R Y S A Limited

The Sheridan Care Home

Inspection report

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Date of inspection visit: 21 and 22 October 2014
Date of publication: 22/01/2015

Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

This was a comprehensive inspection, carried out over two days on 21 and 22 October 2014. The first day was unannounced.

The Sheridan Care Home provides accommodation for up to 30 people who need support with their personal care. These are mainly older people who are living with dementia. The home is a converted period property with a modern, purpose-built extension. Accommodation is arranged over two floors and there is a passenger lift to assist people to get to the upper floor. The home has 26 single bedrooms and two twin-bedded rooms, which two people can choose to share.

There were 29 people living at the home at the time of our inspection. The home had a registered manager. 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 and associated Regulations about how the service is run.

At our last inspection on 2 and 11 September 2014, we asked the provider to take action to make improvements to care and welfare, staffing levels and record keeping. They sent us an action plan that stated they would meet the relevant legal requirements for staffing levels and record keeping by 8 October 2014, and for care and welfare by 20 October 2014.

Summary of findings

After that inspection we received information about further concerns in relation to the service. As a result we undertook this comprehensive inspection. During this inspection we looked to see if these improvements had been made. The action in relation to improved staffing levels had been completed, but the actions in respect of care and welfare and record keeping remained outstanding.

At this inspection, we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

People and their visitors were broadly pleased about the service they received, but expressed reservations about people having meaningful activities to occupy them. Our observations and the records we looked at did not always match the positive views we heard.

People's care was not planned or delivered consistently. Care plans did not reflect people's interests and personal histories, and were not always reviewed or updated when their needs changed. Weight loss was not always promptly followed up. There were not enough meaningful activities for people.

Some records were inaccurate and incomplete, which meant that staff did not have all the information they needed in order to provide the care people needed.

Visitors told us they thought people were safe at the home. However, we found that people's safety was compromised in some areas, including out-of-date risk assessments, staff recruitment checks and handling medicines.

The home's systems to assess and improve the quality of its service were not effective. There was no system for obtaining and recording people's views about the home and using these to drive improvement. There had been no residents' or relatives' meetings, and people's views had not been gathered and recorded by any other means. Learning from accidents and incidents was not systematically shared with staff. Quality assurance checks had not been completed, other than for medicines.

The home is a specialist dementia care home, yet staff had not received training, beyond basic awareness training, in dementia, managing behaviours that challenge others, and the Mental Capacity Act 2005. They had not taken steps to make best interest decisions in line with the Mental Capacity Act 2005, when people lacked the mental capacity to give consent to aspects of their care.

Additionally, we identified areas where improvements could be made to the service.

Whilst staffing levels were sufficient for staff to provide basic care, there was no system to assess staffing levels and adapt them according to people's changing needs. This meant the home's managers could not be sure that there would always be enough staff to meet people's needs.

Snacks and drinks were not to hand for people to help themselves to between meals. It is good practice in dementia care to ensure that people have access to food and drink between meals, when they wish.

People's independence had not been promoted through involving them in the daily routines of running the home or through the provision of equipment that might help them eat meals independently.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

People were not kept safe at the home.

Risk assessments and care plans were not always updated when people's needs changed so people might not always receive the support they needed in order to remain safe.

Recruitment checks were not always sufficiently thorough to ensure staff were safe and sufficiently skilled to work with people.

Although there were sufficient staff to meet people's basic needs, there was no system for organising staffing levels according to people's changing needs.

Is the service effective?

Inadequate

People's needs were not met effectively.

This is a specialist dementia care home, yet staff did not have the knowledge and skills they needed to care for people who live with dementia.

Staff and managers did not follow the requirements of the Mental Capacity Act 2005 to ensure that people consented to their care, or if they were unable to give consent, provided care that was in people's best interest.

Although people's weights were monitored, some people's weight loss was not adequately followed up with health professionals.

Is the service caring?

Requires Improvement

The service was caring but some improvements were recommended.

Visitors said staff were caring and staff treated people with respect and compassion.

However, staff did not always act to maintain people's privacy, dignity and independence. Staff and managers made assumptions about people rather than respecting their preferences.

Is the service responsive?

Inadequate

The service was not responsive to people and their needs.

People's care plans and the care they received did not take into account their individual interests and social histories.

People received little stimulation through encouragement to follow interests or take part in meaningful social activities.

Some people's assessments and care plans were out of date, and records were incomplete or contained errors. This meant staff had insufficient information about the care people needed.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

People and their relatives were given no opportunity to contribute to the running of the service and there was no system for managers to obtain, record and act on people's views.

Managers and staff did not learn from accidents, incidents and complaints in order to improve the service.

Quality assurance systems had been allowed to lapse and there were no systematic checks on the quality of service provided.

The Sheridan 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.

This inspection took place on 21 and 22 October 2014. Our visit was unannounced and the inspection team consisted of two inspectors.

Before our inspection we reviewed the information we held about the home, including notifications of incidents that the provider had sent us since our last inspection in September 2014. We also spoke with the local authority safeguarding and commissioning teams. Because this inspection was undertaken in response to recent information of concern from the local authority safeguarding team, we did not request a Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we met and spoke with all but one of the people who lived in the home. They were living with dementia and were not all able to tell us about their experiences at the home, so 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 also spoke with four visitors, a visiting healthcare professional, three care staff, a member of ancillary staff, two deputy managers and the registered manager. We observed care and support in communal areas and looked at the care records for seven people and medicines administration records for eight people. We also looked at records that related to how the home was managed, including four staff files, staff rotas for the period from 8 September 2014 up to the date of the inspection and the provider's quality assurance records.

Following the inspection, the registered manager sent us copies of policies and their training summary for all staff, as we had requested.

Requires Improvement

Is the service safe?

Our findings

People were not fully protected from risks to their safety.

At our last inspection in September 2014, we found one person's changing needs had not been reassessed or planned for. They were at risk of falls and staff did not have up-to-date information or a plan as how to minimise the risks. This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider sent us an action plan stating care plans would reflect reassessed needs by 20 October 2014.

At this inspection in October 2014, we found that risks were not managed so that people were safe. Risks were not always reassessed when people's needs changed, which meant people may not receive the care and support they require to meet their needs fully. One person's falls risk assessment had not been updated when they were prescribed a medicine that could make them drowsy and increase their risk of falling. Another person had fallen in October 2014 but their falls risk assessment and care plan had not been reviewed and updated following this. This meant that measures they needed to remain safe might not be in place. One of these people's relatives told us the person often behaved in a way that was challenging for staff to manage. However, there was no behaviour management plan so that staff would know how to manage the person's behaviours safely. A further person had an epilepsy care plan that did not specify how long staff should wait before calling emergency services when the person had a seizure. This meant there was a risk this person could experience a delay in receiving medical attention.

These shortfalls in assessing and managing risk were a repeated breach of Regulation 9(1) and 9(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Recruitment practices did not fully protect people from staff who might not be safe to work with them, or who were not sufficiently fluent in English to be able to communicate effectively. Prior to the inspection we had received concerns that some staff did not speak English fluently, and during the inspection two relatives expressed similar concerns. The staff we met were sufficiently fluent to be able to speak with us and we saw they were able to communicate with people at a basic level. Two staff recruitment records contained incomplete records. One staff member had not given a reason for why their previous employment in care ended. Another had no reference from their last employer, and this had not been pursued by the home's management. This meant they did not have complete information to assess whether these staff members were suitable to work with people living at the home. A further staff member's application in 2014 stated they had a 'pre-intermediate' understanding of English, yet they had started work at the home. This meant this member of staff would not be able to understand and have fluent conversations with people living with dementia, who had complex communication needs. This could lead to misunderstandings and the correct care and support not being provided to people.

These shortfalls in recruitment were a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicines were stored safely. Medicines that needed cold storage were stored in a dedicated refrigerator and temperatures were monitored to ensure they remained within safe limits. There were suitable arrangements for controlled drugs, although there were none held at the time of our inspection visit. Regular medicines audits checked that medicines in stock and disposed of could be accounted for.

Staff had been giving one person who had recently moved into the home, a medicine that was not recorded on their medicine administration record (MAR) sheet. This was a cholesterol-lowering medicine in the blister pack supplied by the person's pharmacy. This meant the person could be at risk from a medicine that had not been prescribed or staff not following the prescription instructions, and staff not recording the medicine they had administered. We asked a senior member of care staff about this. They acknowledged it was an error and told us they had queried this with the pharmacy and requested a revised MAR sheet.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our last inspection in September 2014, we were concerned that there were not always enough staff on duty to meet people's needs, particularly during the evenings. Some people were going to bed earlier than they would choose because there were not enough staff to assist them later in the evening. This was a breach of Regulation 22 of

Requires Improvement

Is the service safe?

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider sent us an action plan stating that they would make improvements to evening staffing levels by 8 October 2014. When we inspected the home again in October 2014, we found there had been some improvements.

One person described staff as "very busy". A visitor questioned whether staff had sufficient time to spend with people because they were so hard working but said they thought their relative was well cared for and safe. A care worker commented that they were very busy from day to day trying to get things done on time, and that this was more difficult if people were unsettled.

During the inspection there were sufficient care staff on duty to meet people's needs and we observed that care staff supported people in an unhurried way. For example, where people needed assistance to eat their meals, the staff who assisted them worked at their pace. The rota for the two weeks up to and including the inspection reflected five or six care staff on duty in the morning and four or five in the afternoon. Shift times had been adjusted following the last inspection so that an additional member of staff was on duty until 9pm. The registered manager told us they had introduced this change immediately following our last inspection, so that people don't have to go to bed or get up earlier than they would like.

The staff rotas showed only two staff on duty overnight, between 9pm and 8am. The registered manager said that although seven people needed assistance with personal care from two staff at once, none of these people woke at night, nor was there currently anyone who got up and walked around at night. However, there was no formal system for reviewing staffing levels according to people's individual needs. This is an area for improvement.

We recommend that the provider introduces a system for determining staffing levels according to people's individual needs.

Broken and inadequately cleaned kitchen fixtures and equipment compromised food hygiene. A refrigerator door handle was broken, and a freezer was dirty and frosted up. This meant the refrigerator and freezer might not operate at a safe temperature. The registered manager told us that there had been no outbreaks of food poisoning at the home and said they would purchase a new fridge. We advised the local authority environmental health department and they visited the home shortly after our inspection visit. They informed us that food hygiene was generally well managed and that some of the issues we identified had already been addressed. They identified some requirements consistent with routine wear and tear to improve the fabric of the building, such as replacing cracked tiles and cleaning the wall behind the oven. This is an area for improvement.

Other aspects of premises and equipment were managed to ensure people remained safe. Contractors had recently inspected and serviced the lift and had inspected and certified the hoists within the past six months. The gas system had been serviced within the past year. There were records of monthly checks that hot water temperatures were within safe limits to prevent scalding people and to prevent the growth of Legionella bacteria.

People who were able to said they felt safe. People's relatives also told us they felt their family member was safe. We observed that people were relaxed with staff, and that some actively sought their company. All but one member of staff had within the past two years received training in safeguarding adults. All the care staff we spoke with were aware of how to respond to and report concerns about abuse, including outside agencies they could contact. Information about safeguarding adults was displayed in people's bedrooms. The home's safeguarding policy contained some inaccurate contact information, including details of an organisation that no longer existed and the incorrect contact details for out-of-hours social services. This is an area for improvement.

Inadequate

Is the service effective?

Our findings

Although staff received core training in topics such as food hygiene and safeguarding adults from abuse, this did not equip them to care for people who had specific needs associated with dementia. The home provides a specialist service for people living with dementia. However, our observations and discussions with care staff demonstrated they had a very basic understanding of dementia that made it difficult for them to meet people's social and emotional needs. For example, during our lunchtime observations people did not receive an explanation of what their meals were or a choice of food, as would be good practice in dementia care. Two care staff said they found it hard working with people who live with dementia, and one commented that it was particularly difficult when people were agitated and would not cooperate. The training records showed that only seven of the home's 16 care and management staff had undertaken dementia awareness training, and that no staff had undertaken training about behaviour that challenges others. There was no record that staff or managers had received training in the Mental Capacity Act 2005, including the Deprivation of Liberty Safeguards. The registered manager acknowledged that staff had not undertaken this training.

These shortcomings in staff training were a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because staff did have the skills and knowledge to meet the specialist needs of people living with dementia.

Consent to care was not always sought in line with legislation. In three care records the person's 'next of kin' had given or declined consent to photographs and influenza vaccination. Being 'next of kin' does not give a relative the legal authority to make decisions on someone's behalf.

Where there was no valid consent for people who lived with dementia, staff had not followed the requirements of the Mental Capacity Act 2005. The records we looked at were all for people who live with dementia. None contained, in the absence of valid consent, assessments of the person's ability to make decisions about particular aspects of their care, or of decisions that the care was in the person's best interest. This included mental capacity assessments and best interest decisions about care that could be restrictive, such as the use of bed rails or a person wearing cotton mittens at night to reduce scratching. One person's care plan for as-required medicines stated they had been assessed has having 'no capacity' but there was no record of the mental capacity assessment. The registered manager acknowledged that mental capacity assessments and best interest decisions were not in place.

'Do Not Attempt Resuscitation' (DNAR) forms were not completed properly. DNAR forms had been signed by people's GPs after discussion with staff or management. Often, the forms had been filled in by management staff and stated that managers had discussed with people's families whether they wished the person to be resuscitated. However, the only record of such discussion was the relative's yes or no answer. One person's DNAR form showed their previous address and would not have been valid at The Sheridan Care Home. Another person's was incomplete, with the section about the person's capacity to make decisions about resuscitation left blank. There was a risk that in the event of a medical emergency, a person might be resuscitated when they would not have wanted this or it was not in their best interest. There was also a risk that people might not be resuscitated when this would be in their best interest.

The lack of valid consent or mental capacity assessments and best interest decisions was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The home was meeting the requirements of the Mental Capacity Act 2005 in relation to the Deprivation of Liberty Safeguards (DoLS). The registered manager told us they had applied to the local authority to authorise the use of DoLS in respect of everyone in the home, but had not yet heard the outcome of their applications. Everyone living at the home experiences cognitive impairments and the registered manager confirmed that they would not be safe to leave the house alone.

Prior to the inspection we had received concerns about small portion sizes at meals and little variation in people's diet. We observed lunch on the second day of our visit on both floors of the home. Portion sizes were adequate and drinks and biscuits or cake were served between meals. However, there were no snacks, fruit and drinks available at other times in communal areas for people to help

Inadequate

Is the service effective?

themselves as they wished, as is good practice in dementia care. We saw that stores of food in the kitchen were replenished on the second day of our visit, although there was little fresh fruit other than bananas.

Research has shown that people living with dementia can see food more easily on coloured crockery and may subsequently eat more. None of the main meals in the first floor dining room were served on coloured plates. One person did not eat their main meal, repeatedly saying "Take it away" and "It's too much". Staff took the food away after encouraging them to eat. They gave the person some pudding in a red dish and the person then ate the food.

When the food arrived, staff did not explain to people what the meal was or offer them a choice of food. One person downstairs did not look keen on their main meal and a staff member asked if they would prefer a "butty". They smiled when they received their sandwich and said they enjoyed "butties". People were not offered a choice of drinks with their meal. However, staff did ask people whether they wanted salt and pepper.

One person required a halal diet. The registered manager said they purchased the person's food from a nearby specialist shop.

People's weights were monitored and food and fluid intake records maintained where necessary. Some people's weight loss was followed up. For example, staff had sought a dietitian referral for one person who had lost a lot of weight in a short period. However, another person had lost three kilogrammes in two months and their records showed no evidence that staff had addressed this with healthcare professionals, despite the person seeing their GP for other health issues. We saw supplies of cream used to fortify meals for people who needed this, although the cook demonstrated a limited understanding of special diets and could not tell us who needed fortified food.

The failure to address weight loss was a breach of Regulation 9(1)(b)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's day-to-day health needs were met. Records showed people saw GPs, chiropodists, district nurses, specialist nurses and community mental health staff. A relative whose family member had been unwell commented that the home contacted the GP when needed. A visiting healthcare professional said they had no concerns currently and that as far as they were aware, there were no pressure sores. The records we looked at did not show that people had seen a dentist. The registered manager told us people saw a dentist whenever this was required.

Requires Improvement

Is the service caring?

Our findings

People told us staff were kind. However, staff did not consistently promote people's dignity and independence. One person commented that the registered manager had "a nice manner about him", although they also sensed that staff did not seem interested in what they had to say. Regular visitors said staff were caring. One commented, "They are very caring." Another said, "I'm here for a snapshot of time. What I have seen they've been caring"; they said they were very impressed with a particular member of staff who assisted their family member in a very gentle way.

People and visitors said that staff respected them as individuals. One person said that they liked to spend time on their own and that staff respected this. A relative told us their family member had enjoyed painting and had always been very messy when they did this. They were appreciative that staff had not stopped the person being untidy.

Relatives said they were told about changes affecting people's care. One relative said they did not expect to be kept informed from day to day but were confident they would be advised of anything significant. Another said, "They have kept me informed lately because there has been a need for it." Relatives also said that they could speak with management staff if they had any concerns.

Seat covers were used routinely rather than where people needed them, to protect chairs from spilt urine. This assumed everyone was incontinent and did not use continence aids effectively; it did not promote people's dignity.

People's independence and understanding was not actively promoted. We did not see people involved in daily tasks around the home such as making drinks and laying tables. We observed the support some people received during lunch on the ground and first floors. On the first floor, one person's food was pushed off their plate and they ended up using their fingers to try and stop the food coming off the plate. Staff had not considered providing this person with a plate guard so they could remain independent and have some dignity. A plate guard is a raised plastic rim that fits to a plate to prevent food sliding off, so people can put food on their cutlery independently. One person was brought by staff to sit at the table in the first floor dining room 20 minutes before the main meal. This person was unsettled, repeatedly calling out by the time the meal arrived. Two people were not offered the choice of sitting at the dining room table. Four other people remained in their armchairs in the lounge. This meant people may not have understood that it was mealtime until their meals were placed in front of them. This is an area for improvement.

Whilst people received personal care behind closed doors, there was one occasion where people's privacy and dignity was not respected. A member of management staff showed us to a room where they said we could speak with care staff in private. While we were speaking with a staff member, we realised there were someone's personal effects in the room. The member of management staff confirmed this was someone's room but they did not think the person would mind as they were not often in their room. They had not asked the person beforehand. This indicated a lack of respect for that person's privacy and space.

People were supported to dress appropriately and their clothing was arranged properly to promote their dignity. Early on the first afternoon of our inspection we saw three men, usually clean shaven, who were unshaven. On the second day they had been supported to shave.

Relatives told us they were able to visit their family member when they wanted. We inspected the home during the day and during both days visitors came to see people.

Staff treated people respectfully, with compassion. For example, staff responded to people in communal areas when they asked for attention and spent time talking with them. Staff members crouched or knelt so that they were at eye level with people when they spoke with them. Before lunch downstairs, they explained what they were doing when they assisted people to sit at the table and put on aprons.

We recommend that people's independence is promoted through their involvement in daily living activities and the use of equipment that helps them maintain their independence.

Inadequate

Is the service responsive?

Our findings

At our last inspection in September 2014, we were concerned that staff were not following people's care plans. We found people in bed before their preferred time that was stated in their care plans. A person was not receiving the assistance their care plan said they needed, to reposition in order to reduce the risk of pressure ulcers. One person's risk assessment and care plan had not been reviewed and updated following a fall. This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. In addition, we found that records were incomplete. Fluid records for fluid intake and catheter output were not totalled; it was unclear how staff were monitoring this so they could take action if fluids consumed or urine output were lower than they should be. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider sent us an action plan stating that they would make improvements to records by 8 October 2014 and to care planning and delivery by 20 October 2014.

Overall, relatives were positive about the care their family member received. A regular visitor commented that the person was always clean and another relative said their family member was nicely shaved.

However, people were not supported to follow interests and take part in meaningful social activities. A relative questioned whether their family member received sufficient stimulation through meaningful activities and time spent with staff. Another relative said their family member liked music, but the person's music had gone off and staff had not addressed this. One person spent time in their room with no stimulation, such as music or television, and nothing to do.

People sat in lounges with the television playing but most were not involved in things that gave them interest or enjoyment. On the second morning, we observed staff supporting four people in the downstairs lounge. One person sought attention from staff; a member of the management team spent a while chatting with them about their past. Another person leafed through a magazine and then fell asleep. The other people looked at staff as they passed or gazed into space. Suddenly, for no clear reason, one of the managers sang "It's a Long Way to Tipperary" and tried to get people to join in.

Care staff were not aware of people's interests and personal histories and how they could use these to provide activities that were meaningful for them as individuals. Only the managerial staff were familiar with people's life histories and personal preferences. This information was gathered from families when people moved into the home, but was not reflected in care plans or used to plan activities.

Staff did not always acknowledge or act promptly to assist people with their needs. During our observation of lunch on the first floor, one person had a very itchy back and had told staff this throughout the morning. They found it hard to eat their meal because their back was so itchy and they constantly asked staff to scratch it. Throughout our observation staff repeatedly told the person they would take them to their room after lunch to wash their back and reapply cream. It was not clear why they did not take this person before lunch or whilst they were showing distress about how itchy they were.

On the first day of our inspection, we heard someone calling out from their room. We went to them and saw their call bell was out of reach. We passed the bell to them. They pressed it and staff came to assist them. This person said they had fallen previously a few days before. They were unable then to reach their buzzer and said they had to wait "quite a long time before they came". On the second day, another person who spent much of the time in their room called out, but staff did not respond to them. The registered manager told us that the person had been calling out more recently, but was unable to explain why this was or what was being done to assist the person.

People's care needs were assessed before they moved into the home and were used to develop care plans to meet those needs. However, assessments and care plans were not always reviewed and updated when people's needs changed, and monthly care plan reviews did not always identify where needs had changed. This meant that care staff did not have up-to-date information about how to provide care in order to meet people's needs. One person had recently been discharged from hospital but their care plan, which was undated, had not been reviewed. Another person's mobility care plan was out of date as it stated they tended to walk around the home for much of the day, whereas the person was not currently walking around.

People's needs were not all addressed by care plans, which meant that staff did not have clear, written information

Inadequate

Is the service responsive?

about the care people needed. Whilst the home had applied to the local authority to authorise the deprivation of liberty for everyone who lived at the home, none of the care plans we saw contained any reference to people being deprived of their liberty.

Care plans and records did not all contain sufficiently detailed information so staff knew how to support people, or had received the care they needed. One person's skin integrity care plan did not specify how often they needed repositioning at night to help prevent pressure ulcers. The records for their daytime care did not show when they had been repositioned during the day, including when they were assisted to use the toilet. For example, at 4.30pm on the first afternoon of the inspection, the latest entry in their monitoring record had been recorded at 8am and stated that the person was sitting out. Another person was in bed at 12.05pm and 2.15pm. On both occasions, their records stated that they had last been repositioned at 7am. The registered manager acknowledged that all assistance from staff to reposition, including when people used the toilet, should be recorded. This would ensure staff knew when people were next due to receive assistance, in order to reduce the risk of pressure ulcers.

One person's care plan did not reflect accurately their religious and cultural needs. It specified that the person 'doesn't have non-kosher food'. The person was Muslim rather than Jewish, so required halal, not kosher, food. This placed this person at risk of not having their cultural and religious dietary requirements met.

Some records were erroneous or incomplete, so staff had insufficient information to guide them in caring for people and could not demonstrate they had met people's needs.

Care staff had recorded that one person had spent time looking at their television. This person did not have a television. Another person's moving and handling assessment was not signed or dated, so it was not possible to see who had undertaken it or when. This person had dry and discoloured skin on their legs, and the registered manager told us they had had leg ulcers when they moved in to the home. There was no body map in their records documenting this.

The shortfalls in care planning and provision, including the organisation of meaningful activities, were a repeated breach of Regulation 9(1)(a)(b)(i)(ii) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The shortfalls in record keeping were a repeated breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The procedure for raising concerns and complaints was displayed around the home. Relatives were aware of how to raise complaints and told us they felt able to raise concerns with the home's management if they felt they needed to do so. Staff knew how to respond to complaints. The complaints file contained three records for October 2014, but these related to safeguarding investigations rather than complaints. The registered manager told us they had received positive feedback on the service, but these comments had not been recorded. This meant there was no system in place to learn from feedback and ensure further improvement of the service.

The shortfall in the system for learning from feedback was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service well-led?

Our findings

The home did not promote a person-centred or empowering culture. People were not involved in developing the home as there was no acknowledgement that people living with dementia could make a valuable contribution.

Relatives told us they could speak to the registered manager or deputy if they wished. The registered manager said they often received complimentary feedback from visitors. However, there was no system for obtaining and recording people's views about the home and using these to develop and improve the service provided. There had been no residents' or relatives' meetings, and people's views had not been gathered and recorded by any other means. The most recent quality assurance forms from people and relatives had been returned in 2013. There had been no 2014 quality assurance survey.

There was a whistleblowing policy in place that encouraged staff first to raise concerns with the management team, in line with the Public Interest Disclosure Act 1998. However, the registered manager said that rather than going to the management team, staff went directly to social services, the Commission or the police. They commented that staff tended to do so after they had left employment. This indicated that some staff did not feel able to raise concerns with the home's managers. The staff we spoke with said they could speak with members of the management team if they had concerns about safety or malpractice.

Staff had regular support and development meetings with one of the management staff, where they discussed and received feedback on their work. There were also staff meetings. Minutes of meetings for July and September 2014 showed staff had discussed their apprehension about writing daily notes and supervision and appraisal. However, there was no evidence that staff influenced the development of the service.

Whilst most accidents, incidents and complaints were recorded, there was no evidence that learning from these was shared with staff, although staff meeting minutes showed that staff had been reminded to speak English on duty and report incidents to senior staff. The registered manager told us they gathered the staff after an incident and explained what had happened, but did not record this.

The registered manager told us they obtained information about good practice in dementia care from The Alzheimer's Society. It was not clear how this information was shared with staff.

The systems to assess the quality of service it provides were not effective. They had not identified the shortfalls we found during this inspection. When we asked to see records of quality assurance checks, the management team provided us with records of monthly medication audits, but were unable to provide details of any other checks. One of the management staff told us they checked people's care plans on an ongoing basis but there was no system for checking that care documentation was complete and up to date. We found records that were incomplete and out of date. The most recent "yearly monitoring 'quality of service'" report was from January 2013 and had no dated action plan. The home was not following its own quality assurance policy, which stated there were quarterly audits of catering, housekeeping, caring and administration, and that records of these were kept for review. The registered manager acknowledged there were deficiencies in the home's quality assurance processes and records. They explained that they had appointed a new member of the management team, who had just started work at the home, to help address this.

These matters were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The home met the Commission's registration requirements, including submitting notifications of incidents, such as deaths, as required by the Regulations. There was a registered manager in post, who was a director of the company that owns the home. They were supported by two deputy managers, one of whom had just started in post.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision Service users and others who may be at risk were not protected against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the services provided, and identify, assess and manage risks relating to people's health, welfare and safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not protected against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the recording and safe administration of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not operate effective recruitment procedures in order to ensure that no person is employed unless that person is of good character and has the qualifications, skills and experience which are necessary for the work to be performed. They had not ensured that information specified in Schedule 3 was available in respect of a person employed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Staff were not appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment safely and to an appropriate standard, by receiving appropriate training.

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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of carrying out an assessment of the needs of the service user and the planning and delivery of care and treatment in such a way as to meet the service user's individual needs and ensure their welfare and safety.

The enforcement action we took:
We issued a warning notice for continuing breaches of the regulation to be met by 31 January 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Service users were not protected against the risks of unsafe or inappropriate care or treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user and records in relation to the management of the regulated activity.

The enforcement action we took:
We issued a warning notice for continuing breaches of the regulation to be met by 31 January 2015.