation.

We reviewed whether people's risks from developing pressure ulcers was adequately assessed, mitigated and recorded in their care files. We found some people preferred to stay in their beds during our observations, and some people's condition confined them to their beds. The service used the Waterlow tool to conduct risk assessments about people's likelihood of skin integrity damage. The Waterlow tool provides an internationally-recognised calculation to determine people's risks and provides guidance of prevention techniques based on the score. In one person's care records, we found the Waterlow score recorded consecutively since October 2016 as 'very high'. The person did not leave their bed, and we visited them in their room. We noted that the person was positioned on a standard bed mattress. Where the Waterlow score is 'very high', more interventions must be undertaken to prevent skin damage. This would include the use of

a specialised mattress and air pump which helps distribute the person's weight in the bed by alternating the mattress pressure. The person did not have this in place. We pointed this out to staff members, but they were unable to provide any reasons why more steps were not taken to prevent harm, especially when the risk assessment determined 'very high' risk. This meant the person was placed at risk of developing a pressure ulcer and that the risk assessment was not satisfactorily linked to the care the person required. This meant people did not always receive care that was responsive to their specific needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was not always responsive to the social needs of people who used the service. We received feedback from a local authority contract officer who had received information of concern about the lack of social activities at the home. This was observed during our inspection. We observed staff were mostly task focussed and as a result of this had minimal interactions with people other than when they performed care tasks. This became evident after the lunch period when people continued to sit in the various lounges with little or no stimulation apart from the TV and radio. Some of the units played music that was age appropriate but this did not occur consistently. We noted people had access to hairdressing services; podiatry and could attend regular church services. However, during our visit we only observed one activity that occurred in the morning. People who wished to participate in activities were brought to one of the units. We noted out of 52 people 12 people attended the session. There was no evidence of planned activity programs for people who were restricted or chose to remain in their rooms. Social activity plans viewed only instructed staff to encourage people to participate in activities and communicate with family. On day two of our visit no planned activities took place. This meant people were at risk of becoming socially isolated.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives gave a mixed response in regards how complaints were handled. We heard comments such as, "The only thing I've complained about is this other man but nothing has been done. He comes up behind you and stands really close, it's not right. My friend would talk to the (Registered) manager if there was anything else. She bought the TV for my room"; "I don't have anything to complain about. It's okay here", "There's a resident who swears a lot, using really unpleasant f and c words and I didn't want my wife exposed to it. I told the (Registered) manager but he didn't do anything about it so I said not to bring my wife into the lounge anymore. I don't see why any of us should have to put up with it. I would prefer for her to come to the lounge and her daughter would too. I sent the (Registered) manager an email about it but he never responded to it. Why should we suffer?" and "No, I don't think we've complained about anything."

We examined the complaints system at Salt Hill Care Centre. We were told the registered manager handled complaints. People and others had access to information about how to make a complaint. This was available by way of signage in different parts of the service. The signage was not provided in other formats other than English, which meant people who spoke or read other languages may not understand how to make complaints. The signage stated a one stage process within the service and provider. The complaints information then referred people to other agencies external to the service and provider. The complaints information did not provide any reasonable opportunity for people who wanted to complain to escalate this within the provider. For example, the names and contact details of the company directors were not available. We expressed to the registered manager that this was not a satisfactory method of receiving complaints. This was because if a person or others wanted to make a complaint against the management team, they had no way to contact the limited company to escalate their concerns.

We looked at how complaints were recorded and dealt with by the registered manager. We noted that complaints were recorded on a basic form with little detail. We were then presented with a second version of a complaints record form and the associated policy. This more robust complaints form was not used to record complaints. Although the policy was from a policy company, we saw it was detailed and individualised to the service. However, we found the service did not follow their policy. For example, where complaints were received these were not acknowledged promptly in writing to the person who contacted the service. We did find evidence of e-mail responses to people or relatives who made complaints, but there were no records of investigations, witness statements or copies of documents from care files which supported the outcomes of the registered manager.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in February 2016, we found a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This was because the service did not notify us, without delay, of DoLS applications that were approved by the supervisory body. Prior to this inspection, we checked our records and found the registered manager has submitted DoLS outcomes notifications of to us in 2016 and 2017. We now consider the service is compliant with this regulation.

However, we required an action plan to be submitted to us by 13 April 2016 due to the breach of the regulation. An action plan was not submitted to us. The registered manager stated this had been submitted but was unable to provide any evidence to support this. We checked our records and can find no submission of any action plan which was required after our last inspection.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection, the registered manager was responsible for two of the provider's services: Salt Hill Care Centre and Windsor Care Centre. Between the two services, there were a total of 125 beds that could accommodate and provide care to people as a condition of our registration. Although Salt Hill Care Centre was nearly full, Windsor Care Centre was added as a location to the provider's registration in 2016. The beds were not full at that service, but the registered manager told us that they were actively working on admitting people to that service. When we checked management arrangements and support, we found that the registered manager did not have any deputy managers or clinical leads. There was no managerial support to the registered manager with the absence of a deputy manager at either service. As the registered manager's time was spent roughly equally between both locations, they were not at Salt Hill Care Centre entirely. In these periods, staff could access the advice or assistance of the registered manager by calling their mobile phone. However, there was no clear strategy for management arrangements if the registered manager was away or on leave. It was not feasible that the registered manager could complete all of the necessary tasks in running two services on their own.

We asked the registered manager about this and received differing information from them about support structures. The registered manager told us they previously had a deputy manager, but the person was not in post at the time of our inspection. The registered manager then explained that they were recruiting two deputy managers or equivalent roles. However, when we asked for evidence that advertisements were placed or interviews for applicants were planned, the registered manager was not able to show us this. The legal responsibility for the safety and quality of care at the service was the responsibility of the registered manager and the provider. However, without adequate support from a deputy manager or similar, we found documentation, audits, health and safety checks, staff engagement, staff training and complaints management required improvements or were not sufficiently managed. This meant the safety of people, staff and others was at risk from unsatisfactory management support and the quality of the service was not adequate.

Relatives gave mixed views about the leadership of the service. Comments included, "I know [manager's name] is in charge", "It tries to be well led. They (registered manager) try and do their best. He feeds me and is good in that way", "The (registered) manager shouted at staff in front of residents and relatives. It's embarrassing", "I don't think the manager realises what wonderful staff he has. I appreciate the problems the (registered) manager has. These things have to be managed. He and I will never agree when it comes to drugs, we fundamentally disagree. The manager has never been rude to me but he has not done what I have said when I've raised concerns about medication. I'm preparing to escalate it" and "The (registered) manager is very good. He's quite firm with staff. The (registered) manager has had to raise issues with relatives because they have been violent to staff, so it's not just the residents he has to deal with sometimes. I'd be confident that any issues would be dealt with. Dad and I would be able to see the (registered) manager within 4 to5 days, as he's not here all the time, and that's fine."

A registered manager must be 'of good character' to manage a service registered by us. If the provider discovers information that suggests the registered manager is not of good character, they must take appropriate and timely action to investigate and if necessary rectify any issues. We were notified of four complaints about the registered manager in the year leading up to our inspection. These were from relatives or members of the public who considered that the registered manager was rude or unhelpful to them. A further complaint on a care home review website stated the registered manager was, "Absolutely horribly rude...I would recommend a change of management."

When we checked the records of complaints at the service, there was no log of these complaints and no documents which showed any provider investigation of the allegations about the registered manager's behaviour towards others. In addition, without the appropriate details in the complaints signage and policy, there was no other contact for people and others to lodge complaints about management. We spoke to one of the directors of the service who ensured by the end of our visit, the complaints policy had been updated with their contact details.

Medicines incidents were reported and documented. We reviewed records of medicines incidents. These included common incidents like the staff member who administered the medicine failing to sign the medicines record, or an incorrect dose of a medicine given. In the examples we reviewed, no one had sustained harm and appropriate advice and support was obtained from healthcare professionals, like the GP, when necessary. Where there were more serious medicines incidents noted, staff ensured appropriate action was taken.

We noted the registered manager reviewed most, but not all of the medicines incident records and dated and signed them. There was no evidence that trends or patterns in medicines errors were monitored to determine any way of decreasing the incidence of staff errors. We also found that no investigations were completed when there were medicines incidents. For example, there were no statements from staff involved, no copies of relevant care documents attached, and no records of learning, training or teaching with individual workers or the staff team.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records relating to care and management of the service were not always accurate and kept and kept up to date. This was evident when we reviewed medicine records; care record; the staff training matrix; service user dependency matrix and the service's policies and procedures. For example, one person had a medicine which was only given twice a week. We saw staff signed every day on the person's MAR. This was not a satisfactory method of recording the administration of the medicine. The process made it appear from

records that the person received the medicine daily. When we asked a staff member why every day on the MAR was signed, they told us it indicated that the box or packet of medicine was still within the trolley. This method of signing the MAR could have resulted in an error as staff would not easily know which days of the week to give or not give the medicine. Also, this process would make it difficult to determine whether stock was missing and how much to order in the next medicines round.

Care plan audits were undertaken however, where actions were identified we saw no records of who was responsible to complete the task; date task had to be completed by and confirmation that the required was completed.

The staff training matrix used by the service to monitor staff's training needs did not accurately reflect training staff had completed. We found certificates of completion and attendance for various courses undertaken by staff were not updated on the training matrix. We noted the training matrix only indicated training staff had been assigned to or passed but failed to indicate dates training needed to refreshed or had expired. This meant the system used to monitor and assess staff training needs was ineffective.

The service had a matrix in place to capture expiry dates for staff DBS certificates; staff who were subject to work visas; registered nurses' personal identification numbers. These were issued to nurses when they registered with the Nursing Midwifery Council (NMC) and had to be annually renewed. We noted the matrix had not been updated to reflect the changes in the staff team. For example, new staff that had commenced employment and staff that were no longer employed with the service.

We found a number of policies that had not been reviewed and updated to reflect relevant legislation. For example the service's medicines and reconciliation policy; safeguarding abuse policy; whistle blowing policy and DoLS policy.

Information gathered in the form of audits were not reviewed for their effectiveness and analysed. For instance amongst others, the service undertook audits of accidents that had occurred over a certain period of time. We found there was no analysis of the data to pick up on and emerging trends.

We found care records lacked detailed information in pre-admission assessment; DNACPR; and mental capacity assessments. This meant records relating to the care and treatment for people who used the service was not fit for purpose.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The rating poster from the prior inspection was not conspicuously displayed at the location. The location's/provider's website also did not meet the requirements set of by the relevant regulation. Copies of the prior inspection report were found throughout the location, but this was did not meet the requirement as to display of performance assessments. The registered manager was informed of both issues at the time of the inspection. The rating was put on display in the home during our inspection visit.

People and their relatives spoke about the opportunity they had to give feedback on how the service. We heard comments such as, "I've never heard of a Resident & Relative meeting, I don't think they are on. The staff have meetings and told me 'not to come in until they are done', "The registered manager listens but he doesn't always do anything about it", "I had a survey a while back but it was impossible to fill in because of the questions as they were the wrong sort of questions", "No, I've never heard of a residents and relatives meeting" and "No, I don't think so. I've not filled in a survey."

What people and their relatives had told us was also reflected by our review of minutes of 'resident meetings.' We noted the last meeting was held in February 2016. We spoke to the registered manager who confirmed that this was correct. This meant there were no effective communication system in place to ensure the service sought the views of people and their relatives in relation to their experience of the quality of care and treatment received.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were complementary about the registered manager and said they felt supported. Comments included, "I feel supported and included in everything, [Name of registered manager] is very approachable", "I am supported by the (registered) manager. He is firm and ensures we do work the proper way. He encourages me in terms of personal development" and "Management are top notch. I feel I am supported very well, that's one of the (registered) manager's strength."

Staff spoke to us about quality assurance checks they had to perform in order to maintain people's welfare and safety. However, they were not able to tell us when they had team meetings to discuss; share and be kept updated in regards to work related changes. One staff member commented, "Monthly team meetings? I am not sure when this happens." Minutes of staff meetings were not available for us to view. The registered manager told us staff team meetings had occurred but was not able to produce evidence of these during or after our visit.

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 People's choices about end of life care were not reviewed regularly or discussed with appropriate others, to determine whether changes were needed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Mental capacity assessments contained little information. Some people's ability to consent to care was not always considered, discussed and effectively decisions were made by staff instead. People were subject to restrictions that were not supported by valid decision-making. Staff were unable to readily tell us which people were awaiting DoLS outcomes, which people had DoLS authorisations that were current or who had an expired DoLS. Staff also had no knowledge of what conditions, if any, the standard DoLS authorisations placed on the service. Management was unaware of how to verify whether people had valid EPAs or LPAs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found improper and unsafe management of medicines. This covered the handling and

Treatment of disease, disorder or injury	administration of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The service's failure to ensure all required health and safety checks were conducted meant that people were placed at risk of harm from the premises or equipment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There were no records of investigations, witness statements or copies of documents from care files which supported the outcomes of the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems did not operate effectively to ensure the welfare and safety of people who used the service. Information requested by the Care Quality Commission (CQC) was not submitted by the required deadline. We found unsatisfactory management support placed people's welfare and safety at risk. Records relating to care and the management of the service were not fit for purpose and the service failed to seek the views of people. People and their relatives were not given the opportunity to provide feedback about the service delivered.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing

Staffing levels were not continuously reviewed and adapted to respond to the changing needs and circumstances of people using the service.