Aston Grange Care Limited

Aston Grange Care Home

Inspection report

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Date of inspection visit:
26 September 2016
27 September 2016
28 September 2016
29 September 2016
03 October 2016

Date of publication:
08 February 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 26, 27, 28, 29 September and 3 October 2016 and was unannounced. The service was last inspected in March 2015. At the last inspection CQC extended special measures. This inspection found there was not enough improvement to take the provider out of special measures. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Aston Grange Care Home provides accommodation for people who require nursing or personal care to a maximum of 45 people. At the time of our inspection 30 people were living at the home. The home is a purpose built care home and arranged across three floors. During the inspection only two floors were in use.

There was a registered manager in post although they were not available during the inspection. 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.

Care plans did not contain details of people's preferences and lacked the detail required to provide good quality care. Risk assessments were not robust and did not contain measures designed to mitigate risks faced by people. Records showed that care plans and advice from professionals were not always followed.

The provider had not implemented sufficient measures to ensure that people's nutrition and hydration needs were met. People told us they did not like the food, which looked unappetising and was undercooked.

The provision of activities had improved, but remained limited and were not dementia friendly. People told us they were bored and observations showed task focussed support and a lack of engagement with people living in the home. Working practices within the home meant that people were not consistently treated with dignity and respect.

The improvements in the management of medicines had not been sustained. Medicines were not managed in a safe way and people were not always getting their medicines as prescribed.

The service had taken appropriate action to address the concerns regarding the building. Improvements had been made to the physical environment. The service was now clean and had appropriate infection control practices in place.

The service had enough staff on duty and staff had been recruited in a safe way which ensured they were suitable to work in a care environment. Staff received the training they needed to perform their roles. Not all staff had received supervision and support to develop in their roles.

The leadership and governance of the service was ineffective. Audits and action plans had not improved the quality of care plans or risk assessments and people continued to receive support that was poor quality.

The provider was not consistently working within the principles of the Mental Capacity Act 2005. Records showed the service did not understand Best Interests principles.

Staff were knowledgeable about safeguarding adults and records showed the service escalated concerns appropriately.

The service had a robust complaints procedure and records showed this had been followed.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service remains 'Inadequate' and the service therefore remains in 'Special measures.'

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risk assessments were not robust and did not contain measures to mitigate the risk of harm.

Medicines were not managed in safe way.

There were enough staff on duty, who had been recruited safely. Working practices meant people did not consistently have their needs met.

The home environment was clean and well kept.

Is the service effective?

Inadequate

The service was not effective.

The systems for ensuring people were supported to eat and drink enough to maintain a balanced diet were not effective. People were at risk of malnutrition.

The provider had not always followed best practice in the application of the Mental Capacity Act 2005.

Staff received the training they needed to perform their role. Not all staff received supervision to support their knowledge and skills.

The provider had introduced systems to ensure that health information required to support people to maintain their health was shared.

Is the service caring?

Requires Improvement

The service was not always caring.

Feedback from people and relatives regarding the attitude of staff was mixed. Some people told us staff did not show a caring attitude.

There had been some improvements that meant people were

treated with more dignity and respect. This was not consistent.

Care plans did not contain information about people's preferences.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were not personalised and did not contain details of people's preferences and wishes.

The provision of activities had improved. However, they were not dementia friendly and provision remained limited.

People and relatives were not given opportunities to provide feedback about the service.

There was a complaints policy and complaints were responded to in line with it.

Is the service well-led?

Inadequate

The service was not well led.

Audits had been completed but they were not robust or effective.

Actions completed to address concerns had been ineffective as improvements had not been made or sustained.

The management team had failed to improve the quality of the service in most key areas.

Aston Grange Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 26, 27, 28, 29 September and 3 October 2016 and was unannounced. The inspection was planned to follow up on the comprehensive inspection completed in March 2016 when the service was rated as inadequate and special measures were extended.

Before the inspection feedback was requested from local authority commissioning teams and the local Healthwatch. We reviewed the information we already held about the service, including statutory notifications we had received and previous inspection reports.

The inspection team consisted of three inspectors and an expert-by-experience with experience of caring for someone living with dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with 11 people who lived in the home, three relatives and three friends of people who lived in the home. We spoke with 12 staff including the operations manager, the quality manager, the deputy manager, the chef, the activities coordinator, the housekeeper, three care assistants and three trainee senior care assistants. We viewed six care files including support plans, risk assessments, reviews, and health and medicines records. We looked at six staff files including recruitment records, training, supervisions and appraisals. We viewed a range of audits, various meeting minutes, incident and accident logs, safeguarding records and policies and procedures for the home and other documents relevant to the management of the service.

Inadequate

Is the service safe?

Our findings

At our last inspection we found breaches of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. This was because the building was in a poor state of repair, unclean, not safe for people living in the home and posed an infection control risk to people living in the home. In addition, medicines and other risk assessments were not robust and did not contain sufficient measures to mitigate risks faced by people.

At the last two inspections, in August 2015 and March 2016 we identified that people's risk assessments were not robust or personalised. At this inspection this remained the case. The provider had introduced new forms for moving and handling and falls prevention risk assessments. These instructed staff to list the methods used and precautions taken including details of hoist and sling type where appropriate. However, one person's plan did not describe how to support them, but listed what they could not do. For example, regarding their sitting balance the plan stated, "Unable to sit due to mobility difficulty." There were no instructions on how to support this person with sitting or how to use aids to support their posture. Regarding bathing and showering, the plan stated, "Staff to wash [person] daily" but did not describe any moving or handling support that the person would require to complete this task.

Another person had returned to the home after a period in hospital in August 2016 during which their needs had changed significantly. Records showed their support plans and risk assessments were not updated until during the inspection after we had requested copies of their records. Their moving and handling risk assessment for bathing and showering stated, "N/A full body wash in bed (2xcarers)." This was not a detailed instruction that staff could follow to support this person safely with their personal care. A third person's plan noted their mobility was unsteady, however the support required for walking was described as, "2 carers to assist [person] to continue to walk without their frame. Cognition too poor to manage frame." There was no description of how carers should assist this person to walk safely. This person's falls risk assessment assessed them as being at medium risk of falls during August and September 2016. However, their moving and handling plan dated 18 September 2016 stated, "[Person] continues to be unsteady and at high risk of falls." This meant staff had inconsistent information and risks regarding moving and handling had not been appropriately assessed or mitigated.

The provider completed assessments of people's risk of developing pressure wounds and when people were identified as being at risk a care plan was completed. However, records showed the agreed support plans were not being followed. For example, one person was identified as being at high risk of developing pressure wounds and had a care plan in place requiring repositioning of the person every three to four hours day and night. Records showed staff were instructed to record all occasions when this person was repositioned, day and night, from 18 August 2016. However, records showed on eight occasions between 14 September and 3 October 2016 no repositioning was recorded for more than four hours, and on some occasions as many as eight hours. It was noted on the 28 September this person had developed a grade 1 pressure wound.

Three people were described in their care plans as displaying behaviour which was both physically and verbally aggressive. The behaviour support plans in place were generic, with non-personalised de-escalation

techniques described. Records showed that incidents where people behaved in an aggressive or violent way were not always captured in behaviour monitoring forms as required by care plans. For example, one person's records of care showed two incidents that had not been captured on behaviour monitoring forms. This person's care plan suggested various de-escalation strategies, including the provision of activities, a drink or speaking to their relative. The behaviour monitoring forms did not show these strategies had been followed.

Another person was described in their care plan as, "Verbally abusive to staff." The plan continued, "[Person] can be anxious if they believe they are not getting enough attention or time from staff." The plans for addressing this were generic de-escalation techniques, the additional information section stated, "[Person] can manage his own nutritional needs and is able to mobilise but they prefer assistance with everything and to remain in bed." This information was not relevant to addressing the behaviours the person could present with.

In addition, other risks were identified but there were no plans in place to mitigate them. For example, one person had a specific health issue which could pose risks to staff and other residents. The person was described as having no insight into their condition but there were no measures in place to minimise the risks associated with their condition. This meant the service was not adequately identifying and mitigating risks faced by people living in the home.

At our previous two inspections medicines risk assessments were identified as being insufficient as they described only the administration process rather than addressing the individual risks people faced regarding their medicines. At this inspection the progress noted with regards to medicines errors and recording practice at the March 2016 inspection had not been sustained. During the inspection we found that people had not been receiving their medicines as prescribed and record keeping was not clear. For example, one person missed a dose of an anti-epilepsy medicine and no action was taken until we identified the error.

Another person had been prescribed pain relief as a variable dose. The instructions were to administer one or two tablets as required and staff were instructed to record on the back of the medicines administration record how many tablets had been given. The records indicated there were only two occasions when this person received one tablet. The records indicated two tablets were administered on all other occasions. However, the actual medicines in the service indicated that on 12 occasions only one tablet had been given. This meant the records did not reflect what had been administered.

A third person had been prescribed a pain relief patch. Records showed that this had not been delivered and the person had not received their pain relieving medicine for three weeks. Although there were records indicating that there had been contact with medical professionals to pursue receipt of this medicine, they had not been effective as they continued without it for three weeks. This person's care plan also indicated they were receiving their medicines covertly. Despite feedback from the March 2016 inspection regarding recording covert administration practice, the plan had not been updated and did not include all the medicines this person was prescribed. This meant the service would not have been able to administer all their medicines if they had been refused as they were not included in the covert medicines plan.

Where people were prescribed medicines on an 'as needed' basis there were guidelines in place within the medicines file. However, every guideline viewed was overdue for review. The home's action plan had stated that each person living in the home should have a medicines risk assessment and care plan which needed to include "detailed information about how to administer their medication safely but also in line with their personal preferences." The provider submitted updated medicines plans after the inspection. These

detailed people's medical conditions, allergies and indicated where their medicines were located, whether they were self-medicating or not and whether they received their medicines covertly. However, these did not contain a list of the person's medicines and what they were for. Side effects or risks that staff should be aware of were only listed for some medicines. People's preferences for how they liked to receive their medicines were not recorded. This meant that the service was not ensuring that people's medicines were administered safely and in line with their preferences as this information was not recorded.

The service completed daily checks of medicines administration records to ensure they were properly completed. These continued to identify gaps in record keeping. Some medicines were supplied in their original packaging rather than in monitored dosage systems. This meant staff were required to keep a running total of medicines in stock on the medicines administration record. However, these were not always completed and this meant the service could not effectively audit what medicines were in stock. The medicines return book, used to record medicines returned to the pharmacy that had not been administered or had been spoiled, had not been completed on the first floor since 17 August 2016. This meant the service could not identify with certainty what medicines were in the building.

The above issues are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At the last inspection we found that clinical waste areas were not secure, were cramped with equipment, with damaged wall surfaces and were unclean. At this inspection the clinical waste areas had been fitted with keypad locks and were secured when checked. The clinical waste areas had been cleaned, refitted and equipment had been replaced meaning they were suitable and safe to use. At the last inspection we found that shared and en-suite bathroom facilities were in a poor condition and were unclean, with ingrained dirt in the floors, fixtures and equipment. At this inspection these issues had been addressed. The bathrooms had been re-fitted with new flooring, and deep cleaned. The equipment that had been in a poor state of repair had been replaced.

The service had appointed a housekeeper from the domestic staff team. The housekeeper demonstrated they understood infection control practice and records showed they, and senior managers, checked that other staff followed good practice in terms of infection control and hygiene. The storage of cleaning materials and equipment was improved and correct practice in terms of storage of equipment not in use was being followed. The service now had a clear programme for cleaning the service including regular deep cleans of bedrooms, bathrooms and communal areas. Records showed these were being completed. The home presented as clean.

At the previous inspections in August 2015 and March 2016 the service was found to be in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were not enough staff to meet people's needs.

At this inspection we found the staffing numbers were sufficient, however the way in which staff worked meant that people did not consistently have their needs met. For example, observations on the ground floor during the morning showed that while one staff member was administering medicines, the other two staff members were tidying up after breakfast. During the 30 minute observation period, when four people were the focus of our observations, there were a total of 11 interactions with staff. These were almost all focussed on the task of administering medicines. Only one of the interactions during this entire period was positive. Rather than spending time with people meeting social or emotional needs, staff completed domestic tasks including cleaning the drinks station. During observations on the first floor it was noted that one care worker was in the lounge with eight people. One of these people indicated they needed support which was

provided to them. However, after this seven people were left in the lounge with no staff available for twenty minutes. On another occasion three staff were completing their record keeping at the same time. This meant that people were not offered support opportunities to engage with activities or social stimulation during these times.

At our last inspection half the staff team had received training in safeguarding adults from harm. At this inspection the number of staff with training in safeguarding adults had dropped to 46%. The provider told us they were in negotiations with a new training provider to deliver training to staff. Staff we spoke with were knowledgeable about the different types of abuse people might be vulnerable to. However, only one staff identified neglect as a type of abuse people may be vulnerable to. This was despite a recent safeguarding investigation in relation to neglect taking place at the home. Staff told us they would report any concerns to a senior member of staff or the manager. Records showed staff were appropriately recording their concerns and the service was escalating concerns appropriately for investigation.

The service had a robust recruitment system. Appropriate checks were carried out before staff started working at the service. References were obtained and criminal records checks were carried out to check that staff were of a suitable character to work in a care setting. Interview records for both external and internal candidates showed that staff attitudes and skills were evaluated to ensure they were suitable to work in the service. At the last inspection we found there was no skills profile for the post of senior carer, however records contained clear role and job descriptions at this inspection.

Inadequate

Is the service effective?

Our findings

At our last two inspections the home was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the arrangements for monitoring and meeting the hydration and nutrition needs of people were not robust.

One person had been identified by a dietician as being severely undernourished in July 2016. The dietician had recommended a plan to support this person to increase their nutritional input. However, when the dietician had visited in September 2016 they noted that the plan had not been implemented and the person remained severely undernourished. The home was instructed by the dietician to monitor this person's dietary intake through the use of food and fluid monitoring charts and weigh them weekly. Records showed the home was not routinely recording this person's dietary intake. Food monitoring charts from the date of the dietician's visit to the end of September 2016 showed two days when no meals were recorded, two days when only one meal was recorded and four days when two meals were recorded. Records did not show what food the person had actually eaten. Records showed the proportion of the plate the person had eaten and all records described this as "soft diet" or "puree." There were no details of this person's dietary preferences in their care plan. This meant the home was not able to ensure they were offered food they were more likely to want to eat. The fluid intake charts were reviewed. These did not contain guidance regarding how much fluid the person should aim to consume and did not contain daily totals so the home could monitor their intake. The records showed that between the date of the dietician's visit and the end of September there had been 12 occasions when the person had consumed less than 500ml of fluid, including two days when less than 200ml had been recorded. Despite the instruction to weigh this person on a weekly basis, no weights were recorded between 1 and 31 August 2016.

Another person's nutrition care plan noted on 27 June 2016 that they should be referred to the GP and dietician and weighed weekly due to concerns about weight loss and nutritional intake. There was no record of a dietician's involvement in this person's file and no weight measurements during July as instructed by the care plan. This person's fluid intake was not being recorded, and their food monitoring charts did not record what they were eating, simply the proportion of "soft diet" consumed.

The home's guidelines on nutrition and hydration risk management stated that if a person scored two or more on their nutritional risk assessment they should be closely monitored and a GP referral made. One person's score had been "two" for two months running but there was no record of a GP referral in their file. The nutritional audit completed in September 2016 noted the person should be referred to health professionals, "If weight drops" and that the person had been seen by the GP in July 2016. This meant the service was not ensuring that people's nutrition and hydration needs were met as records were insufficient and health professionals' advice was not followed.

Although one person told us, "The food is lovely." Other people told us the food was unappetising. One person said, "You can't like the food here." Another person said, "The food here is rubbish. There is no taste to it. I'm always complaining about it to the registered manager. They did try a new menu but I can't see anything's really changed." A third person said, "I don't like the food. They keep telling me to eat but it

doesn't help me eat." A relative said, "I don't think a lot of the food. My relative finds the food bland." During the inspection we overheard one person being asked by a staff member how they found their lunch, they replied, "Horrible, I couldn't eat the meat."

Observations during lunchtime and dinner showed that people were not eating well. The home had held a meeting with people who lived in the home in April 2016 about food. The menu had been updated as a result but the feedback remained that the food was not appetising to people.

The chef had a list of people who required specialist diets due to diabetes. However, when asked about people who required the texture of their meals to be modified the chef stated, "We have one person on a pureed diet." Observations of mealtimes showed at least five people were receiving pureed meals. During the inspection a member of the inspection team tasted the food and found the vegetables to be undercooked, tough, and difficult to both cut and chew. The chef told us, "When it is cooked, we get a vegetable and feel it with our hands to check if it is cooked." This was not an effective way of checking if vegetables were cooked, as undercooked vegetables were being served. One member of staff told us, "The veg is rock hard and undercooked." Another staff member said, "Most times the food is good. Quality is ok." People were asked to choose their lunch during the mornings, and staff were observed checking that people were happy with their choices when they had lunch. Staff offered people choices regarding desserts and drinks throughout mealtimes.

The above is a continued breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection in March 2016 the service was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they were not following best practice regarding application of the Mental Capacity Act 2005.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

During the inspection the quality manager updated their audit on regarding applications and authorisations to deprive people of their liberty. This showed for one person the authorisation had been allowed to expire before a new application had been submitted. For the remaining people appropriate applications had been submitted. The service did not have clear records regarding whether people had legally appointed decision makers.

Following our last inspection, the service had introduced a new format for recording when decisions were made in a person's best interests. Records showed this had been used to record the process by which people had moved bedrooms following the closure of one of the floors for business reasons. One person affected by this decision was assessed as lacking capacity and was living with dementia. The assessment form stated, "The purpose of this assessment is to make a decision about moving rooms / floors so the home can close the second floor." It continued, "We will transfer [person to a different bedroom]. Person was shown the room. Transfer will take place today." This was signed by the registered manager and the

keyworker. The form also recorded, "Telephone conversation with [relative]." There was no record that this person was supported to understand the decision or be involved in making it. In addition, the decision was made for business reasons, and to frame it as being in the person's best interests shows a lack of understanding of Best Interests as a process. There was no transition plan and no records to show how this person was involved in the process other than being shown the room the day they moved. Records of care showed this person had been disorientated by the move and was regularly struggling to find where their bedroom now was. Visual prompts to support this person's orientation were introduced after feedback from the inspector.

Records regarding whether people had consented to their care were unclear and inconsistent. For example, one person was described as lacking capacity and having no insight into their condition but had signed parts of their care plan. There were no best interests decisions recorded in their file. Another person was described as lacking capacity and their relative had signed their care plan. However, the home had no record that this relative had the legal authority to consent on their behalf. This meant the home was still not following best practice guidance about how to act in accordance with the MCA.

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

At our last inspection we found the training completed by new staff was minimal and that staff were not being supported to complete the Care Certificate. The Care Certificate is a recognised training scheme which provides staff with the fundamental knowledge required to work in the care sector. Records showed that staff had now completed online training in areas including health and safety, manual handling, medicines, dementia awareness, infection control, equality and diversity, fire safety, the MCA, first aid, and food hygiene. Records showed that new staff were now completing the care certificate. The service completed monthly reports regarding training levels in the service which ensured that people's training was up to date. At the time of our inspection the service was liaising with training providers regarding the provision of on-going training.

The home was visited once a week by the GP. People told us that if they were unwell the home would arrange for them to see the doctor. One person said, "If I'm not well they get the doctor." The home had introduced professionals feedback forms within care files so that information and guidance received from healthcare professionals could be recorded easily. The home expressed that they faced challenges in getting all health professionals involved in people's care to record their advice. Records showed that health professionals' visits were recorded in end of shift reports and these were reviewed by the manager. Staff recorded that all information contained in these reports was also contained in daily logs and care plans were updated when required.

The home had a policy regarding staff supervision which stated that staff should receive four supervisions a year including an annual appraisal of their performance. Meeting records showed that the registered manager had agreed that all care workers would receive monthly supervisions from them. No care worker or senior care worker had received monthly supervisions. Records showed that while some staff had received regular supervisions in line with the provider's policy, many others had not. No night worker had received supervision since July 2016 and three night workers had no supervisions recorded since before our last inspection. This meant not all staff were receiving the support they need to perform their roles.

We recommend the service seeks and follows best practice guidance on support and supervision for staff.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in March 2016 we found the service was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not always treated with dignity and respect. We found the service was now meeting the regulation.

At this inspection we found that staff spoke to people politely and respectfully. We observed there was sufficient equipment to ensure that people did not have to wait for care to be delivered. Observations showed that staff communicated clearly to people when assisting them with their mobility and while using moving and handling equipment.

Feedback regarding the attitude of staff was mixed. One person said, "They [staff] are all kind and nice here." Another person said, "I feel well looked after." A friend told us, "When we visit our friend he seems happy and tells us he is happy here. The carers seem kind to him." However, a relative said, "I don't think staff have the time to sit and talk much but I've no problem with them." One person said, "Most of the staff are kind on the outside and on the inside too. Some staff have no empathy." Another person said, "I don't think they care a lot, but they do treat me with dignity." A third person said, "My carer talks to me without looking at me."

On the final day of our inspection we completed the Short Observation Framework for Inspections (SOFI). We completed one SOFI on the ground floor, and one on the first floor. On the ground floor we observed a lack of positive interactions and task focussed support. The interactions between staff and people were entirely functional. We noted that three people were not supported to remove clothes protectors after their breakfast had been tidied away. It took the intervention of another person who lived in the home to prompt staff to remove one person's clothes protector. The other two people still had theirs on at the end of the 30 minute observation period despite having finished their food before the observations started.

However, on the first floor care workers were interacting positively with people in a way that encouraged people and their self-esteem. One care worker was playing dominoes with two people who lived in the home and there were many positive interactions, including with a third person who was sitting at the same table but not joining in the game. At the break in each round staff checked whether this person wished to join in. This reflects the feedback from people and relatives, that there was significant variation in the caring attitude of staff working in the home.

At our last two inspections we found care plans contained limited information about people's life histories and preferences. This continued to be the case at this inspection. Although most care plans now contained documents called "Personal preference plans" these were poorly completed and were not included in all the care files viewed. The plans provided a template for staff to record people's routine preferences for mealtimes, personal care, dressing and grooming, and night time and sleep preferences. However, it was not clear what people's preferences actually were from the forms. For example, on one person's plan both the boxes stating, "I would like personal care before breakfast" and, "I would like breakfast before personal care" were ticked. This meant the person's preferences were not clear. Another person's plan recorded that they would like the window both open and closed at night.

Care plans recorded if people followed a religious faith. Where people wished to be supported to follow their faith, visiting representatives of their faith groups attended the service. Visitors to the home told us they felt welcome.

Records showed that people's relatives had been involved in making decisions about people's care. Records did not show that people were involved in making decisions about their care. In two files reviewed people were assessed as having capacity to consent to their care, however, they had not signed their care plans and their views were not clearly recorded. One of these people's files contained records showing their relatives had consented to care on their behalf.

Inadequate

Is the service responsive?

Our findings

At our last inspections in August 2015 and March 2016 we found the service was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care plans did not reflect preferences and care was not designed with a view to achieving their preferences.

Care plans continued to lack the detail required to provide staff with the information they needed to provide personalised care. For example, one person's care plan stated, "Needs assistance of two staff with personal care, dressing, toileting, bathing / showering." There were no further details regarding how staff should provide this support and what this person's preferences were. Another person's care plan relating to personal care was updated during the inspection, the update read, "No longer able [to wash and dress herself independently] 2x carers to attend personal care in bed." There were no recorded preferences and no instructions regarding how staff should attend to this person's personal care. A third person's care plan stated, "We are supporting [person] to maintain what capabilities she has and promote her independence." There were no details regarding how this support was provided.

Two people's sleeping care plans recorded plans that seemed to contradict their expressed wishes. One person's care plan noted they had difficulty in sleeping and prior to coming to the home would often stay up at night and doze in an armchair. Their sleeping care plan stated their ideal sleeping environment was "7pm on the evening." The second person's care plan recorded clearly that the person liked to lock their bedroom door and did not like to be disturbed at night. However, it was also recorded that staff should perform hourly checks on them. For example, the June 2016 review stated, "Although [Person] doesn't want to be disturbed still staff has to check and monitor him for his best interests." Further reviews noted this person slept well and there were no recorded night time risks that would warrant him being checked against his expressed wishes.

Care plans were not designed to meet people's needs. For example, one person's wellbeing assessment identified significant cause for concern regarding their mental health. Documents noted that this person had expressed a wish to harm themselves in the past, although there was no date recorded for this. The person's wellbeing plan stated, "Cannot play dominoes anymore due to [on-going health condition]. Music / radio and TV programmes. Is happiest when receiving visits from friends. Carers to support [person] with conversation whilst attending for personal care and nutrition. Spend time when passing their room to engage. Encourage contact with friends. Talk about what's on their mind. Listen." Given the level of concern about this person's mental wellbeing these measures were not sufficient. The home had not identified this person's level of disengagement may be an indicator of mental ill-health, it was viewed and recorded in the care plan as an active choice. The service had put in place a care plan for depression which stated, "Staff need to chat to him and try and make him feel better." There was no record of a referral to the GP or community mental health professionals.

Records showed that staff checked and signed care plans on a regular basis. However, they did not amend and update care plans in response to changes in need. One person had had a significant change in need following a hospital admission. Their care plan documentation was not updated until during the inspection

which was six weeks after their return to the home. Their wellbeing assessment and plan had not been updated despite clear changes in the person's engagement and wellbeing. Another person's care plan contained a handwritten, undated note stating their nearest relative had moved abroad and the home was still awaiting contact details for them. However, their plan for times of distress had not been updated and still instructed staff to support the person to phone their relative.

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

At our last inspection in March 2016 we found that provision of activities was extremely limited. This had improved at this inspection. The activities coordinator had attended training and developed a programme of group activities in the home. Records showed the activities coordinator facilitated ball and balloon sessions, chocolate tasting, coffee mornings, film screenings and skittles. They also facilitated visiting activities such as an ice-cream vendor and petting animals. The activities coordinator also spent time with people on a one-to-one basis if they were unable to leave their rooms.

However, records showed that the provision of activities and engagement was the sole responsibility of the activities coordinator and other staff in the home did not engage people in activities when the activities coordinator was not working. Although we observed some activities being facilitated by staff on the first floor on the last day of our inspection, this was not the usual practice within the home. One staff member commented to us that they had enjoyed doing this as it was not something they usually did.

People told us they found the activities provided were limited. One person said, "The activities are pretty mild. I take part if I can for the sake of the people who organise it." Another person said, "I'm getting bored here. There's not enough to do." A third person said, "I go to bed in the afternoons because there is not always enough to do."

Activities sessions were not always dementia friendly. For example, during one session with the ball it was noted that people who did not wish to join in were not supported to leave the area, this meant they remained in their chair sat between two people who were actively throwing and kicking a large inflatable ball around the room. It was also noted that both music was playing and the television, which was muted, were on during the activity. This meant the environment was chaotic and noisy. It was noted on multiple occasions that televisions were on while music was playing in the lounges of the home. On one occasion staff muted the television and put on music without checking if anyone was watching the television or asking what music people would like to listen to.

The service had a robust complaints policy which included the details of the expected timescale for response and how to escalate concerns. People and relatives told us they knew how to raise any concerns they had. Records showed the home had recorded no complaints between our inspection in March 2016 and July 2016. However, in July the records showed people and relatives said they had made complaints previously that had not been responded to. The Quality Manager had taken the lead in responding to complaints made since July and records showed robust and timely investigations and responses to complainants. Records showed that people were satisfied with the complaints process.

Three people told us they didn't think the service held meetings for people living in the home. Records showed one meeting took place in April 2016 which focussed on the food. There had been no meeting for relatives since January 2016. This meant the service did not provide opportunities for people and their relatives to provide feedback and be involved in making decisions about the home. It also meant people and relatives had not been given the opportunity to discuss our inspection report findings and our concerns.

Inadequate

Is the service well-led?

Our findings

At our last two inspections in August 2015 and March 2016 we found the service was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the systems to monitor, evaluate and improve the quality of care were not sufficient.

Following our last inspection the service had developed a home action plan to address the issues identified. However, the measures in place had been ineffective in improving the quality of the service. The service had introduce a system where the registered manager performed daily management checks which included reviewing end of shift summaries, checking the building and following up on any issues raised. These were not effective as issues raised had not been resolved, for example, one person was without a prescribed medicine for three weeks. Although the service had identified the person was without their medicines, actions had not ensured they received them.

The service had completed an audit of all care plans in July 2016. However, this had only considered whether or not care plans had been written and did not evaluate their contents. The registered manager completed a monthly audit and analysis of incidents and accidents. However, this did not consider incidents of behaviour that challenged the service or medicines errors as incidents. It only considered falls. This meant that it was an ineffective audit of incidents as not all incidents were considered. In addition, the level of analysis was poor. For example, one analysis section stated, "Having a look at the falls matrix it is clear that 2 falls took place at night. [Registered manager] to inform night staff to check on residents who are prone or have a history of falls hourly."

The service was regularly checking the medicines administration records for errors. However, both recording and administration errors continued to occur. The actions recorded on these audits were for staff to attend training, to return to the service to sign for medicines and for the manager to speak to them. These measures had not been effective in improving the record keeping around medicines.

The incident forms that had been completed contained a section for the registered manager to sign off the form and indicate any further actions required. 18 incident forms were reviewed. Seven forms had been signed by the manager with no comment. Where comments had been recorded on four forms the manager's comments related to the completion of paperwork. None of the comments recommended that a person's risk assessments or care plans should be updated. As there was no analysis of incidents of behaviour which challenged the service, or of violence or aggression from people living in the home, the provider had not addressed the issue raised at the last inspection whereby there was no analysis of the potential causes or triggers to behaviour.

The home action plan had marked as complete actions relating to the provision of personalised and detailed risk assessments and care plans for people living in the home. As detailed above, these had not been provided and demonstrated that the provider had not understood what quality looked like. When the quality of care plans was discussed with the provider they advised they would request two senior staff update all care plans to the required standard within two weeks of the last day of the inspection. They

explained their approach had been to get staff to understand the purpose of care plans and complete the work themselves. This demonstrated that despite serious concerns we had previously raised regarding care planning and risk assessments the provider had failed to respond with appropriate urgency. The provider informed us the delay in updating care plans was due to prioritising the building work that had also been required.

Records showed the quality manager and deputy manager had completed a range of audits, including health and safety audits, infection control audits, and a housekeeping audit. The operations manager told us they had also completed quality assurance visits. However, records of these were not available during the inspection. The operations manager said they held these records separately from the service.

At our last inspection we noted that the registered manager had not received the support and supervision required to perform their role. The registered manager was not available during this inspection. Records showed that despite the serious issues at the service only two supervisions were recorded for the registered manager, the most recent one having taken place in June 2016. The provider told us the registered manager had received more supervision and support than this, but the records were not available during the inspection. The provider was asked to submit these records to CQC within 5 working days but they were not received.

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

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not personalised and were not designed or implemented in a way that met people's needs or preferences.

The enforcement action we took:

We have issued a notice of decision to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Records regarding capacity and consent were unclear and inconsistent. The service was not working within the principles of the Mental Capacity Act 2005.

The enforcement action we took:

We have issued a notice of decision to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not robust. Risks had not been identified and measures in place to mitigate risk were insufficient.

The enforcement action we took:

We have issued a notice of decision to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The service was not ensuring that people's nutrition and hydration needs were met.

The enforcement action we took:

We have issued a notice of decision to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

We have issued a notice of decision to cancel the provider's registration.