Larchwood Care Homes (South) Limited

Rose Martha Court

Inspection report

64 Leigh Road
Leigh on Sea
Essex
SS9 1LS

Tel: 01702482252

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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

Rose Martha Court provides accommodation and personal care for up to 76 older people. Some people also have dementia related needs.

The inspection was completed on 30 June 2016, 1 July 2016 and 4 July 2016 and was unannounced. There were 62 people living at the service when we inspected.

A registered manager was in post. 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.

There was a lack of provider and managerial oversight of the service. Quality assurance checks and audits carried out by the registered manager were not robust, did not identify the issues we identified during our inspection and had not identified where people were put at risk of harm or where their health and wellbeing was compromised.

Suitable control measures were not put in place to mitigate risks or potential risk of harm for people using the service as steps to ensure people and others health and safety were not always considered. Risk assessments had not been developed for all areas of identified risk, pressure mattresses were not correctly set in relation to people's weight and bedrail assessments had not always been completed to determine that these were suitable for the individual person so that any risks identified were balanced against the anticipated benefits.

Although people did not think that there were sufficient numbers of staff available to meet their needs or their relative's needs, our observations showed that staffing levels were suitable at the time of this inspection. However, staff did not always have time to spend with the people they supported to meet their needs and the majority of interactions by staff were routine and task orientated. People's comments about the care and support they received were variable. Whilst some staff's interactions with people were positive and staff had a good rapport with the people they supported, this was in contrast to other observations. These showed that some staffs practice when supporting people living with dementia required further improvement and development.

The implementation of staff training was not as effective as it should be so as to ensure that staff knew how to apply their training and provide safe and effective care to the people they supported. Although staff had received appropriate training relating to manual handling and dementia awareness, staff did not recognise the importance of safe manual handling procedures and the significance of good person centred care for people living with dementia.

The dining experience was not always positive and person focussed. Consideration by staff was not always

well-thought-out to ensure that eating and drinking was an important part of people's daily life or treated as a social occasion. Where instructions recorded that people should be weighed at regular intervals, this had not always been followed. Records of the meals provided and fluids taken had not always been maintained in sufficient detail to establish if people's dietary needs were being monitored, managed or encouraged where this was required.

Not all of a person's care and support needs has been identified and documented. Improvements were required to ensure that the care plans for people who could be anxious or distressed, considered the reasons for people becoming anxious and the steps staff should take to comfort and reassure them. The needs of people approaching the end of their life and associated records relating to their end of life care needs were either not recorded or contained minimal information. Improvements were needed in the way the service and staff supported people to lead meaningful lives and to participate in social activities of their choice and ability, particularly for people living with dementia.

The arrangements for the effective management of medicines required improvement. Although these were generally in good order as they provided an account of medicines used and demonstrated that people were given their medicines as prescribed. Although there was a complaints system in place, not all complaints evidenced fully how conclusions had been reached and actions followed up.

Suitable arrangements were in place to ensure that the right staff were employed at the service. Although staff received regular supervision, not all staff felt supported by the registered manager or other members of the management team. Improvements were required to ensure that where subjects and topics were raised by staff, this was followed up and there was a clear audit trail to demonstrate actions taken.

Assessments had been carried out where people living at the service were not able to make decisions for themselves and to help ensure their rights were protected however these required improvement as some of the information was contradictory. People's preferences and choices for their end of life care were not robust or as detailed as they should be.

Staff were able to demonstrate an understanding and awareness of the different types of abuse and how to respond appropriately where abuse was suspected.

Where appropriate people were enabled and supported to be independent. People were also treated with dignity and respect.

You can see what actions 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?

Inadequate

The service was not safe.

Risks were not appropriately managed or mitigated so as to ensure people's safety and wellbeing.

Arrangements were not always in place to ensure that there were sufficient numbers of staff available to support people safely.

Improvements were required to ensure that the management of medicines was appropriate.

Effective recruitment procedures were in place to safeguard people using the service.

Staff had a good understanding of safeguarding procedures to enable them to keep people safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff training was not as effective as it should be so as to ensure that staff knew how to apply their training and provide safe and effective care to the people they supported.

The dining experience was variable across the service. Where instructions recorded that people should be weighed at regular intervals, this had not always been followed and records of the meals provided and fluids taken had not always been maintained in sufficient detail.

People were supported to access appropriate services for their on-going healthcare needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Although some people stated that staff treated them with care and kindness, care provided was often task focused and people said that staff did not sit and talk with them for any meaningful

period of time. Staff communication with some people was poor. People did not always feel listened to or that their views were acted upon.

Where appropriate people were enabled and supported to be as independent as they wanted to be. People were treated with privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care plans were not sufficiently detailed or accurate to include all of a person's care needs and the care and support to be delivered by staff.

Not all people who used the service were engaged in meaningful activities or supported to pursue pastimes that interested them.

Improvements were required to ensure that complaints management was thorough.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Although systems were in place to regularly assess and monitor the quality of the service provided, further improvements were required as they had not highlighted the areas of concern we had identified.

Systems were in place to seek the views of people who used the service and those acting on their behalf.

Rose Martha Court

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 30 June 2016, 1 July 2016 and 4 July 2016 and was unannounced. The inspection team consisted of two inspectors on two days, one inspector on one day and an expert by experience on one day. An expert by experience is a person who has personal experience of caring for older people and people living with dementia.

We reviewed the information we held about the service including safeguarding alerts and other notifications. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law.

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 20 people who used the service, nine members of care staff, seven relatives, the registered manager, the deputy manager and two people responsible for providing activities to people living at the service.

We reviewed 12 people's care plans and care records. We looked at the service's staff support records for six members of staff. We also looked at the service's arrangements for the management of medicines, complaints and compliments information and quality monitoring and audit information.

Inadequate

Is the service safe?

Our findings

Although intuitively staff knew the people they supported and some risks were identified and recorded relating to people's health and wellbeing, for example, the risk of poor nutrition, poor mobility and the risk of developing pressure ulcers, this was inconsistently applied. Additionally where risks were identified, suitable control measures were not put in place to mitigate the risk or potential risk of harm for people using the service.

Staff told us and records confirmed for one person that they had a catheter fitted. No risk assessment was completed detailing suitable control measures put in place to mitigate the risk or potential risk of harm for the person. For example, the potential risk of harm to the person, such as, the development of urinary tract infections, bladder spasms and leakage around the catheter site which could be a sign that the catheter was blocked. Another person was noted to have a stoma. This is an opening on the front of the person's stomach which diverts waste products into a pouch on the outside of their body. Although daily care records completed by staff showed, and staff confirmed that stoma care was provided, such as, changing the stoma bag, a risk assessment was not evident. A risk assessment had not been considered to evidence suitable control measures put in place to mitigate the risk or potential risk of harm for the person using the service, for example, stoma blockage or leakage, irritation or soreness around the stoma site and other complications. There was no evidence to indicate how frequently the stoma pouch required changing. We discussed the latter with the deputy manager and they confirmed that the stoma pouch should be changed twice daily, however evidence available showed this was not happening.

Some people were assessed as at high risk of developing pressure ulcers. We checked the setting of pressure relieving mattresses that were in place to help prevent pressure ulcers developing or deteriorating further. We found that three out of six pressure mattresses were not correctly set in relation to the person's weight. Additionally, we found that although another two people's pressure mattresses were switched on and set, the person refused to be weighed; therefore we could not be assured that the current setting was appropriate and properly set in relation to either person's weight. Records showed and the registered manager confirmed that each of the above people were assessed as 'high' or 'very high' risk of developing pressure ulcers and three people had a pressure ulcer. This meant that we could not be assured that the amount of support the person received through their pressure relieving mattress was correct and would aid the prevention of pressure ulcers developing or deteriorating further. The registered manager confirmed on the second day of inspection that they had contacted a healthcare professional and advice had been sought so as to enable them to weigh the person without the procedure being invasive.

Our observations showed that several people throughout the service had bedrails fitted to prevent them from falling out of bed and injuring themselves. Where these were in place a risk assessment had not always been completed to determine that these were suitable for the individual person so that any risks identified were balanced against the anticipated benefits. Additionally, the bedrail assessment for one person identified that the person was at high risk of climbing over the bedrails and at high risk of entrapment. There was no information recorded to suggest that other measures had been considered, for example, netting or mesh bed sides, 'ultra-low height' beds, positional wedges, alarm systems or fall mats to reduce the risk of

injury. Where one person had bedrails fitted we found that no formal bedrails assessment had been completed to evidence that this item of equipment was suitable.

Although staff had received manual handling training, on the first day of our inspection we observed poor staff practice on the first floor in relation to moving and handling on four separate occasions between 09.40 and 11.35 a.m. For example, we observed on one occasion two members of staff assisting a person to move in a way that was unsafe and put them at risk of harm. Staff were observed to transfer the person from their wheelchair to a comfortable chair in the communal lounge by placing their arms under the person's armpits, pulling the person up and twisting their body as they were placed onto a comfortable chair. The person was seen to look uncomfortable whilst the manual handling procedure was being carried out. On another occasion staff attempted to hoist one person from a horizontal flat position whilst in their comfortable chair. The person looked very uncomfortable and frowned on several occasions whilst staff tried to perform the manual handling technique. We intervened with the senior member of staff and the latter instructed staff to use a slide sheet to transfer the person to a better position prior to being re-hoisted.

As a result of our concerns we discussed the above with the registered manager and they initiated a safeguarding alert to the Local Authority. Additionally, staff involved with the poor manual handling techniques attended a formal supervision with the deputy manager shortly after our observations. The registered manager confirmed on the second day of inspection that refresher training was booked for staff.

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

People's comments about staffing levels were variable. Some people felt on occasions that there were insufficient staff available. One person told us, "There's not enough staff. If I call them, they [staff] sometimes come and then say 'I'll be back' but then they forget because they're so busy." One relative told us, "They need more staff. I think they [staff] rush people." Another relative told us, "I think they [staff] sometimes take short cuts because of time. A third relative told us, "At weekends there doesn't seem to be enough staff. Even if I call in the mornings they [staff] don't answer the phone. You see no-one." Two people told us if they used their call alarm facility staff attended to them promptly. Staff's comments about staffing levels were variable. Some staff felt that staffing levels were appropriate whilst others advised that staffing levels were not always maintained especially at weekends. Four members of staff advised that in recent weeks there had been a weekend where the shift had been short by two or three members of staff. Although the deployment of staff on both days of inspection was observed to be appropriate, the staff rosters for the period 23 May 2016 to 3 June 2016 inclusive showed that staffing levels as told to us by the registered manager had not always been maintained and this included weekends.

Medicines were stored safely for the protection of people who used the service. We found that the arrangements for the management of medicines were generally safe. The service used an electronic management system to ensure staff that administer medication, can easily document medication administration, along with other observations that are logged so to maintain a clear and accurate audit trail. There were arrangements in place to record when medicines were received into the service and given to people. We looked at the records for 10 of the 62 people who used the service. In general these were in good order, provided an account of medicines used and demonstrated that people were given their medicines as prescribed, with the exception of some emollient and topical creams. In relation to the latter it was difficult to determine if staff had failed to apply the topical cream or solely failed to record the administration as these were incomplete. For example, the medication administration record for one person detailed that their topical cream used to prevent irritation to a person's skin should be applied once daily. However it was not possible to determine if this had always been applied by staff as the records were blank for a total of 16

out of a possible 30 entries. We discussed this with the deputy manager and they confirmed that suitable arrangements would be put in place to monitor this more closely.

Observation of the medication rounds throughout the inspection showed these were completed with due regard to people's dignity and personal choice. Staff involved in the administration of medication had received appropriate training. Regular audits had been completed and where these highlighted areas for corrective action, a record was maintained of the actions taken.

Most people told us that they felt safe living at the service. People were protected from the risk of abuse. Staff had received appropriate safeguarding training. Staff were able to demonstrate a good understanding and awareness of the different types of abuse, how to respond appropriately where abuse was suspected and how to escalate any concerns about a person's safety to a senior member of staff or a member of the management team. Staff were confident that the registered manager and deputy manager would act appropriately on people's behalf. Staff also confirmed they would report any concerns to external agencies such as the Local Authority or the Care Quality Commission if they felt that the management team or registered provider were not responsive.

Suitable arrangements were in place to ensure that the right staff were employed at the service. Staff recruitment records for three staff appointed within the last six months showed that the provider had operated a thorough recruitment procedure in line with their policy and procedure. This showed that staff employed had had the appropriate checks to ensure that they were suitable to work with people.

Requires Improvement

Is the service effective?

Our findings

Improvements were needed to ensure where staff had received training, their ongoing competency to implement their training and provide effective care was being monitored to ensure good care delivery. Our observations showed that people's needs were not consistently met by a staff team who had the right competencies, knowledge and skills to meet people's diverse care and support needs. This was demonstrated in staff's care practices and attitude towards the support individual people received. For example, although staff had received appropriate training relating to manual handling and dementia awareness, staff did not recognise the importance of safe manual handling procedures and the significance of good person centred care for people living with dementia. Additionally, staff failed to identify where one person's wound covering on their foot was exposed. The person's wound dressing had fallen off and staff did not demonstrate or acknowledge an understanding of the support to be provided to address this.

Comments about the quality of the meals were variable and although staff had an understanding of each person's nutritional needs and how these were to be met, some staff's practice required improvement so as to ensure that people's nutritional needs were appropriate to meet their needs.
One person told us, "The meals are not bad. Not like good old fashioned home cooking but never mind." Another person told us, "The vegetables are always boiled too much – they're all so soft. The cabbage is like damp lettuce and the fruit is all tinned. Why can't we have fresh fruit desserts?" A member of staff told us that people would not feel able to ask for drinks other than at set refreshment times in the morning, afternoon and evening, and that food was not available other than at mealtimes. They told us, "If someone wants something different, or fancies some toast at night, it's just not available." We spoke to people using the service and those acting on their behalf and they confirmed what staff had told us.

Our observations showed that the dining experience was variable across the service. Assistance provided by staff within one dining room on the ground floor was seen to be appropriate. However, this was in contrast to what we observed within the smaller of the two dining rooms on the ground floor and one dining room on the first floor. Consideration by staff was not always well-thought-out to ensure that eating and drinking was an important part of people's daily life, was a positive experience for people or treated as a social occasion.

People were not always given a choice of drinks and some staff failed to provide sufficient information, explanation or reminder to people about the actual meals provided, for example, people were not told or reminded what food items were on their plate so as to give people living with dementia an indication what they were about to eat. One person had their meal given to them, but when it was placed in front of them, the person immediately stated, "I only want a fraction of that, I don't like a big plate of food." Although the member of staff acknowledged the comments made, they walked away, without making any attempt to help the person in line with their expressed wishes. The person looked unhappy and sat, with their arms folded, staring at a large plate of food. Eventually the person picked at their food and ate a small amount. They appeared sad and told us that they did not feel listened to. Additionally, not all staff tried to include people in conversation whilst supporting them to eat, for example, providing words of encouragement to eat better or to check out if the person was enjoying their meal. One person was given a plated meal. The person had their eyes closed and their meal remained untouched for 15 minutes before a member of staff

intervened and physically assisted the person to eat.

The nutritional needs of people were identified and where people who used the service were considered to be at nutritional risk, we found that referrals to a healthcare professional such as GP, Speech and Language Therapist and/or dietician had been made. Where instructions recorded that people should be weighed at regular intervals, such as, weekly or monthly, this had not always been followed. For example, where one person had sustained a weight loss of four kilograms, the instruction recorded within their care file stated they should be weighed each week. No records were available to suggest that this was being carried out and when discussed with the deputy manager they confirmed that the instructions as noted within the person's care plan were not and had not been carried out.

We also found that a record of the meals provided and fluids taken had not always been maintained in sufficient detail to establish if people's dietary needs were being monitored, managed or encouraged where this was required. Where people refused a meal, there was limited evidence to show that alternatives to the menu were routinely offered and/or provided by staff and fluid charts were not routinely tallied to give a daily total of fluids consumed. Records relating to the latter were observed on the first day of inspection to be completed retrospectively. This meant that we could not be assured if the information recorded was accurate and people had received sufficient nutrition and hydration.

This is a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. 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.

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.

Staff told us that they had received Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Staff were able to demonstrate a basic understanding of MCA and DoLS, how people's ability to make informed decisions can change and fluctuate from time to time and when these should be applied. Not all records showed that each person who used the service had had their capacity to make decisions formally assessed. In some cases information recorded was noted to be conflicting and contradictory. For example, three people's care plans made reference to them not having capacity to make day-to-day decisions and yet in another part of their care plan this stated that the person could make some basic decisions and choices. This meant that the person had variable capacity to make day-to-day decisions. Appropriate Deprivation of Liberty applications had been made to the Local Authority for their consideration and authorisation and where approved the Care Quality Commission had been notified.

The registered manager confirmed that all newly employed staff received a comprehensive induction. This related to both an 'in-house' orientation induction and completion of Skills for Care 'Care Certificate' or an equivalent. Staff told us that in addition to the above they were given the opportunity to 'shadow' and work

alongside more experienced members of staff for a minimum of three days. The registered manager confirmed that this could be flexible according to previous experience and level of competence. One newly employed member of staff confirmed they had received an induction and that this had been invaluable.

Staff confirmed and records showed that they received regular supervision. Not all staff felt supported by the registered manager or other members of the management team. However, improvements were required to ensure that where subjects and topics were raised by staff, this was followed up and there was a clear audit trail to demonstrate actions taken. Supervisions had not picked up or identified those members of staff whose competencies relating to manual handling practices and dementia care were poor and required further improvement. Staff told us and records confirmed that staff employed longer than 12 months had received an appraisal of their overall performance for the preceding 12 months.

People told us that their healthcare needs were well managed. One person told us that the staff took appropriate action if they were feeling unwell. They told us, "Last week they [staff] rang the doctor because they said I looked unwell. He [doctor] came and gave me some 'happy pills,' I call them. I do feel better now." Another person told us, "They'd [staff] notice if I wasn't well, and they'd call the doctor if I needed him." People's care records showed that their healthcare needs were recorded and this included evidence of staff interventions and the outcomes of healthcare appointments. Each person was noted to have access to local healthcare services and healthcare professionals so as to maintain their health and wellbeing, for example, to attend hospital and GP appointments, District Nurse and Community Dementia Nurse Specialist.

Requires Improvement

Is the service caring?

Our findings

People's comments about the care and support they received were variable. One person told us, "Everybody here is very nice; I think most of them [staff] are absolutely amazing." Another person told us, "Most of them [staff] are alright, but some of them I think are a bit cheeky to me sometimes." When questioned further about what they meant by 'cheeky' they told us that in their opinion some staff spoke down to them, and did not always listen to them. One relative explained to us that their member of family had a progressive neurological condition which could have an impact on their day-to-day abilities to undertake activities of daily living. They told us that their member of family had complained to them that staff rushed them when assisting them to bed and were gone before they could ask for additional help and support.

People's preferences and choices for their end of life care were not robust or as detailed as they should be. We found that the needs of people approaching the end of their life and associated records relating to their end of life care needs were either not recorded or contained minimal information. For example, the care plans provided little or no information detailing people's pain management arrangements and the care to be provided so as to provide comfort and dignity for the person nearing the end of their life. No information was recorded to identify who may have a few months, weeks or days to live; in order to aid care planning arrangements and discussions with the person and those acting on their behalf. In addition, no Preferred Priorities for Care [PPC] documents were in use. This is designed to help people prepare for the future and gives them an opportunity to think about, talk about and write down their preferences and priorities for care at the end of their life. The registered manager confirmed that these were to be introduced in the future. This meant that people's 'end of life' wishes were not recorded, in line with new guidelines issued by the National Institute for Health and Care Excellence [NICE]. The latter places emphasis for a more individualised approach to 'end of life' care.

Although the above was noted, the registered manager confirmed that the involvement of appropriate healthcare professionals, such as, District Nurse services and the local Palliative Care Team were available as and when required and following discussions with people's GP.

Though the above was highlighted, people were encouraged to make day-to-day choices and their independence was promoted and encouraged where appropriate and according to their abilities. For example, several people at lunchtime were supported to maintain their independence to eat their meal and some people confirmed that they were able to manage some aspects of their personal care with limited staff support. Two people told us that they regularly accessed the local shops to purchase personal items. One person told us that they valued this level of independence and stated, "I'm never out for very long. I'm quite independent and I don't need them [staff] to do things for me really." We saw that staff knocked on people's doors before entering and staff were observed to use the term of address favoured by the individual. In addition, we saw that people were supported to maintain their personal appearance so as to ensure their self-esteem and sense of self-worth. People were supported to wear clothes they liked, that suited their individual needs and were colour co-ordinated.

People were supported to maintain relationships with others. People's relatives and those acting on their

behalf visited at any time. Staff told us that people's friends and family were welcome at all times. Relatives confirmed that there were no restrictions when they visited and that they were always made to feel welcome. All visitors told us that they always felt welcomed when they visited the service and could stay as long as they wanted.

Requires Improvement

Is the service responsive?

Our findings

Appropriate arrangements were in place to assess the needs of people prior to admission. This ensured that the service were able to meet the person's needs. Evidence showed that where able, people and those acting on their behalf had been involved in the development and review of their care plan.

Although some people's care plans provided sufficient detail to give staff the information they needed to provide personalised care and support that was consistent and responsive to their individual needs, others were not as fully reflective or accurate of people's care needs as they should be. This meant that there was a risk that relevant information was not captured for use by other care staff and professionals or provided sufficient evidence to show that appropriate care was being provided and delivered. For example, where people were assessed as living with dementia, information relating to how this affected all activities of their daily living were not clearly recorded. Where assessments used numerical data to provide a risk score, these were not always accurate. For example, one person's falls risk assessment incorrectly recorded them as being at low risk of falls. This was not accurate and should have recorded that the person was at medium risk. Care records did not always include specific detail about people's strengths, abilities and aspirations. Staff confirmed that not all care records provided enough information for them in relation to people's background and life history.

Staff told us that there were some people who could become anxious or distressed. Improvements were required to ensure that the care plans for these people considered the reasons for becoming anxious and the steps staff should take to reassure them. Guidance and directions on the best ways to support the person required reviewing so that staff had all of the information required to support the person appropriately and to reduce their anxiety. The daily records for one person consistently showed that they could be anxious particularly when their personal routine and craving to have a cigarette took hold. Although the person's care plan made reference to their anxiety being triggered by the person running out of cigarettes, no plan was recorded detailing how this was to be managed over a 24 hour period so as to relieve the person's anxiety and distress.

People told us they had the choice as to whether or not they joined in with social activities at the service. Some people confirmed that they preferred to spend time in their room rather than join in with social activities. However, others told us that they were lonely and bored. One person told us, "They [staff] look after your physical needs here, but not always your mental and emotional needs." They explained that they spent most of their time in their room, as they struggled to sit in the communal lounge areas with people living with dementia. They further stated, "I feel lonely . . . I speak and sing to myself. I hardly speak to anyone some days, other than saying 'thank you' for my meals, or 'Yes or No' in reply to a question. I have the television on most of the time – I don't watch it, it's just for some company. I would just like someone to come in, and sit with me for a while to have a chat."

Although the service employed two members of staff to provide social activities to people living at the service, our observations throughout the inspection showed that there were few opportunities provided for people to join in, particularly for people living with more advanced stages of dementia and who required

more support to benefit from occupation and stimulation. For example, there were no signs to show that people, where appropriate, were supported and enabled to participate in activities of daily living, such as, setting tables, helping with laundry or dusting. Additionally, there was an over reliance on the use of the television or radio in communal areas and we observed long periods of inactivity where people were either asleep or disengaged with their surroundings and the people they lived with. Staff confirmed that there was a budget of £150 per month for social activities. However, this did not allow them to provide all the activities that they would wish to organise. Additionally the service had a mini-bus, people using the service and staff confirmed that it was not used very often as there were few drivers available to drive it. This meant that there were few opportunities throughout the year for people using the service to access the local community or farther afield.

The majority of people living on the first floor were very reliant on the care and support provided by staff as a result of them living with varying levels of dementia. Whilst we observed that some staff interactions with people were positive and staff had a good rapport with the people they supported, this was in contrast to other observations. These showed that some staff's practice when supporting people living with dementia required improvement and development. For example, some staff were observed to avoid spending time with the person with dementia, particularly where people were not able to verbally communicate. Staff were seen to primarily focus solely on tasks and actions. This showed that the culture within the service was task orientated. Staff did not always pick up on people's non-verbal communication, such as, gestures or facial expressions, where people spoke quietly or where people were unable to find the right words to communicate their needs. It was not possible to determine if this was due to staff feeling unconfident because of a lack of understanding about dementia. Several people also told us that they sometimes struggled to understand staff due to their accents. One person told us, "Language can be a real difficulty. I struggle with their accent and they speak quickly."

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

Staff were made aware of changes in people's needs through handover meetings, discussions with senior members of staff and the management team. Staff told us that handover meetings were undertaken between each shift and were important in making sure that they had up-to-date information each day about people who used the service. This meant that staff had day-to-day information required so as to ensure that people who used the service would receive the care and support needed.

Information on how to make a complaint was available for people to access. People spoken with knew how to make a complaint and who to complain to. People and their relatives told us that if they had any worries or concerns they would discuss these with the management team and staff on duty. Staff told us that they were aware of the complaints procedure and knew how to respond to people's concerns.

Complaint records showed there had been nine complaints in the preceding 12 months. Although a record had been maintained of each complaint and there was documented evidence to show that each one had been responded to by the registered manager or the provider, further improvements were required. Not all complaints evidenced fully how conclusions had been reached and actions followed up. For example, the action from one complaint detailed that 'Customer Care' training was to be provided for one member of staff. The training matrix showed that this training had not been provided and this was confirmed by the member of staff. Another complaint highlighted that a window latch was broken in one person's bedroom. The complainant recorded that the impact of this was that there was a draft entering the person's bedroom as a result of the window not closing properly. Although there was an audit trail showing that quotes had been sourced by the provider in April 2016 to get the window fixed, at the time of the inspection, this

remained outstanding some four months after the initial complaint had been raised. A further 38 windows were highlighted in March 2016 as not closing properly and at the time of the inspection, these had not been fixed.

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

Requires Improvement

Is the service well-led?

Our findings

The provider was able to demonstrate to us the arrangements in place to regularly assess and monitor the quality of the service provided. This included the use of questionnaires for people who used the service and those acting on their behalf. In addition to this the management team monitored the quality of the service through the completion of a number of audits, for example medication, health and safety, infection control and clinical audits relating to pressure ulcers and skin tears, falls and people's weight loss and gain. This also included an internal review by the organisation's internal quality assurance team at regular intervals.

Although these systems were in place, they did not identify the issues we identified during our inspection and had not identified where people were put at risk of harm or where their health and wellbeing was compromised. There was evidence to show that because of this some people did not experience positive care outcomes and the lack of robust quality monitoring meant that there was a lack of consistency in how well the service was managed and led.

For example, checks were not effective to monitor and ensure pressure mattresses were set at the correct setting each day so as to aid pressure ulcers developing or deteriorating further. The registered manager confirmed that this was accurate. The registered manager was unable to provide a rationale as to why this had not been picked up sooner. The monthly medication audits had not picked up that there were gaps in people's topical creams and emollients documentation or that there were limited records to confirm that one person's stoma pouch had been changed twice daily as required. Records were not properly maintained, for example, in relation to risk assessments, care planning and end of life care. We asked to see evidence of care plan audits undertaken. The registered manager confirmed and records showed that care plan audits had only commenced in April 2016 and at the time of this inspection nine out of 62 care plans had been reviewed. Where corrective actions were highlighted, there was no information to show that the actions highlighted had been addressed. Whilst it was recognised that as part of the provider's own internal monitoring systems a sample of people's care files were viewed as part of the process; the provider's internal Quality Monitoring Reports for the period 22 January 2016 to 31 May 2016 showed that improvements required to the service's care planning and risk assessment procedures had not been picked up. The above suggested that the provider's quality monitoring processes were not as robust or effective as they should be so as to demonstrate and drive improvement.

Some aspects of care practices required improvement. These related to staff's manual handling practices and procedures, communication with people living at the service, staffs understanding of how to provide care and support to people living with dementia and care and support to be less routine and task focused. The provider's internal Quality Monitoring Reports for the period 22 January 2016 to 31 May 2016 did not highlight any concerns relating to care provided or care practices at the service. The registered manager confirmed that they were aware of some of the above issues, namely that care provided to people living at the service was not as person-centred as it should be. An action plan as to how this was to be addressed had not been devised and implemented so as to measure and review the delivery of care against current best practice guidance.

Staff felt that the overall culture across the service was not always as open and inclusive as it should be. Staff told us that communication between the management team and staff and between individual staff team members required improvement. Seven out of 10 members of staff told us that 'staff morale' was not good and this primarily related to a lack of teamwork between individual staff members.

Staff's comments about the support provided from the registered manager and management team were mixed with both positive and negative comments. One staff member told us, "The manager is very good and very supportive." Another member of staff stated, "The manager has only been here since December [2015]. They are good and have tried to put things in place but not all staff are receptive." Another member of staff told us, "I do not always feel supported in my role." They told us that in their opinion the registered manager did not always listen to issues raised by staff or effectively manage these. We discussed this with the registered manager. The registered manager stated that efforts were being made to build a cohesive staff team, however they had been met with resistance as some members of staff were not happy with proposed changes and changes made. The registered manager confirmed that this was proving to be challenging.

The provider confirmed that the views of people who used the service, those acting on their behalf and staff had been sought in March 2016. The feedback summary report detailed that a response was received from two relatives, five people who used the service and 28 members of staff. The responses were collated and presented in a 'bar chart' format with the collected data. The majority of findings were positive and although a summary of actions from the questionnaires had been completed, these had not highlighted all comments made, for example, 50% of visitors were 'uncertain' if their member of family received the right level of help when they needed it and 50% of visitors did not think that staff were available when their member of family needed them. No actual comments from people using the service, relatives or staff were recorded to put the above percentage figures into context. This meant that lessons could not be learnt where improvements were required.

Although staff meetings were held at regular intervals which gave the staff the opportunity to express their views and opinions on the quality of the service, they did not show that discussions held were always acted on. Minutes of these meetings were available and confirmed the topics raised and discussed. However, where actions had been highlighted, there was not always an action plan completed to evidence the service's accomplishments and the dates these were concluded. Meetings for people who used the service and those acting on their behalf had been conducted on two occasions since the appointment of the new manager in December 2015. Where actions had been highlighted, no action plan had been completed to evidence feedback acted on and the dates these were concluded.

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

The registered manager confirmed that the service had just commenced the Promoting Safer Provision of Care for Elderly Residents (PROSPER) project in relation to falls, urinary tract infections and pressure ulcers management. This is a project that aims to improve safety, reduce harm and reduce emergency hospital admissions for people living in care homes across Essex by developing the skills of staff employed within the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who use services did not receive person-centred care and treatment that was appropriate to meet their needs. Assessments of people's care did not include all of their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Not all care and treatment was provided in a safe way for people using the service. Risks were not always mitigated to ensure people's safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People who use services did not always have their nutritional or hydration needs met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints People who use services were not supported by the provider's effective complaints procedure.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

People who use services were not supported by the providers systems and processes to assess and monitor the quality of service provided. The arrangements in place were not effective in identifying where quality or safety were compromised.