Prestwick Care Limited

Hadrian House

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

Hadrian House is a residential care home in Wallsend, North Tyneside. It provides accommodation, personal and nursing care for up to 50 older people who may also have physical and mental health related conditions. At the time of our inspection the home was at full capacity.

This unannounced comprehensive inspection took place on 10, 14 and 15 March 2017. This was the second rated inspection of the service since its registration with the Care Quality Commission (CQC) in May 2011. We previously inspected the service in May 2016 and rated the service as 'Good', however at that time we identified one breach of the regulations which related to the management of medicines.

A registered manager was in post and this manager had not changed since our last inspection of the service. 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 initially looked at how the service managed medicines. We found that the service continued to fall short of expectations and this led us to conduct another fully comprehensive inspection. We saw that PRN and topical medicine protocols were still not in place for each individual person and medicine care plans were not up to date or accurate. We also saw multiple examples of medicine administration records (MARs) which continued to contain gaps in the recording of administration without a corresponding explanation. Therefore, we could not be certain that people had received their medicines appropriately and as prescribed. Additionally we found concerns around the receipt, storage and disposal of medicines.

The governance of the service was not thorough and effective. Following our last inspection in May 2016, the provider and registered manager had not returned an action plan to CQC as requested as part of the requirement notice which was served to them in relation to the breach of regulation 12, safe care and treatment. Neither had they drafted their own action plan to address the shortfalls in the management of medicines which we identified. This meant those shortfalls had not been addressed when we visited on 10 March 2017.

Internal audits and monitoring of the service had taken place however this had not been robust enough to identify the issues we highlighted during our inspection. The provider had recently made changes throughout the senior management team and they told us about the improvements they planned to make regarding governance and oversight of the service. Following this inspection, the senior management team sent us an internal action plan to tell us how they planned to immediately address the shortfalls throughout the service.

Overall staff morale was low and there were differing opinions from staff about the leadership of the service. Some staff told us they felt supported by the management team and had received regular supervision and

appraisal. Staff supervision and team meetings had not been held as often as planned however some staff told us they felt able to approach the registered manager whenever necessary. Equally there were some staff who felt undervalued by the management.

A robust induction programme such as the 'care certificate' had not been fully implemented at the service and because of this; some staff had not had their competency assessed against the minimum standards which are expected. Formal 'on-the-job' competency checks of experienced staff were not conducted. Training which the provider deemed mandatory had not always been refreshed in line with the targets they had set themselves and specific training to meet the needs of the people who used the service such as dementia awareness and challenging behaviour was not routinely arranged. This meant the provider and registered manager could not assure themselves that staff were competent in their role or that they were formally supported to develop their skills and knowledge. Staff continued to be recruited in line with safe working practice.

Individual care records were in place and contained personalised information in them about people preferences, routines and wishes. However we did not consider the staff approach to care documentation to be person-centred. We examined seven individual care records thoroughly and reviewed others. We found that the majority of them contained inaccuracies or incomplete forms and some documentation held within the records were not always signed and dated by people, their relatives (if appropriate) and staff. Evaluations of care plans and reviews of risk assessments were not routinely being carried out.

Record keeping was poor in aspects of the service such as care planning, medicine administration, food and fluid monitoring and weight records which caused us concern and we asked the registered manager to address some individual issues immediately. Risks which people faced in their daily lives were not always identified and addressed to reduce the possibility of people coming to harm. Those we reviewed had not always been completed accurately. Records were not always stored securely which did not support the confidentiality of people who used the service.

We observed staff interacting with people throughout the inspection. Interactions were not always dignified and respectful between staff and people who were diagnosed with dementia. The registered manager and provider told us they would take immediate action to address this issue although they told us that some staff felt under pressure due to the inspectors presence. Other staff displayed kind and caring attitudes and people told us staff were nice to them. People enjoyed a friendly relationship with the staff and it was apparent they knew each other well.

The Care Quality Commission (CQC) is required by law to monitor the operations of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests'. It also ensures unlawful restrictions are not placed on people in care homes and hospitals. In England, the local authority authorises applications to deprive people of their liberty. We found the provider was complying with their legal requirements with regards to DoLS with a systematic process but decisions made in people's best interests were not always appropriately taken or correctly recorded. In most records there was evidence that people had consented to their care and treatment.

The service offered people choices at mealtimes. The food appeared appetising and well balanced. Alternative options were available for people who didn't want what was offered. Special diets were catered for, such as vegetarian, diabetic and soft diets. Catering staff were familiar with people's dietary requirements. We observed mealtimes to be functional but they lacked an opportunity for stimulation and

socialisation.

People we spoke with during the inspection told us they felt safe living at Hadrian House. Staff were trained in the safeguarding of vulnerable adults and they demonstrated an awareness with regards to protecting people from abuse and their responsibilities if they suspected wrong-doing. Policies and procedures were in place to support staff with the operation of the service; however we found some working practices were not always in line with company policy.

People told us they generally felt there was enough staff employed at the service and staff responded to them when called upon. There were mixed opinions amongst the staff team about staffing levels. Some staff told us they felt hurried in their duties and other's felt they were able to meet people's needs. Staff, including nurses felt there was not enough time to complete documentation appropriately. We felt there was an issue with the staffing in one area of the home and we reported this to registered manager and provider who told us they would look into the matter immediately.

Accidents and incidents continued to be recorded, investigated and monitored. An audit tracker was in place to identify types, places and times of events to monitor trends. The registered manager had reported these events to external agencies as required.

Routine safety and maintenance checks were carried out around the premises. Personal Emergency Evacuation Plans (PEEPs) had not been routinely reviewed. We found examples of people who had not had their PEEP recently evaluated; including those whose mobility needs had changed. The premises were clean and well-presented however equipment such as wheelchairs and some dining room furniture and flooring were encrusted with food and had staining from drink spillages.

There were two activity coordinators employed at the service which meant there was ample activity provision available on weekdays. We saw information was on display about forthcoming events and activities and we observed people engaging in a variety of activities which were meaningful and interesting to them.

The complaints procedure remained in place. We reviewed recent response letters and saw evidence of internal investigations into the issues raised had taken place and complainants had received a timely response in line with the policy. Feedback continued to be sought from people, relatives and staff.

We have identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 namely, Dignity and respect, Need for consent, Safe care and treatment, Staffing and Good governance. You can see what action we told the provider to take at the back of the full version of the 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 safe.

There continued to be concerns around the management of medicines.

Individual risks which people faced where not always identified and addressed in a timely manner.

We identified issues related to infection control risks particularly around the cleaning of the premises and equipment.

Staff were aware of how to safeguard people from harm however working practices where not always in line with company policies and procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

Management and staff did not fully understand the Mental Capacity Act (2005) and did not always apply the principals of the Act appropriately and consistently.

Not all staff had completed a robust induction process and some training was not up to date. Staff competencies were not carried out for all aspects of their role.

Staff supervision and appraisals took place but the timescales were not always in line with company policy meaning some staff did not receive formal supervision regularly.

People enjoyed a variety of meals which were pleasant and well balanced and they had regular contact with external health professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

Interactions between staff and people were not always respectful and some people's dignity and privacy was not always protected

and promoted.

Other staff displayed kind and caring attitudes and people told us they enjoyed a friendly relationship with the staff.

Staff knew people well and could tell us about individual's needs, routines, wishes and preferences.

Information which may benefit people was on display around the home.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff did not always approach their duties in a person-centred manner. Individual care plans were generically written and did not always reflect the identity of the person.

Care plans and other records were not routinely reviewed and therefore they did not always match the current needs of the person.

Record keeping was poor which meant there was sometimes a delay in people receiving the care they required.

Stimulating and meaningful activities were provided, including access to the community and outdoor space.

Complaints were responded to appropriately and in a timely manner.

Is the service well-led?

Requires Improvement

The service was not well-led.

The registered manager and provider had failed to address the shortfalls in the service from our last inspection.

Audits and checks of the service had not been robust enough to identify the concerns we raised during this inspection.

Records were not accurate, complete and contemporaneous in respect of each person who used the service.

Communication between management and staff was not effectively implemented throughout the home.

There were mixed views from staff about the leadership of the

service.

Hadrian House

Detailed findings

Background to this inspection

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

This inspection took place on 10, 14 and 15 March 2017 and was unannounced. The inspection team consisted of two adult social care inspectors.

Prior to the inspection we reviewed information we held about Hadrian House, including any statutory notifications which the provider had sent us and any safeguarding and whistle blowing information we had received. Notifications are made to us by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. They are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

We had not asked for a Provider Information Return (PIR) to be completed on this occasion. The PIR 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. This was because we initially intended to complete a focussed inspection around the management of medicines only.

We liaised with North Tyneside Council's contracts monitoring and adult safeguarding teams and North Tyneside Clinical Commission Group (CCG) to share information and use any information they held to inform the planning of our inspection.

During the inspection we spoke with five people who used the service and one relative. We spoke with 22 members of staff, which included the registered manager, the deputy manager, two nurses, a physiotherapist, eight care workers and four staff in non-care related roles, such as administration, domestic, activities and catering. Five representatives from the provider organisation also attended parts of the inspection and we were able to speak with them about compliance, leadership and governance. We reviewed a range of care records and the records regarding the management of the service. This included looking at seven people's care records in depth and reviewing others. We also looked at three staff files.

Requires Improvement

Is the service safe?

Our findings

We found that previous shortfalls related to the management of medicines which had been identified at our last inspection had not been addressed, such as the omission of PRN and topical medicine protocols and up to date medicine care plans. PRN medicines are taken 'as and when required' for example, for pain relief. Topical medicines are medicines such as creams, drops or ointment which are applied to the surface of the body. As people's records were not up to date and accurate this meant they may not have been given the opportunity to have medicines administered when they required them.

There was a medicine policy in place; however staff working practices did not always reflect the expectations outlined in the provider's medicine policy. Nurses were not always recording details on the reverse of the medicine administration records (MARs) of PRN medicines administered, as instructed in the medicine policy. This information would have helped to ensure people were given their medicines in a safe, consistent and appropriate way. We also found that peoples' MARs were not always completed correctly which could increase the risk of errors and we found multiple examples of gaps in administration records which were not supported by an explanation on the reverse of the corresponding MAR. This meant we could not be certain people had received their medicines appropriately and as prescribed.

The application of transdermal patches was not robustly monitored. These patches are applied to the skin usually to provide long lasting pain relief and can be left in place for up to seven days. There was no body map record kept to provide evidence of where a patch had been sited on a person's body. There was also no procedure in place to record information relating to the positional changes of the patch or evidence that a daily check was carried out to ensure the patch was still intact.

We raised concerns about staff working practices with regards to the receipt, storage and disposal of medicines. For example, medicines which had been delivered to the home were left unaccounted for, for two days during our inspection. They were not stored in a locked room within a treatment room as instructed in the medicine policy. We observed an accumulation of more than 10 boxes of unused medicines which were also not stored in a locked room within a treatment room whilst they awaited collection for disposal. Some of these boxes contained loose tablets which were not bagged or labelled. This meant that there was a possibility these medicines could be tampered with or misused.

Senior staff carried out checks of MARs to ensure they were completed but these checks had failed to address the issues we found. We looked at how the registered manager monitored and checked medicines to ensure they were handled properly and that systems were safe. Although audits were carried out, these had not been effective. Despite an internal auditor highlighting issues similar to those we identified, timely action had not been taken to address them. The registered manager and provider gave us their assurance that the process around the safe management of medicines would be tightened immediately.

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

Risks which people faced in their everyday lives were not always identified. We raised concerns about several individuals who did not have risk assessments in place or whose needs had changed and their care records were not up to date. For example, on the second day of our inspection we identified one person was not safely transported in their wheelchair as their feet were not placed firmly on the foot rests before it was pushed by care staff. Consequently there was a risk that the person could injure their feet and/or legs during such manoeuvres, as they could become trapped or hit the floor. We highlighted this to the care staff on duty who told us this person did not like to keep their feet on the foot rests of their wheelchair. The nurse on duty was not aware that this was a concern until we shared our observations with them. On the third day of our inspection, a physiotherapist employed by the provider visited the home and we discussed with them the possibility of getting a foot plate for this person's wheelchair. This was arranged and fitted to the person's wheelchair promptly. Following our intervention and the adaptation to this person's wheelchair, this risk was eliminated and the person concerned was then transferred around the home safely. The physiotherapist told us they would update the person's mobility care plan and risk assessment as it did not reflect the person's current needs.

We found three people who were at risk from severe weight loss and malnutrition. One person did not have a nutritional risk assessment in place, despite having their weight closely monitored and being prescribed nutritional supplements due to being significantly underweight and at risk of various health conditions. A second person who was also underweight had lost 10% of their body weight in recent months and no actions had been recorded to address this or seek further medical advice. A third person had their weight wrongly recorded in four separate places which meant their weight loss of 10% had not been recognised by staff. We asked the deputy manager to address this concern immediately which they did.

We found other examples of risks which were not fully addressed. These included insufficient records kept informing care workers of important safety information in relation to the management of PEG feeding and the management of skin integrity. A PEG (Percutaneous Endoscopic Gastrostomy) feeding tube allows nutrition, fluids and/or medicines to be put directly into the stomach, bypassing the mouth using a flexible tube which is inserted into the stomach. This meant people were potentially at risk of serious health conditions including pressure damage and choking if care staff were unaware of their responsibilities in relation to people's current plan of needs.

We identified an area of the home where staff did not manage the risks to controlling infection as well as the rest of the home. We saw staff transporting people in wheelchairs which were encrusted with food debris. Furniture and flooring in one communal dining room also had food debris and staining from spillages. We found this area of the home was unkempt, with people's personal items left lying around in communal areas. For example in a communal bathroom we found two face cloths and a pair of slippers had been left behind after the room was used. We also saw a used disposable glove and a red disposable laundry bag were left on the floor and a packet of baby wipes were left in a sink. In a communal lounge, several pairs of glasses and a hearing aid were stored in a drawer which was accessible to everyone.

Personal Emergency Evacuation Plans (PEEPs) had not been routinely reviewed. We saw examples in people's records where their PEEP had not been recently evaluated, some of which included people whose mobility needs had changed. A PEEP is used by staff and sometimes by the emergency services as it provides instant information about the mobility needs of people in the event of an urgent evacuation of the home. This demonstrated that staff may not have been fully prepared in an emergency.

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

It was difficult for most people to communicate verbally with us during the inspection however the people we spoke with indicated they felt safe living at Hadrian House and they responded positively when we asked them if they were happy. One person told us, "I'm really happy here, the staff will do anything for you." A visiting external nurse told us, "I have high regard for this home, it's very good and I have no concerns."

The providers safeguarding policy remained the same as at our previous inspection and the staff continued to follow the local authority's safeguarding procedures with regards to reporting suspicion or allegations of abuse. Staff had undertaken a safeguarding of vulnerable adults training course and through discussions with us, they demonstrated an understanding of their responsibilities towards protecting people. We reviewed safeguarding incidents which had occurred from January 2016 to present. We saw thorough investigations were carried out and conclusions were acted upon. Where required the registered manager had notified CQC of the outcome to specific incidents. There were no 'open' safeguarding investigations at the time of our inspection, although we spoke to the local authority afterwards about some of our findings.

Accidents and other types of incidents continued to be recorded. An audit tracker was in place to identify the types, places and times of each accident or incident to monitor trends. The registered manager had reported these to the local authority and CQC as necessary.

During our inspection, we observed the handyman carried out repairs and routine checks on the safety and maintenance of the premises. Daily, weekly and monthly checks were conducted and comprehensive records were kept. Any faults, comments or immediate actions taken were recorded and reported to the registered manager to follow up and action further. Fire fighting equipment was in place and serviced regularly. Tests of specialist equipment and utilities such as gas, electricity and water were carried out by approved external contractors. Overall the premises, both internally and externally were well maintained, clean and comfortable with the exception of the issues we have reported on in one area of the home.

People told us that staff responded to them when called upon. Comments included, "I always get a good response when I press the buzzer", "There is plenty of them [staff]" and "They come when I need them. I have had two falls and I need help now to go to the toilet." There were mixed opinions amongst the staff team about staffing levels. Nurses and care workers said there was not enough time to complete care monitoring documentation appropriately. Some staff told us they felt hurried in their duties. They said, "This is an issue, as a (job title) I don't feel in control of doing my job. It is difficult to tell if the issue is staff numbers or skill mix. I have high standards but it feels out of control" and "I have had no time to read people's care plans. I want to but have no time." Another said, "Me and (name of colleague) do our best, we really do. The main battle is the staff team, they say they've done things but they aren't done and it's so stressful." Other staff which included care, catering and activities staff told us they felt that they were able to meet people's needs. We considered there was a staffing issue in one area of the home and we reported this to the registered manager and provider who told us they would look into the matter.

Safe staff recruitment was sustained. We reviewed three personnel files of new employees. There was evidence of a proper recruitment process and pre-employment vetting checks in place. The new staff we spoke with confirmed they had supplied the evidence for the appropriate checks to be carried out.

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 so that they can 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. DoLS applications had been made for each person living at the home and these were being systematically processed. In the records we reviewed we saw that not everyone had a fully completed capacity assessment in place which meant some DoLS applications had been made to the local authority inappropriately. This was further corroborated by the local authority who had refused several applications.

Information in people's care records indicated that there was a lack of understanding of the application of the MCA by management and clinical staff. There was paperwork in people's records about best interest decision making that was incomplete and it did not always demonstrate who had been involved in the process. We found examples of people with capacity being involved in best interest decision making about areas of their care, where there was no need for this process to be followed, as they had the capacity and ability to make their own decisions. In other cases we saw best interest decisions had been recorded as having taken place, but there were no associated capacity assessments about each of these decisions. For example, a best interest decision had been made for one person about the use of bed rails for safety; however, there was no linked capacity assessment to show that a best interest decision was necessary in line with the person's lack of capacity. This meant the principles of the MCA had not been followed when imposing this restriction on this person's movement.

Some best interest decision making paperwork showed that only a nurse and the registered manager of the home had been involved in the decision making process. This meant there was only one party making the decision, namely the service themselves, as the person did not have the capacity to be involved in the decision themselves. A communal decision was therefore not made and the principals of the MCA were not appropriately followed. A relative told us they had not been involved in the decision making process regarding their parent's admission into residential care. Records and management confirmed that people who lacked capacity did not always have a capacity assessment or best interest decision recorded properly about their admission into permanent residential care. This demonstrated that the registered manager and clinical staff did not fully understand or apply the principals of the MCA consistently within the service.

Care records contained evidence which showed the service asked people for their consent in some aspects of the care planning process. We saw in records that people had given their consent "not to have their bedroom door locked" and "to have their photograph taken", however poorly maintained records meant

that care plans were not always signed as agreed by the person or a relative acting legally on their behalf. Records showed that people had relatives who acted on their behalf formally with legal arrangements in place such as a 'Lasting Power of Attorney' (LPA) for finances and health matters. We saw references to people's LPA status in care records, however we did not see any evidence of the formal agreement which meant staff could not be certain that relatives had the legal authority to make decisions on people's behalf.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Need for consent.

Newly employed staff received a company induction which covered operational activity and company policies. CQC expect registered providers to have introduced the new 'Care Certificate' for new staff employed after 1st April 2015. Whilst it is not mandatory, providers should be able to demonstrate that staff are competent in the standards. The care certificate is a benchmark for induction of new staff. It assesses the fundamental skills, knowledge and behaviours that are required by staff to provide safe, effective, compassionate care. Although the registered manager had resourced this for new staff as per company policy, we found some staff, who had been employed over one year had still not completed this induction process. The guidelines suggest the 'Care Certificate' is completed within the first 12 weeks of employment. Staff we spoke with told us they had enrolled on the 'Care Certificate' but had not completed the reflective accounts which are written statements to demonstrate competence in certain aspects of care work, such as principals of care, equality and dignity. They had also not been visually assessed against the criteria. Information sent to us after the inspection by the Head of Compliance showed that out of a possible nine staff, only two had started their reflective accounts and no-one had completed the 'Care Certificate'. Training statistics showed that only 45.5% of the entire workforce had completed an induction.

Staff supervision and annual appraisal meetings were scheduled but they had not taken place routinely and in line with the company policy. Formal 'on-the-job' competency checks of experienced staff were also not formally conducted or recorded. One member of staff told us, "I did some induction about filling in company documents but no other induction – in the end I didn't bother asking." This meant the registered manager and provider could not assure themselves that staff were competent in their role or that they were formally supported to develop their skills and knowledge. The registered manager and training manager told us they were aware that some staff had fallen behind with this and planned to support the staff to complete the 'Care Certificate' with immediate effect.

Training was delivered to staff through internal and external providers which included face-to-face sessions. We reviewed the training matrix for the service and saw that some staff were overdue annual refresher sessions in key topics such as fire safety and moving and handling which the provider deemed mandatory. Specific training to meet people's individual needs was not routinely delivered to staff. For example only 27% of the workforce had completed a dementia awareness session and no-one had undertaken a challenging behaviour training course. This meant that staff may not be aware of current best practice guidelines in some aspects of care work or be specifically equipped to manage the complex needs of some people who used the service in the best possible manner. The registered manager, provider and other senior management staff told us they were aware that the training and development of staff required improvement and they showed us a plan of training which was scheduled to take place in the near future.

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

Monthly and Bi-monthly staff meetings had also not been held as often as described in the company policy. We reviewed the minutes of previous meetings and saw that issues such as safeguarding, nutrition, infection

control and medicines were regular agenda items however there had been very few meetings held between June 2016 and December 2016. This showed that formal communication between the management and staff had been overlooked which may have contributed to the inconsistencies in service delivery throughout the home. Following our inspection several staff meetings were immediately convened and we were sent the minutes to review.

There was a variety of choices on offer at mealtimes. There were dementia friendly menus on display which showed a picture of the meal to help people recognise the food on offer. There was a homely feel in the dining areas on the ground floor and upper floors with tables well presented with table cloths, cutlery and condiments. This was not the case in the dementia unit on the middle floor where tables were bare, not always clean and the dining room lacked a homely touch. Some people chose to stay in their bedrooms and staff supported this decision and took their meals to them on a tray. We saw catering staff and care staff served people meals which appeared appetising and well balanced. Alternative options were available for people who did not want what was offered. For example, we saw one person chose a cheese sandwich because they did not want the roast chicken dinner.

People with special dietary requirements continued to have their needs catered for, such as vegetarian, diabetic and soft diets. Easily digestible food was prepared for people with swallowing difficulties. One person told us they followed a diabetic food controlled diet and added, "There are good meals and I can choose something else, I'm a bit fussy." The catering staff we spoke with were familiar with people's dietary requirements. We observed mealtimes to be functional but they lacked an opportunity for stimulation and socialisation as staff did not interact with people other than to assist them with their meal and drinks.

There remained good access to external healthcare professionals to monitor and support people's general health and well-being. We saw communication and visits from external professionals did take place such as opticians, dentists, dieticians and chiropodists but these weren't always recorded in the corresponding section of the person's care plan which made monitoring any actions difficult to follow. During our inspection we saw several external professionals visited the home including a GP and a community mental health nurse. The visiting nurse told us, "They manage very well here from my perspective."

The attractive and homely decoration and design of the home was sustained. The premises incorporated elements of dementia friendly care. 'Ward' lighting, similar to those used in hospitals was used throughout the home to create a relaxing and comfortable setting, carpets were designed especially for dementia care environments and there was appropriate pictorial signage to assist people to recognise rooms. People's bedrooms were individually decorated and styled with ornaments and photographs which were personal and sentimental to them. Activity areas had memorabilia on the walls, such as posters and old advertisements. There were ornaments, old-fashioned artefacts and items of interest, such as a grand piano in activity areas to stimulate memories and conversation. We saw people were interested in these items and they provided a temporary distraction for those who were restless or agitated due to their health conditions.

There was ample access to outdoor space which included an enclosed balcony, terrace and garden areas.

Requires Improvement

Is the service caring?

Our findings

We observed staff interacting with people throughout the inspection. People's dignity was not always protected and promoted by staff. Interactions were not always respectful between staff and people who were diagnosed with a dementia related condition. For example, some people with dementia care needs had food debris and staining on their clothing and the equipment they used for mobility was encrusted with food. A relative told us, "His [their relation] wheelchair is not cleaned there were peas under it yesterday in the seat cushion and the wheels get caked with food."

On the second day of our inspection we observed some of the breakfast time meal. Eight people with a dementia care need were sitting at tables in a dining room having already finished their meal, for over an hour and a half before they were assisted to leave the area. Some people had been in the dining room for over two and a half hours according to their completed food and fluid charts, which indicated the time at which they had eaten their breakfast. Once they had finished their meal, people were not supported to move out of this area into a more comfortable part of the home. They were sitting at tables, some with drinks and some without. Some people who we saw arrive into the dining room during our observation, had drinks and food placed in front of them which then went cold. This was not refreshed for them before they were encouraged by staff to try to eat and drink up to 45 minutes later. Some people did not leave the dining room until 11:30am and at 12:10pm; these same people were assisted back into the dining room again for their lunch. The breakfast dining experience was prolonged for people when there was no need for it to be and this resulted in some people becoming disengaged and sleepy at the tables.

On the second day of our inspection we saw that one person was incontinent and had not been supported with this element of their personal care. We observed that staff did not notice they needed this support despite assisting them to the dining room for lunch and supporting them during the lunch period for over two hours. When we shared our observation with care staff they supported this person to change their clothing following our intervention. This meant the person's dignity had been compromised.

We heard staff talking about people in front of them in a disrespectful manner. We heard comments which included, "Take them to the lounge and we will toilet them from there", and, "I need you to move all of them out of here [dining room] before I can clean it". This demonstrated that people were not always treated with dignity and respect. When we told the registered manager and provider about these observations, they told us they would take immediate action to address it, but they added that some care staff had told them they felt under pressure due to the inspectors' presence.

A relative told us that their relation had not received basic personal care, including having their teeth cleaned, on two days over a recent weekend. They knew this as the person's tooth paste was still sealed. They also told us their relation did not appear to have been shaven. We checked the daily personal care records for this person and they showed that no personal care had been delivered on the specified dates. This corroborated what we had been told. We shared this information with the nurse on duty who could not confirm that personal care had been delivered to the person concerned.

Confidentiality was not always maintained during our inspection as we heard staff holding sensitive conversations in corridors and communal areas. People's personal data and confidential records were not always kept private as we found multiple care records left unattended in communal areas. We observed private information about people who had special dietary requirements was on display in some of the communal dining areas which included, meal plans, fortified diets, and textured food guidance. This did not support the confidentiality of people who used the service.

This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Dignity and respect.

Other staff we observed and spoke with displayed kind and caring attitudes. People we spoke with told us staff were nice to them. We heard comments such as, "All the staff are lovely", "Staff get on well with my family" and "Nurses are good and there's a good activities lady." We saw that most people enjoyed a friendly relationship with the staff and it was apparent they knew each other well.

On the third day of our inspection, the dining experience at breakfast time was different. When we entered the same dining room at 10:30am there were only four people in the room and other people who had finished their meal were either in the communal lounge or were pursuing activities. Staff told us there was more organisation on this day and they were aware of the need to help people to relocate away from the dining room, once they had finished breakfast.

Training records showed that 63.5% of staff had attended a training course in dignity awareness and overall, the staff we spoke with displayed respect for people and could tell us how they maintained and promoted peoples' privacy and dignity. Care workers we spoke with told us how they knocked on peoples' doors and sought permission to enter; how they covered people over during assistance with intimate personal care tasks and that they ensured people felt comfortable during support. We observed most staff treated people as individuals and considered people's differing needs when going about their duties, which they did with kindness and compassion. A visiting nurse described the staff as "professional, warm and welcoming."

Discussions with the staff revealed that people who used the service had particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010; age, disability, gender, marital status, race, religion and sexual orientation. There was no evidence to suggest that people who used the service were discriminated against and no one told us anything to contradict this. We saw some examples of positive care planning were recorded to ensure people's needs were met in a way which reflected their individuality and identity, although this was not always reviewed.

We spoke with staff about people's individual care needs and they were able to tell us about people's life histories, preferences, likes and dislikes. Both experienced and new staff clearly knew this information about people without referring to paperwork.

There was information, advice and guidance displayed on noticeboards around the home about aspects of the service such as newsletters and activity programmes to inform people of current and relevant topics of interest. People had been given a 'service users guide' upon admission and these booklets contained information about the service; what to expect, what services are offered and the local amenities. Other relevant information which would benefit people was also on display such as safeguarding contacts and leaflets on dementia awareness and advocacy services.

The service continued to access an independent advocate service, if people needed it, through the local authority. An advocate is a person who represents and works with people who need support and

encouragement to exercise their rights, in order to ensure that their rights are upheld.

There was a process in place to ask people about their end of life wishes and in some care records these were documented. However, in other care records, we saw documentation regarding advanced care planning, emergency healthcare wishes and resuscitation preferences were not always completed, accurate and up to date.

Requires Improvement

Is the service responsive?

Our findings

The was an established individual care record for each person in place which contained personalised information about their needs, assessments, routines, preferences and wishes. This information had been gathered through a pre-assessment meeting or a meeting with people and/or their relatives upon admission. We looked at seven individuals care records in depth and reviewed many others. We considered that the staff approach to completing the documentation was not person–centred because there were many inaccuracies and mistakes contained within them. For example, care records contained multiple errors which did not reflect the identity of the person who the record belonged to. One person was referred to with four different names in a variety of their care plans. One female was referred to as "him" throughout two of their assessments. These errors indicated that staff had copied other people's records rather than drafting an individual person-centred record for each person.

The records we examined in depth contained incomplete forms and inaccurate information. For example, a body map was put in place for one person, dated '7/1/17'. This person was not admitted into the home until 6 February 2017. The 'daily personal care' record showed no entries for their glasses being cleaned. There was no 'moving and handling care plan' completed at all despite the person requiring full assistance with all transfers from staff. The 'safe use of bedrails checklist' was not completed despite a best interest decision being recorded for their use. Their 'medicine care plan' was undated. Their 'personal hygiene care plan' was undated. Their 'mobility care plan' was undated. A 'summary of care needs' was not completed and there was no pre-admission assessment despite this person having multiple complex care needs.

Evaluations of care plans and reviews of risk assessments had not been carried out periodically. The provider's policy stated that care plans should be reviewed every four to six weeks. More complex care plans had daily, weekly and monthly review target dates; however we found most records had not been reviewed recently. For example, one person's 'mobility care plan' had not been evaluated since July 2016. Their 'cognitive and behaviour care plan', 'communication care plan', 'emotional need/dignity care plan' and 'falls care plan' had also not been evaluated since July 2016. Their 'sleep care plan' was last evaluated in June 2016. An accident report of a fracture suffered during a fall was not dated and their PEEP had not been evaluated since July 2016. This demonstrated that the registered manager and provider had failed to keep an up to date record of all assessments and care plans for each person who used the service.

As well as care planning, record keeping was poor in other aspects of the service too such as medicine administration and weight records which we have reported on in the 'safe' domain of this report. We also found multiple examples of food and fluid intake charts which were not fully completed or signed as checked by senior staff. A sample of charts reviewed showed that very few had a recorded target for fluid intake. We observed care workers retrospectively completing food and fluid intake charts from memory, several hours after mealtimes. We checked these entries made by care workers against our own noted observations and found some entries to be inaccurate. This meant the registered manager and provider had failed to ensure complete, accurate and up to date records were kept without undue delay in respect of the care and support each person received.

We observed a nurse spent three hours conducting one medicine round which meant she was unable to supervise care staff, monitor care delivery or check care records appropriately. Staff told us they did not have time to read people's records or look at care plans.

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

We found evidence in 'daily notes' records to suggest that staff were responsive in meeting people's needs, for example by involving GP's to manage acute conditions such as pain, constipation, water retention and infections. However the information about their visits or actions to be addressed was not always recorded in the corresponding section of the person's individual care record. This meant communication between staff may be ineffective and the outcome was difficult to monitor.

The two activities coordinators remained in post and we spoke with one of them. They told us they invited people on an individual and small group basis to participate in activities which were set out in a specific area of the home. They said that they were led by what people were drawn to. They confirmed that they still undertook individual sessions with people who either did not like, or were unable to participate in group based activities. These activities depended on people's interests and needs. We saw activities were underway during our inspection and people told us they had enjoyed individual sessions either playing cards, reading newspaper's, watching TV or chatting. We were only able to review a small number of records but saw one to one support was given to people.

The homes' weekly 'Wednesday Walk' was still promoted and staff told us about escorting people out into the local community to access outdoor space. We were told relatives continued to participate if they wished. Some staff assisted on their day off to escort people to church or the shops. Other interesting activities took place such as animal interactions, making bird feeders, painting and live entertainment. A St. Patricks day party was planned. This meant people were supported to engage in activities which were meaningful and stimulating.

The provider's complaints policy remained in place and information about how to raise a concern or complaint was on display around the home. The registered manager maintained a complaints log which showed there had been seven formal complaints recorded since January 2016. Records showed that complaints had been investigated, a formal response provided and, where necessary, an apology was offered. An explanation about any action taken was documented alongside any outcomes. People we spoke with told us they knew how to complain and would initially raise any concerns with senior staff at the home. This demonstrated there was a responsive process in place to address any concerns people raised.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in May 2016, we found one breach of the Health and Social Care Regulations, namely, Regulation 12, entitled Safe Care and Treatment, in respect of the management of medicines. We issued the registered manager and provider with a requirement notice and asked them to send us an action plan to inform us of how they intended to address the shortfalls. They did not complete and return an action plan. At this inspection we found the previous shortfalls in medicines remained and an internal action plan had also not been drafted to ensure a delegated person took responsibility for the improvements required.

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

We reviewed two medicine audits which we were told by senior staff were carried out in January and February 2017, however these were undated. The Head of Compliance and the deputy manager were not able to find audits which had been carried out in November and December 2016 in the absence of the registered manager on the first day of our inspection. The registered manager later confirmed that these two audits could not be located.

We saw that the two internal medicine audits completed in January and February 2017 had been rated as achieving 80% and 87% compliance. Below 85% was deemed as 'unacceptable' on the provider's own scale of compliance. Actions to be addressed had been noted, however, these had not been delegated to a person responsible for completion, nor had a target date for completion been set. The actions identified in the medicine audits included issues which had existed at our previous inspection in May 2016 and those which remained unresolved at this inspection. They included shortfalls in respect of PRN and topical medicine care plans and the refusal of medicines not being recorded on the reverse of MARs.

Through inefficient audit processes, the registered manager and provider had failed to ensure that accurate, complete and comprehensive records about each person were maintained in order to support them to receive safe and appropriate care and treatment. We found records were disorganised, inaccurate, incomplete and not securely stored to support the confidentiality of all people who used the service.

Other audits such as infection control audits and care plan audits had not highlighted or addressed the issues we found at this inspection. The registered manager and provider did not ensure that effective governance and quality assurance systems were in place. Where shortfalls had been identified, they failed to appropriately plan and address these and in doing so they failed to fully protect people's safety, as the governance arrangements related to the management of medicines and risks were not robust.

An out of hours communication file showed that records related to spot checks of the service conducted by the registered manager had ceased in April 2016. She told us that she regularly worked out of hours and conducted spontaneous 'walk-arounds' on all floors to check service delivery; however, there was no formal written evidence of these checks presented to us upon request during the inspection.

The registered manager had not ensured that regular departmental staff meetings took place periodically. For example, there had been no clinical team meetings held between June 2016 and January 2017. This meant that systems were not effectively operated to formally communicate information to staff in aspects of the service such as the health and welfare of people who used the service, best practice guidelines and service improvements. It also meant staff did not have regular formal opportunity to provide feedback from their own observations.

Handover meetings continued to take place when shifts changed each morning and each evening. Daily concerns, issues and actions required were noted. The quality of the information passed between staff at these meetings had not been maintained since our last inspection and this may have affected the continuity of care provided throughout the home. Nurses were regularly not recording who was present at these meetings.

These issues constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Good governance.

At the time of this inspection there was a registered manager in place. Our records showed she had been formally registered with the Commission since January 2016. She was not available of the first day of the inspection but we were assisted by the deputy manager and the Head of Compliance. On the second day of the inspection the registered manager was present and she was supported by the Head of Care. On the third day of the inspection, the training manager and a support manager also attended along with the registered provider. During the inspection and afterwards during feedback, the management team displayed openness and transparency towards the evidence we presented to them and in their responses to our findings. They all promptly confirmed immediate action had been started to address the safety issues and an action plan had been drafted to respond to the shortfalls in service provision and drive through improvements. The provider told us they would continue to support the senior staff at Hadrian House for as long as was required to ensure compliance with the regulations.

We spoke with the majority of staff on duty during the inspection to gather their views as we were made aware of some dissatisfaction amongst the staff. It was apparent during the inspection that a group of staff in one part of the home were unhappy with the management and this was reflected in both what we observed and what we were told. We heard mixed comments about the leadership of the service from the staff. One member of staff said, "I have raised concerns, the manager says she is sorting it but nothing changes and there's no feedback" and "I have told the manager the staffing is atrocious, I've named those [staff] who don't pull their weight and nothing has changed." Another told us, "I haven't taken this to the manager, I don't know if the nurse has but I don't think it would do any good. I think she knows how staff are working."

Positive comments which came from staff in another part of the home included, "I'm really happy, I love it", "There is plenty of support and supervision, it's a good place to work."

The 'Friday Three O'clock Stop' was still promoted in the home. This was to ensure all staff got to feel involved in the care and support of people and to have an understanding of them as individuals. The idea was for all staff at the home to stop what they were doing and sit and have a drink and a chat with people, to help build relationships and a sense of community. We saw this event was advertised throughout the home.

The registered manager had arranged 'resident and relatives' meetings, however these had been poorly attended. We saw instead she had implemented a 'weekly open surgery' for relatives to call in and see her to discuss any issues. Annual surveys were also used to gather feedback from people and relatives.

The service had maintained good partnerships with other organisations. The registered manager continued to work in partnership with a number of other organisations, in addition to the work they had participated in with the local authority, local authority Clinical Commissioning Group (CCG) and the medicines optimisation team. The service had been involved in a project with the medical council to minimise the amount of medicines given to people and provided work place opportunities for students from a local university.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect at all times by all staff. We observed people left in undignified situations. Conversations were not always held in a place where they could not be overheard. Regulation 10 (1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff did not always act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. Staff did not always follow policies and procedures for obtaining people's consent to care and treatment or a relative acting legally on their behalf. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing New staff were not fully prepared for their role through a robust induction programme such as the 'Care Certificate'. Formal competency checks of staff were not carried out for all aspects of their role. Training which the provider deemed mandatory was not up to date. Specific training

to meet the complex needs of some people who used the service was not routinely provided to staff to enable them to have the necessary skills.

Regulation 18 (1)(2)(a)

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in the safest way possible. Risks to people were not always identified and mitigated against. Staff did not have their competence formally assessed or have the specific skills to appropriately care for all people who used the service. Medicines continued to be inappropriately managed. PRN and topical medicine care plans were still not in place. There were additional issues with the receipt, storage, recording and disposal of medicines. Risks associated with infection control were not always identified and addressed. Regulation 12 (1) (2) (a)(b)(c)(g)(h)

The enforcement action we took:

We issued the registered manager and the registered provider with a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not effectively operated to ensure compliance with the regulations. Quality assurance audits were not effective enough to address the shortfalls in the service. Information was not up to date, accurate and regularly reviewed. There was a failure to evaluate and improve the service based on information from quality assurance audits and inspections.

The registered manager and provide failed to ensure risks were properly assessed, monitored and mitigated regarding the health and welfare of all people who used the service.

Secure, accurate, complete and contemporaneous records were not maintained in respect of the care and support each person who used the service received.

The registered manager and provider failed to send to the Commission when requested to do so a report/action plan in relation to improving the services provided to people with a view to ensuring their health and welfare.

Regulation 17 (1)(2)(a)(b)(c)(e)(f)(3)(a)(b)

The enforcement action we took:

We issued the registered manager and provider with a warning notice.