Handsale Limited

Handsale Limited - Shakespeare Court Care Home

Inspection report

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15 November 2017

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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?	Inadequate

Summary of findings

Overall summary

The inspection was carried out on 14 and 15 November 2017 and was unannounced on the first day. There were 59 people who used the service at the time of our inspection.

Shakespeare Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Accommodation is provided in four separate units, each unit accommodates up to 20 people. Nursing care was provided on two units, Willow and Cedar with Cedar specialising in the care of people living with dementia. Residential care specialised in nursing care, Cedar and Rowan, are dedicated to the care of people living with dementia.

The last inspection was carried out in January 2017; the report was published in March 2017. At the last inspection we found the provider was in breach of three regulations. These related to staff training, (Regulation 18), the management of covert (hidden) medicines, (Regulation 11), and governance, (Regulation 17). The overall rating for the service was 'requires improvement'. Following the last inspection we met with the provider and they provided an action plan detailed the actions they would take to improve the service.

During this inspection we found that while some improvements had been made the provider remained in breach of regulations.

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

We found people's medicines were managed safely and improvements had been made to the way covert medicines were managed. However, we found the provider was still not working in line with the Mental Capacity Act. This was because they had not always ensured people's representatives had the correct legal authority to make decisions about their care and treatment.

Most people told us they felt safe. Two people told us they sometimes felt unsafe because of actions by other people who lived there. Staff knew how to recognise and report concerns about people's safety and welfare..

In most cases risks to people's safety and wellbeing were identified and managed. Incidents were reviewed and ways to improve the service were identified. However, we found this learning was not always put into practice.

There were enough staff deployed. However, the home was finding it difficult to recruit nurses and needed to use a lot of agency staff. This sometimes meant there was reduced leadership on the nursing units. This also had a negative impact on the effectiveness of the management team. Improvements had been made to staff training. Staff told us they felt supported to carry out their duties.

The home was clean and safe. Some areas were in need of refurbishment and this was being addressed. There had been some adaptations to the building to support people living with dementia.

People had enough to eat and drink and there was a varied menu. Feedback about the food was mixed. We found people were not always supported to make informed choices about what they wanted to eat. We found more needed to be done to improve people's meal time experiences.

Staff knew about people's physical care needs but did not always know much about people's life stories and this information was not always recorded. This is important to delivering person centred care.

Most people were satisfied their needs were met. However, we found inconsistencies in people's care records which created a risk people would not always receive appropriate care.

People were supported to meet their healthcare needs and had access to the full range of NHS services.

Most people told us staff were caring and treated then with kindness. We saw staff interacting with people in a positive way which helped people to feel better. However, we also saw a lot of interactions were task based and did not enhance people's wellbeing. There was a programme of activities however we found for some people there was not enough stimulation or interaction.

We found the provider had taken action to deal with complaints about the service.

There were systems in place to assess, monitor and improve the quality and safety of the services provided. However, these were not robust enough and needed further development. The provider was committed to improving people's experiences and had engaged a consultant to support the home's management team in achieving this.

We identified four breaches of regulations, these related to person centred care, (Regulation 9), dignity and respect, (Regulation 10), consent to care and treatment (Regulation 11) and governance, (Regulation 17). Two of these breaches, (Regulations 11 and 17), are continued breaches from the previous inspection.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People's medicines were managed safely.

People felt the service was safe. In most cases risks were identified and managed. However, we found learning from incidents was not always put into practice to improve the service.

There were enough staff deployed but difficulties recruiting nurses meant the home used a lot of agency nursing staff. This sometimes meant there was reduced leadership on the nursing units.

The premises were safe and clean. There were plans to refurbish parts of the home which were showing signs of wear and tear.

Is the service effective?

Requires Improvement

The service was not always effective.

Improvements had been in the way best interest decisions were recorded for covert medicines. However, the service did not always check that representatives of people who lived at the home had the proper authority to make decisions on their behalf.

Improvements had been made to the training and support provided to staff.

People had enough to eat and drink and there was a variety of food to cater for people's preferences and cultural needs.

People were supported to meet their healthcare needs.

Some adaptations had been made to the building to support people living with dementia.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Most people told us the staff were kind and treated them well.

We saw positive interaction between staff and people who used the service. However, a lot of interactions were task based and did nothing to enhance people's wellbeing.

Although staff knew about people's physical care needs they did not always know about people's life stories. This information is vital to the delivery of person centred care.

People told us staff supported them to maintain their independence. However, we found people were not always supported to exercise choice and the meal time experiences could be improved.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care was not always delivered in line with their care plans. Some people's care plans did not provide accurate information about their needs.

The records showed people and their relatives were involved in planning how their care needs would be met.

People were not supported to plan for their end of life care.

There was a programme of planned activities. However, we found more could be done to provide a stimulating environment for people.

Complaints were dealt with in line with the provider's policy.

Is the service well-led?

Inadequate

The service was not well led.

Systems to check the quality and safety of the service were in place but were not always working effectively.

People were asked for their views of the service but this information was not always used effectively to improve the service.

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Detailed findings

Background to this inspection

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

This inspection took place on 14 and 15 November 2017, the first day of the inspection was unannounced.

This inspection was brought forward because we had received information of concern about the service. This included information from the local authority commissioning team, safeguarding and members of the public. At the time of our inspection the local authority had placed an embargo on new admissions to the home. Before the inspection we reviewed all the information we held about the service, this included notifications sent to us by the service as well as the information referred to above. We did not ask the provider to complete Provider Information Return (PIR) on this occasion. This is a document which gives the provider the opportunity to tell us about the service and any planned improvements. However, the provider had sent us an improvement action plan. We took all this into account when making our judgements.

On first day the inspection team was made up of four adult social care inspectors and an expert by experience. On the second day two adult social care inspectors visited the home. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case their expertise was in the care of older people.

During the inspection we spoke with ten people who used the service and three people's relatives and two health care professionals. We spoke with eight care staff, two housekeeping staff, the cook, the

administrator, an activities organiser, both deputy managers, the registered manager, one of the directors and a consultant.

We looked at 11 people's care records, medication records and other records relating to the day to day running of the home such as maintenance records, staff files, training records, meeting notes and audits. We observed the meal service at lunch time on three units and observed people being supported in the communal areas of the home. We carried out formal observations using the Short Observational Framework for Inspection (SOFI). This is a way of observing which helps to give us information about the experiences of people with more complex needs. We looked around the communal areas of the home and looked at a selection of people's bedrooms.

Requires Improvement

Is the service safe?

Our findings

Most of the people we spoke with told us they felt safe at Shakespeare Court. Comments included, "It's alright here, yes I do feel safe, I get well looked after and I think there's enough staff." "It's okay here. The people looking after me make me feel safe." "I like it here; I've been here for three years. I feel safe the way people treat me." "I'm happy here, I do feel safe. I trust the people who work here. I love the people here, there are enough staff and they usually come within five minutes of me ringing."

A relative we spoke with said, "He's safer here than he was at home. He's been well looked after and there seems enough staff to look after him."

Two people who used the service told us they did not always feel safe. One person said they didn't feel safe when other people walked into their bedroom. Another person said they didn't always feel safe when other people who used the service were shouting at each other.

Staff we spoke with knew how to identify and act on safeguarding concerns. They said they had not witnessed anything of concern whilst working in the home, but were confident if they reported any issues they would be dealt with effectively by management.

The service supported some people by managing small amounts of spending money. We found all transactions were recorded, receipts were available for all money spent and money was stored securely. This helped to reduce the risk of financial abuse.

We saw safeguarding incidents were reported and in most cases acted on appropriately including referral to the local authority. However, we identified two concerns which had not been formally reported to the local safeguarding team. We discussed this with the registered manager who explained they had discussed the concerns with the safeguarding team and been advised formal referrals were not necessary. This was confirmed by the safeguarding team.

Following incidents we saw management investigations took place to help protect people from harm. Whilst this happened in most cases, we saw one person had become physically aggressive with other residents on several occasions. This included hitting another person who used the service in the face in October 2017. The person did not have a challenging behaviour care plan in place and care plans contained no reference to these recent incidents or how to help prevent a re-occurrence.

This demonstrated the providers systems to manage risks to people's safety and welfare were not always operated effectively. This was a breach of Regulation 17(1)(2)(b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Incidents were analysed on a monthly basis to help inform learning and help identify any key trends or themes. For example where concerns over staff practice had been identified; we saw disciplinary processes had been followed to help keep people safe. However, we found improvements were not always embedded

in practice. During the inspection relatives of a person who lived at the home told us they had not been informed about a recent fall. They had not known about the fall until they visited and found their relative had bruising on their face. A similar incident had been raised with the provider before the inspection. This was discussed with the registered manager.

This demonstrated the provider was not effectively using feedback about the service to bring about improvements. This was a breach of Regulation 17(1)(2)(e) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Within people's care records risks to their health and wellbeing were identified and assessed. This included areas such as falls, moving and handling, nutrition and skin integrity. We saw action was taken to mitigate identified risks, for example, sensor mats were used to alert staff when people were at risk of fallings.

We observed staff were kind and patient with people who became upset and helped calm distress by using distraction and redirection techniques or leaving people to calm down.

At the last inspection we recommended staffing levels should be kept under review to take account of people's needs and the number of people who used the service. During this inspection the registered manager told us the staffing levels were reviewed to take account of people's needs and would be reviewed when occupancy increased.

The registered manager was supported by a deputy manager who was also the clinical lead for the two nursing units. A new role of residential deputy manager had been created since the last inspection to provide management oversight of the two residential units, Aspen and Rowan.

The registered manager told us they had been "struggling to recruit nurses." They said they were advertising for 44 hours of nursing staff. The home relied heavily on agency nursing staff, for example, on the day of our inspection there were agency nurses in charge on both the nursing units, Cedar and Willow. This meant there was reduced leadership on the nursing units. We discussed this with the registered manager who told us they tried to mitigate this by having regular agency staff.

On Cedar we found staffing levels were sufficient to ensure people received the required care and support although staff were busy at times and interactions were very task focused. Staff we spoke with said there were enough staff on Cedar and Willow although they did comment that staffing levels in the morning on Rowan unit were not always sufficient and two care workers were not enough. Rowan provided residential care to people living with dementia.

The registered manager told us and the duty rotas confirmed the two care workers on Rowan were supported by a team leader or senior carer during the morning shift, 8am to 2pm. In the afternoon, from 2pm to 8pm, there were four staff in total on Rowan. The registered manager told us they were reviewed the morning staffing levels on Rowan with a view to having four staff all day. We spoke with a visiting health care professional and they told us they did not have any concerns about the staffing levels on Rowan. They said staff were sometimes "a bit pushed" but overall felt there were enough available. While observing on Rowan Unit we saw that one of the housekeeping staff spent time with people chatting, singing and dancing. One person liked housework and the housekeeping assistant gave them a duster so they could help. We saw people enjoyed these interactions.

The majority of people we spoke with felt there were enough staff. One person said, "I think there are enough staff in the day but at night sometimes they seem a bit short." Overnight there were two staff on

each of the four units.

We concluded that although there were enough staff deployed but the reliance on agency nurse meant there was reduced leadership on the nursing units.

Safe recruitment procedures were in place. Staff were required to attend an interview where their competency and character was assessed. Staff had to provide references and undertake a Disclosure and Baring Service [DBS] check to help ensure they were of suitable character to work with vulnerable people. Staff confirmed these checks took place. DBS checks were rechecked by the manager on a 3 yearly basis.

We looked at the systems in place for managing medicines in the home.

Most people told us they received their medicines at the correct times. However, one person said, "I should get my medication at 07:00 hours but it's usually 09:00 hours when it arrives. That's painkillers too for my wrist and back."

The registered manager told us senior care staff administered medication on the two ground floor units and nurses administered medications on the two nursing units on the first floor. Since the last inspection the provider had introduced a new electronic system to record all medication administration. The senior care worker showed us how the system worked which ensured medication was administered safely and at the time it was required. The registered manager was able to run a report at any time to check the medication was administered correctly. For example, the registered manager showed us a report which told us that one person had received their medication every four hours as prescribed.

At the last inspection we identified a concern about the use of thickening powders which were prescribed for individuals with swallowing difficulties. During this inspection we found these concerns had been addressed and the powders were stored where they were safe but accessible to staff.

Weekly audits were undertaken to ensure any errors or mistakes were addressed and dealt with quickly. The quality assurance manager also reviewed the medication procedures and produced an action plan where needed. We saw evidence that any issues identified had been dealt with.

Staff who were responsible for administering medication had received training. This included additional training to use the 'well pad' [an electronic devise to confirm medication had been administered] which had replaced the paper medication administration records. We found periodic competency checks were carried out to make sure staff were working to expected standards. We observed staff administering medication to people who used the service. They did this in a safe way that reflected good practice guidance.

We checked the controlled drugs [CD's] held for people who used the service. CD's are governed by the Misuse of Drugs Legislation and have strict control over their administration and storage. We found that they were appropriately recorded and the amounts tallied with the records held.

We saw only one of the four units used single dosage medicine pots when dispensing medication. The medication store cupboards did not have suitable facilities to clean the pots. We discussed this with the deputy manager and it was dealt with during the inspection. We concluded people's medicines were managed safely.

The premises were well maintained. Safety features were installed, for example, window restrictors to reduce the risk of falls, radiator guards and thermostatic valves on hot water taps to reduce the risk of burns

and scalds. Wardrobes were attached to the walls to reduce the risk of injury. There had been good progress updating and improving the environment over recent years. There was further refurbishment work planned such as updating carpets within the Cedar Unit.

We looked at a selection of maintenance records and they showed the provider had suitable arrangements in place to make sure installations and equipment were maintained in safe working order. This included electricity, gas, water, passenger lifts, hoists and slings and fire safety systems. We saw fire drills were carried out on a regular basis; however, all the drills recorded had taken place during the day. The residential services manager told us they had recently carried out a fire drill for night staff but we were unable to confirm this as the records could not be located. The registered manager said they would ensure a night staff fire drill was carried out. Following the inspection they confirmed this had been done.

We saw people had personal emergency evacuation plans (PEEPs). These were kept in the fire box along with other information about the emergency procedures.

All the people we spoke with were satisfied with the standards of cleanliness. Comments included: "It's always clean, they keep it lovely." "Oh they do keep my room very clean and they even vac under the bed." "It's nice and clean whenever I visit."

We saw staff followed good hygiene procedures by using hygienic hand gels before dispensing and administering medication to people who used the service.

A domestic assistant was allocated to each unit to ensure it was kept clean throughout the day. We spoke with two domestic assistants. They told us there were enough resources allocated to cleaning to ensure the home was kept in a clean and hygienic condition. We looked round the home and found the environment, fixtures and furniture to be clean. Infection control and hand hygiene audits were undertaken to help ensure staff worked to best practice techniques. Some parts of the building were showing signs of wear and tear. The provider told us they had a refurbishment plan in place to address this.

Requires Improvement

Is the service effective?

Our findings

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 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.

At the previous inspection we found the provider was not working within the legal requirements of the Mental Capacity Act 2005 (MCA). This was in relation to the records held for people who were administered their medication covertly, for example, disguised in food. During this inspection we found improvements had been made to the recording of decisions to support the administration of covert medicines. We looked at three people's medication records who were administered their medication covertly. There was clear evidence of best interest meeting taking place involving staff, the person's relative and their doctor. We also saw the pharmacist had been involved to ensure the medication would not be affected by crushing or cutting. Each person had a detailed care plan which gave instructions to staff if the person refused to take their medication.

We identified one person required a capacity assessment for a medicine they were taking. The medicines required the person's pulse to be taken before administration, however, they had been refusing to let staff do this. Although this had been flagged with the doctor on a number of occasions there was an absence of a best interest decision around whether it would be safe to continue to offer this medicine without measuring the pulse. We asked the agency staff on shift what they would do if the person refused pulse and they did not know. We discussed this with the management team and they assured us they would address this.

The manager understood the requirements of the Act and demonstrated they were acting within its legal framework. Appropriate DoLS applications had been made for people who lacked capacity and who the provider had assessed were being deprived of their liberty. When DoLS were close to expiring, reapplications had been made in a timely way. There were only three authorised DoLS in place, a due to backlogs within the supervisory body, assessments and re-assessments had not been completed by the supervisory body in a timely manner. Some DoLS had conditions attached. We looked at one of these and saw staff had made efforts to comply with the condition, making the required contact with the person's GP to inform them that they were required to update a document.

Care records demonstrated people's consent had been sought and where people lacked capacity best interest decisions had been held. For example, around the provision of bed rails or as to whether to shave

facial hair.

Whilst the registered manager understood the significance of Lasting Power of Attorney (LPA) agreements, information was not kept on file to confirm which relatives held these powers. A LPA is a legal document that allows someone to make decisions for you, or act on your behalf, if you're no longer able to or if you no longer want to make your own decisions. LPA's can be put in place for property and financial affairs or health and welfare. One person's care records stated that the person's relative held an LPA, but this documentation had not been checked by the home. The relative had made some specific requests about the person's care and treatment so it was important that is was verified that they held a LPA for this person.

This meant the provider had failed to ensure decisions about care and treatment where people lacked capacity were only made by people who were properly authorised to do so. Therefore, despite the improvements in relation to the management of convert medication the provider remained in breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found the provider was in breach of regulation because staff training was not up to date. During this inspection we found improvements had been made. Most of the people we spoke with told us they felt confident staff knew what they were doing.

There was a training matrix in place which showed what training staff were required to attend and how often. The matrix showed the majority of staff were up to date with training on safe working practices. This included fire safety and moving and handling training which had been identified as a concern at the last inspection.

Staff we spoke with told us they received the training they needed to carry out their roles. The provider had recently changed the way training was provided and the majority was done on-line. Some staff said they preferred the class room style training. Newly appointed staff received induction training and this included shadowing more experienced staff until they felt competent and confident to carry out their duties.

Staff we spoke with said they felt supported by management and received regular supervision and appraisal. Supervision and appraisal records demonstrated this to be the case.

We found people had access to a varied diet. For example, at breakfast time people could choose from cereals, toast, porridge and a cooked option. We saw a number of people had cereal followed by bacon and sausages, although the breakfast was served rather late on the Cedar Unit at around 9:45am. People's dietary needs and preferences were catered for. For example, there were vegetarian options and Halal meat was provided.

People had access to drinks throughout the day. This included water, fruit juice, tea and coffee. We saw staff routinely encouraging people to have a drink and to keep them hydrated.

The chef had information about people's dietary needs so they could meet people's individual needs. Food was fortified with cream and butter and milkshakes, fruit and cakes were brought around on a daily basis to help ensure people had enough to eat and drink. The chef told us they attended a meeting each day to get the latest information on people's nutritional needs to help ensure they provided an appropriate diet. We saw care workers and kitchen staff were aware of people's dietary requirements and ensured the correct consistency of food and fluid was provided to people.

People had nutritional care plans and risk assessments in place. In most cases we saw appropriate action

was taken to investigate any weight loss. However, we saw one person's weight had dropped from 36.6kg in August to 33.4kg in November. The malnutrition [MUST] score had been incorrectly calculated and there was no evidence of any actions taken to address this. We spoke with the registered manager and asked them to investigate. Following the inspection the provider told us there had been an error with the weight recording and confirmed the person had not lost any weight. Overall we concluded people's nutrition and hydration needs were met.

Meetings took place between the district nurses and the management team to help co-ordinate care between different agencies. We spoke with a district nurse who visited the residential units on a weekly basis. They told us they had a good working relationship with the home and said staff followed their advice.

Care records showed people had access to a range of health professionals. Hospital passports were in place which would travel with people should they be admitted to hospital. This would help ensure hospital staff were aware of people's needs to aid better co-ordination of care. However, we found some people's hospital passports were not as detailed as others. For example, we looked at the hospital passport of one person who was of South Asian origin and whose first language was not English. It was not dated and did not include specific information about their cultural and religious needs in relation to communication and dietary needs. In the records of another person who was living with dementia the hospital passport was only partially completed. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found nursing care planning for people living with dementia was basic and the service could better utilise best practice guidance to develop more person centred and effective plans of care to help meet people's individual needs.

Adaptions had been made to the parts of the home to make it more 'dementia friendly'. For example, on Cedar Unit we saw points of interest, reminiscence boxes and memory boxes were in use to help provide people with stimulation and occupation. Staff had received training on dementia which included a sensory experience to help them understand how people with dementia perceived the environment around them. Dementia friendly plates were in use on Cedar, although there were not enough for everyone to use. A nurse we spoke with could not identify that the plates were dementia friendly and told us they thought they were for safety.

On Rowan unit there were picture signs to help people living with dementia find their way around independently. However, the clock in dining room had stopped and was showing the wrong time. In the lounge there were two clocks but only one was working and showing the correct time.

Requires Improvement

Is the service caring?

Our findings

We found people's meal time experience was varied depending on which part of the home they lived in. For example, on Willow Unit we found the meals displayed on the menu board were not the same as those offered. A member of staff told us they had been too busy to change the board. These two choices on the board did not appear on any of the four weekly menus which were displayed in the dining area. Eight people were assisted to eat at tables in the dining room. The tables were laid with clean table linen and some with paper napkins. All tables had bud vases with no flowers and only two of the four tables had condiments. We saw some people who would have benefitted from having paper napkins were not offered any. Some people were offered anti-bacterial hand wipes before and after eating but other were not. People were presented with a plate of food but were not told what there was to eat. The main hot dishes were chicken in a creamy sauce, vegetable lasagne, curry or vegetable burgers. We saw people were offered alternatives if they did not want the meal they had chosen. The menu showed ice cream as an alternative dessert but this was not offered to anyone. A choice of hot and cold drinks were served. We observed staff supporting people and encouraging them to eat.

On Cedar Unit we found whilst people got the support they needed there was a lack of conversation and encouragement at times and some staff could had to break off from tasks to assist other people which made for a disjointed experience. People were offered sandwiches at teatime but a care worker we spoke with did not know what was in all the sandwiches and we saw this was not fully explained to people.

On Rowan Unit we observed people were offered a choice but this was done verbally and people were not shown the food to help them make an informed choice. The tables were set nicely and although there were paper napkins available they were not offered to people. We saw staff were supportive and encouraging. However, on occasions we saw staff who were supporting people to eat break off from what they were doing and attend to other tasks. We saw one person was supported to eat by two different staff without any explanation being offered to the person.

Feedback from people about the food was mixed. One person said, "I enjoy my food here, there is always a choice of two hot dishes at lunchtime and they will make you something else if you don't want either of those." Another person said, "Yes, the food is ok here." However another person said, "The food is dodgy here and it's always cold. I've just had a jacket potato with cheese for my lunch and it was like a brick. The pudding was some sponge; it was so dry with no custard. My [relative] brings me food in, usually sandwiches but otherwise I have to eat what they give me. I don't have a choice."

People who chose to have their meals in their rooms told us the food was often cold when they received it.

While we found people's nutritional needs were met we concluded improvements were needed to the dining experience to ensure people's dignity was respected and they were supported to make informed choices. This was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw examples of staff treating people with dignity and respect. For example staff adjusted people's clothing to preserve their dignity. When people spilled food or drink on their clothes staff were quick to step in and offer people a change of clothing. When staff helped people to the toilet they did this in a discrete way to help preserve people's dignity.

Most people we spoke with said the staff were kind and caring and respected their privacy/dignity.

During this inspection we observed care using the Short Observation for Inspection (SOFI). We found interactions with people were consistently neutral or positive. Positive interactions enhance people's feelings of wellbeing. We saw staff used appropriate communication techniques to help aid people's understanding. This included speaking slowly and clearly and using body language and touch to comfort people's anxieties. For example, we observed a care worker gently touching a person's arm to see if they were cold. They asked the person, "Are you warm enough? Would you like me to close the window? Are you sure?"

We saw the activities co-ordinator encouraging people to sing which made them laugh and smile.

Whilst there was some good interaction between staff and people late morning, at other times of day we found interactions were rather task based. We saw people were not provided with a great deal of stimulation and became withdrawn or fell asleep.

There was a lack of information recorded on people's life histories within their care and support files. On the second day of the inspection we asked the nurse in charge (not agency) whether they knew anything about a person's life story and biography and they said they did not. This information can greatly assist in the provision of person centred and appropriate dementia care to help ensure people's needs are met. Staff we spoke with did however demonstrate an appropriate knowledge of people's physical care needs for example around diet and continence. Most people felt staff knew about their needs and preferences. One person said, "The staff don't come pestering me, they know me here. I do what I can for myself. They are good people who look after me and they are kind."

Photographs of staff with their names were displayed in the home. However, we saw staff were not wearing name badges. The use of name badges is widely accepted as being of benefit to people who use services and essential to providing compassionate and person centred care.

The majority of people we spoke said staff were respectful and helped them to maintain their independence. One person said, "As a rule the service is good, they let me do what I can manage and help me to get dressed. They knock on the door before they come in and keep the door closed while I am in the bathroom or getting dressed."

Another person said, "When they take me for a shower they help me then I do what I can, they cover me up with a towel and do it well."

Some of the people who lived at the home were from an Asian background. We saw staff speaking with people in their first language and that this helped people to understand. We saw people's dietary preferences were catered for. For instance people of the Muslim faith were provided with Halal meat.

Staff told us a priest and nuns came into the home to support some people who used the service to meet their religious needs.

These examples demonstrated the service was responsive to the diverse needs of people who used the service and working within the framework of the Equalities Act 2010. However improvements were needed in how this information was recorded and shared with other care providers.
Other protected characteristics are age, disability, gender, marital status, religion and sexual orientation. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

We saw care records were kept securely within the nurses' office which was consistently kept locked when not in use.

Requires Improvement

Is the service responsive?

Our findings

Most people told us they received the help they needed during the day and at night.

At the time of our inspection the provider was in the process of changing the care records to a new electronic system. Staff were recording daily care notes electronically and hand written care plans were still in place.

People's care needs were assessed and the information was used to develop plans of care. Most of these covered people's basic care needs but were not person centred enough to ensure the consistent delivery of appropriate and safe care which reflected people's needs and preferences.

We saw examples of care plans being followed. For example we saw people were using pressure reliving mattresses and cushions in line with their plans of care. However, we also saw examples of care plans not being followed. For example, one person's care plan stated they should have a plate guard to help them eat independently. At lunch time the person was not provided with a plate guard.

On the Cedar Unit we found staff were not always responsive to people's toileting needs. For example through observations and review of records we saw two people had not been offered toileting between 8am and after 2pm, despite relying on staff for regular continence care.

We saw one person was provided with a puree diet in line in line with advice from Speech and Language Therapy (SaLT). However, their care plan said they required a fork mashable diet. The SALT advice and care plan did not contain consistent information which could lead to misunderstandings amongst staff. In another example, advice from SALT about how to use a prescribed thickening powder had not been included in the person's care plan. Staff were aware of how to use the thickening agent but because it was not included in the care plan there was a risk it would not always be used correctly.

In another person's records we saw a care plan which referred to them having their medication via a Percutaneous Endoscopic Gastrostomy (PEG) feeding tube. However, other information in their records showed the PEG was no longer in place.

In the care plans of people who presented behaviours which challenged we saw they were not detailed enough to provide clear guidance for staff on how to respond to this. For example, in the case of a person who was living with dementia the care plan stated the person 'remains verbally and physically aggressive towards staff when attending care' but did not detail the strategies for helping reduce distress to the person.

In another person's records we saw they had recently been prescribed a new medication. A nurse specialist had provided detailed information on the possible side effects staff should observe for. This information had not been included in the person's care plan.

People's care plans were evaluated monthly, however evaluations needed to provide a more thoughtful

evaluation on the success of the care plan and any additional strategies needed to assist the person. For example one person had a care plan for preventing them developing diabetes as the doctor had assessed they had a borderline diagnosis. The monthly evaluation simply stated they had not developed diabetes rather than considering how effective the care plan had been, and it had not considered factors such as the recent weight they had put on.

Within the care records we found a lack of information to demonstrate people were supported to plan for their end of life care.

These examples demonstrate there was a risk people would not always receive appropriate care which took account of their wishes. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most of the people we spoke with could not recall being involved in their care planning. However, the care records showed people and relatives were involved in regular care reviews. This meant people were provided with an opportunity to share their views about the current plan of care to say if changes were needed. The care records we reviewed showed relatives were happy with the care provision.

The provider had measures in place to help ensure people were provided with responsive care. Handover meetings were held twice a day where staff shared key information about people's needs. The electronic care management system also contained a summary page of any changes to people's needs and/or any key information which needed to be passed on. In addition, each day there was an '11am meeting.' This was attended by the heads of each department to discuss any risks, issues or changes to people's needs.

We looked at what the service was doing to meet the Accessible Information Standard. The registered manager told us they had attended training about the standard. We found people's communication needs were assessed to determine whether they had any particular sensory needs. We saw staff using a range of techniques to speak with people appropriately. Staff said they had received dementia training where had included a sensory experience demonstrating how the senses of people living with dementia may be altered. Staff told us this training was excellent and had given them a heightened awareness of people's sensory needs. During the inspection we observed staff used a variety of communication techniques to help meet people's needs including body language.

Shakespeare Court had two activities co-ordinators, one full time and one part time. The weekly activity programme was displayed in the home. We saw staff provided some activities to people. For example we saw the activities co-ordinator singing with people and care workers, singing, playing skittles and doing a quiz with people. Staff also told us that Bingo, dominos and other games took place regularly. However there were times on Cedar and Willow units where there was not enough stimulation or interaction with staff practice being very task focused.

Information on how to complain was on display throughout the premises. We saw seven complaints had been received within 2017. Each one of these was acknowledged and responded to within a prompt way. Whilst not everyone was completely satisfied with the outcome of complaints, we concluded the service had taken every effort to investigate and resolve complaints.

Inadequate

Is the service well-led?

Our findings

This domain has been rated inadequate because the overall rating for the service has been inadequate or requires improvement since October 2014 when we carried out the first rating inspection. This demonstrates the provider has failed to effectively implement and sustain improvements.

A registered manager was in place supported by a deputy manager who was also the clinical lead for the nursing units. At the time of the inspection there were vacancies for senior nurses to oversee care and support on Willow and Cedar, the nursing units. A night manager was also due to begin working at the home in November 2017. The vacancies combined with the use of agency nurses to take charge of units reduced the effectiveness of the management team and historically contributed to the providers failure to implement and sustain improvements to the service.

Five people who used the service and one relative we spoke with told us they did not know who the manager was. One person said, "No I don't know who the manager is, I've never seen one." Another person said, "There doesn't seem to be a Manager."

At the last inspection we found the provider was in breach of three regulations. These related to staff training (Regulation 18) the management of covert medication (Regulation 11) and good governance (Regulation 17). Following the inspection the provider sent us an action plan. During this inspection we found that although some improvements had been made the provider remained in breach of regulations 11 and 17 and we identified two additional breaches in relation to person centred care (Regulation 9) and dignity and respect (Regulation 10).

This demonstrated the providers governance systems were not operating effectively.

The provider has put systems in place to assess and monitor the service and we saw audits and checks were being carried out. These covered areas such as care plans, skin integrity, nutrition, the dining experience and dignity. We saw examples of where these audits had been effective in identifying some issues and these issues had been addressed. For example, the care plan audit had identified that information on people's mental capacity was needed in some care plans. We saw this had now been rectified. .However, during the inspection we identified concerns in some care plans as detailed in the effective and responsive sections of this report which created a risk people would not always receive care which was appropriate to the needs. In addition, we identified concerns about people's meal time experiences which had not been identified or addressed by the provider's audits.

The provider had put other measures in place to improve the management oversight of the service. These included a daily management walkabout and monthly reports from each unit on matters such as pressure area care, incidents, safeguarding and complaints. However, at the time of our inspection it was too soon to judge how effective these processes would be in ensuring improvements were implemented and sustained. Incidents were analysed on a monthly basis to help inform learning and help identify any key trends or themes. For example where concerns over staff practice had been identified; we saw disciplinary processes

had been followed to help keep people safe. However, we found improvements were not always embedded in practice as detailed in the safe section of this report.

Action plans were in place to drive improvement to the service. The service had enlisted the support of care consultants to develop the service. We saw they completed regular quality audits and provided input to improve working practices. We concluded through speaking with management, staff and reviewing documents that a number of positive improvements had been made to the service over recent months. For example staff disciplinary processes had been followed and increased management presence at key times of the day had been put in place to drive some improvements.
A range of meetings took place, these included health and safety meetings, unit meetings, overall staff meeting, nursing meetings and managers meeting. We saw quality issues were discussed including the results of any audits and these meetings were being used to help implement and sustain improvements to the service.

Regular resident meetings were held on each unit to help ensure people had the opportunity to share their views. However, it was too soon for us to be assured the provider would use this feedback effectively to bring about and sustain improvements.

Despite all these interventions people who used the service continued to experience care which fell below the required standard. In addition we found the provider's governance systems were not robust enough to prevent the issues we identified during our inspection.

We concluded the provider's quality assurance systems were not robust enough to ensure the consistent delivery of high-quality care. Therefore they remained in breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the service was working with other agencies such as the district nursing teams to help ensure people's health care needs were met.

Systems were in place to seek people's feedback. These included annual quality surveys were sent out to people and relatives; we did not review these as a survey had not been completed since our last inspection in January 2017.
A home wide relatives meeting was also held on a periodic basis. We reviewed the minutes of the latest meeting, which showed only one relative had attended. However the service took the opportunity to offer the relative a review of the person's care which they accepted.

Staff told us they felt the manager was approachable. One staff member said, "The manager here is very good, I think she is approachable and I can discuss things with her."

We saw the provider had introduced a staff reward and recognition scheme (STAR Awards) to help improve the service. The awards were given to staff who had gone out of their way or worked exceptionally hard to improve the lives of people who used the service.

The rating from the last inspection was displayed as required by law.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were at risk of not consistently receiving care which was appropriate and met their needs. 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. 10(1)

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 The registered persons had failed to ensure decisions made on behalf of people who lacked capacity were only made by people who had the legal authority to do so. 11(3)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated effectively to monitor, assess and improve the quality and safety of the services provided and ensure compliance with regulations. 17(1)(2)(a) Accurate and up to date records in relation to people's care and treatment were not always maintained. 17(1)(2)(c) Feedback was not always used effectively to bring about improvements. 17(1)(2)(e)

The enforcement action we took:

Warning notice