Sun Care Homes Limited

Victoria Cottage Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced focused inspection of this service in April 2016 and found breaches of regulation. We carried out an unannounced focused inspection to check for improvements in October 2016 and we found continued breaches of regulation. After the focused inspection, the provider wrote to us to say what they would do to meet the legal requirements. We returned to the service to carry out a further focused inspection on 17 January 2017 and we found the provider had not yet made all of the improvements to meet the legal requirements.

We undertook this focused inspection to check how the provider was progressing with their action plan and to check if they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Victoria Cottage Residential Home on our website at www.cqc.org.uk.

We inspected the service on 17 January 2017. The inspection was unannounced. Victoria Cottage Residential Home is owned and managed by Sun Care Homes Limited. It is registered to provide accommodation for up to 18 older people. On the day of our inspection eight people were using the service.

The service did not have a registered manager in place at the time of our inspection and had not had one in place since September 2015. 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.

The provider had engaged another consultant since we last inspected in order to try and drive improvements in the service. We found this had brought about improvements in some areas but there were still a number of further improvements needed.

People were still not protected from the risk of harm, due to a lack of effective systems. Risks in relation to people's daily life were not always assessed or planned for. Medicines were not always managed safely to ensure people were receiving their medicines as prescribed.

People were supported to make decisions if they had the capacity to do so. However people who did not have the capacity to make certain decisions were still not always protected by the Mental Capacity Act 2005. People were not always adequately supported with their nutritional needs. More training had been given to staff and people now were supported by staff who had the knowledge and skills to provide safe and appropriate care and support.

Some improvements had been made in relation to how care was planned for and delivered. However we found this had not happened for everyone which resulted in the risk of those people not always being cared

for appropriately.

People were involved in giving their views on how the service was run and their concerns were listened to and acted on.

A new manager had started working in the service since we last inspected the service and was working to establish an open and inclusive culture in the service. There had been improvements made to implement systems to assess and monitor the quality of the service, however there were further improvements needed. This resulted in ongoing breaches in regulation.

Although we found there had been improvements to the quality of the service, the overall rating for this provider remains 'Inadequate' and the service therefore remains in 'Special measures'. We could not improve the rating from inadequate because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People may not be protected from the risk of harm because the systems in place to protect people from the risk were not yet robust.

People continued to be exposed to risks to their health and wellbeing because ways of minimising these were not identified and planned for.

People lived in an environment which was not always clean and hygienic.

People were not always receiving their medicines as prescribed. There were enough staff to provide care and support to people.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Where people needed support to make decisions they were not protected under the Mental Capacity Act 2005.

People were not always supported to maintain their nutrition.

People were supported by staff who had been provided with more training to give them the skills and knowledge they needed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We found action had been taken to implement new care plans but this was not always consistent and therefore had not resulted in improvements to the care some people were receiving.

Concerns were listened to and there were systems in place to deal with concerns raised.

Is the service well-led?

Inadequate

The service was not well led.

We found that action had been taken to improve the way the service was monitored but this had not yet been fully effective in improving the quality of care some people were receiving.

People were involved in giving their views on how the service was run.

Victoria Cottage Residential 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.

We undertook an unannounced focused inspection of Victoria Cottage Residential Home on 17 January 2017. This inspection was done to check that improvements to meet legal requirements planned by the provider after our April and October 2016 inspections had been made. The team inspected the service against four of the five questions we ask about services: is the service safe, is the service effective, is the service responsive and is the service well led. This is because the service was not meeting some legal requirements. The inspection team consisted of three inspectors.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and notifications that had been received. A notification is information about important events which the provider is required to send us by law. We spoke with commissioners who fund the care for some people.

During the visit we observed the care and support people received, as well as using 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 four members of support staff, the cook, maintenance staff, the housekeeper and the manager. We looked at the care records of seven people who used the service, medicines records, staff training records, as well as a range of records relating to the running of the service.

Requires Improvement

Is the service safe?

Our findings

The last time we inspected the service we found there were improvements needed in relation to safeguarding people from the risk of abuse, safe recruitment of staff and assessing and minimising the risks to people's wellbeing. This resulted in breaches of Regulations 12, 13 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this visit we found that although some improvements had been made, there were still some concerns about safeguarding people and risk management.

People were not always protected from the risk of harm as systems put in place were still not always robust. The manager had implemented incident records to enable an analysis of incidents and ensure any required actions had been taken and referrals made to external agencies where needed. Records showed the manager had shared information with the local authority as part of this process when there had been incidents in the service and the staff we spoke with knew about the systems they needed to follow. However the manager told us this system was still in development and we found this to be the case as we found the incident reporting process was not always followed. We saw one incident had been recorded by staff stating a person who lived with a dementia related illness had become anxious and had trapped their fingers in the kitchen door. There was a section on the incident form for the manager to complete to record any action taken following each incident, however this had not been completed. There was no record of an investigation being undertaken to assess if this incident could have been avoided and no consideration had been given to whether the information should be shared with the local authority safeguarding adult's team.

This person had a tissue viability care plan in place which stated that an incident form must be completed for wounds or bruises observed by staff. However we found this was not being followed. There was a body map in the person's care plan dated 15 December 2016 which stated there was an unexplained mark on the person's arm. We saw there was a further body map which staff had completed on 4 January 2017 stating the person had some soreness to the top of their legs which had been recorded as being caused by an incontinence aid. There was no incident record in place for either of these and no record that an investigation had been undertaken to further explore the cause of these injuries, to ascertain the need for safeguarding referrals or to reduce the likelihood of future incidents.

This was an ongoing breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A new care planning system had been introduced but not all of the people who used the service had one of the new care plans in place at the time we visited. We looked at the care plan of one such person and some areas of this person's care plan had not been updated since May 2016 and did not fully reflect their current needs. For example, prior to our visit the manager had informed us this person had developed an infection in their urine. This had not led to their care plan being updated so that staff would know how to reduce the risk of a further infection or how to recognise the symptoms of the person having another infection.

The last time we inspected the service we had concerns about another person who was at high risk of developing a urine infection and had previously been hospitalised as a result of this. We had found there was no care plan in place for this risk. Since that time records showed the person had developed other infections in their urine and had again on one occasion been hospitalised due to this. Despite this a care plan had still not been implemented giving staff guidance on how to reduce the risk of the person developing another infection or how to recognise the early stages of another infection. The manager told us this person's care plan had been re-written onto the new format but had not yet been put into circulation so at the time of our inspection the care plan being used by staff did not contain the information required to guide staff in monitoring and managing this risk.

We found ongoing concerns in relation to infection control in the service which placed people at risk of acquiring a social care related infection. The manager told us that they been unsuccessful in recruiting more cleaning staff and so this was due to be contracted out. In the meantime there was one cleaner working in the service during the week and care staff were required to clean the service at weekends.

Some areas of the home had malodours and we looked at the records staff kept for cleaning completed and saw there were regular occasions when daily cleaning tasks had not been recorded as completed. This meant there was no evidence of bedrooms or communal areas being cleaned on some days. For example daily cleaning tasks were recorded as being completed on 4 January 2017 and then not completed again until 9 January 2017. This had been an area of concern during our April and October 2016 inspections. In December 2016 there were frequent gaps in cleaning records maintained for toilets and bathrooms over the weekends. Additionally cleaning records kept by the night staff had not been completed since November 2016.

We looked at the environment including bathrooms, lounges and bedrooms and we found that not all areas were clean and hygienic. We found wheelchairs were marked with food and liquid debris and slings used on transferring hoists were stained. The trolley used to store cleaning materials was dirty. In one bathroom we found a urine bottle which was not clean and had a strong odour and a commode chair was wet with urine and there was evidence that this chair was beginning to rust. Two bedrooms smelled of urine, as did one bathroom. One of these bedrooms was unoccupied as the person had moved out the day prior to our visit; however they had been sleeping in a room which smelled strongly of urine until that time. We found the room which was temporarily being used to store medicines whilst the medicines room was refurbished, also smelt of urine. One bathroom had flooring that was not sealed at the edges resulting in gaps, which posed a risk of infection harbouring in spilt fluids. The manager informed us this bathroom was going to be refurbished; however steps had not been taken to mitigate the risk until this time. All of this meant that people were still being placed at risk of acquiring a health and social care associated infection due to a lack of robust infection control systems.

There was a risk that people may not receive their medicines as prescribed. We looked at the medicines systems to assess if medicines were being managed safely and people were receiving their medicines as prescribed. We saw that one person had run out of their pain relieving medicine and had been without this for three days. We spoke with staff and they told us they had tried to get the medicine from the GP but there had been difficulties with the prescription. However it was important the person took their medicine as their care plan detailed they suffered with pain from a health condition and staff should have taken action sooner to ensure that they had an adequate supply of medicine. We saw that another person had not received one of their medicines on one occasion, although staff had signed to say they were on social leave.

This was an ongoing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

With the exception of the above, we found that medicines systems were organised and observed staff administering medicines during two medicines rounds and saw this was carried out safely. Where people were prescribed pain relief as and when required we observed the member of staff spoke with each person and asked if they were in any pain and if they wanted the pain relief.

We saw staff were following safe protocols for the receipt, storage and disposal of medicines. For example, staff were keeping tallies of boxed medicines to ensure these had been given as prescribed and were carrying out regular checks on the temperatures at which the medicines were stored. Regular checks of the medicines were being undertaken by senior staff and the manager to ensure medicines were being managed safely. The medicines room was being refurbished and during this process medicines were being stored safely.

The manager had implemented systems to assess risks in relation to the care people received such as monthly assessments of the risks of people developing a pressure ulcer and assessments of people's nutritional needs. Checks were also made in relation to the environment such as ensuring fire systems were working effectively.

The last time we inspected the service we found that robust recruitment procedures had not been followed to ensure staff were suitable to work in the service. The provider told us in their action plan that they would carry out a comprehensive audit of staff files to identify the missing documents and during this visit we found this had been completed. Where it was practical the staff had been asked to bring in the required information, such as a proof of identity or details of their previous working history. Where this was not possible or practical a risk assessment was used to determine if this presented a risk to people who used the service.

People were supported by adequate numbers of staff. We observed there were enough staff on the day we visited to give people assistance when they requested or needed it. Staff had the time to sit with people and undertake activities such as playing board games and giving hand massages.

The manager told us there were two care staff and a senior member of care staff planned to be on duty during each day and two care staff at night. They told us that although one person with a high level of need had recently moved out of the service, they would continue with this level of staff. In addition there was domestic and kitchen support each day and a maintenance person employed on week days. The manager told us they ensured the required number care staff were provided each shift and if any absence from work could not be covered from within the staff team they would arrange for an agency member of staff to work that shift. They told us that the agency staff used were regular workers who knew the needs of people who used the service.

Staff we spoke with confirmed what the manager had told us. Staff said they now always had two care staff and a senior on duty throughout the day. If cover was needed then they would do this amongst the staff team or use an agency worker. There was an enhanced payment for staff who worked additional hours, subject to them having had a full work attendance. Staff spoke of feeling confident with the other staff they worked with and described themselves as working well as a team.

The last time we visited we had concerns about how people were supported to transfer from chair to chair using equipment such as stand aids. We were concerned this was not being done safely. We observed staff supporting people to use a stand aid and other equipment during this visit and found this had improved and staff supported people safely. For example, we observed two staff support one person to be transferred into an armchair from a wheelchair. This was done sensitively and at one point when the person was not co-

operating with the transfer the staff introduced a distraction which they knew the person would respond to and which enabled staff to successfully transfer them.

Requires Improvement

Is the service effective?

Our findings

When we inspected the service in October 2016 we found there were improvements needed in relation to staff training and skill, nutrition and healthcare and the protection of people's rights under the Mental Capacity Act (MCA) 2005. This resulted in breaches of Regulations 11, 13, 14 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found improvements had been made in relation to ensuring staff were given training, although further training was needed in relation to the MCA. Although some improvements had been made to the application of the principles of the MCA further improvements were still required. We found some ongoing concerns in relation to people being supported with nutrition and health care.

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.

The manager told us that staff had been given guidance and support to enable them to understand the MCA and what role they played in supporting people who lacked the capacity to make certain decisions. They told us that despite this they still found staff to have a limited understanding of the Act and so were sourcing more training. We found this to be the case and when we spoke with staff there was an initial uncertainty until we prompted them.

Records showed that the manager had implemented mental capacity assessment forms for two aspects of people's support, their understanding of why they lived in the service and in relation to staff administering their medicines. The assessments included records of how people's capacity had been assessed such as what discussions had taken place and the person's response to this. However the second stage of the assessment called the best interests decision had not yet been undertaken and further assessments had not yet taken place in relation to other decisions being made. The manager told us they knew these were still outstanding and were working towards getting these done. This meant that there was a risk that people's rights under the MCA may not be protected.

Additionally one person one person had a 'tilt chair' which they sat in. This was used to prevent them from slipping out of the chair due to their risk of falling and so restricted their movement. There was no mental capacity or best interests assessment in place to show this had been assessed under the MCA and that preventing them from getting out of the chair was the least restrictive method of minimising these risks. Another person had a mental capacity assessment in place which detailed that staff must follow the guidance given by a health professional in relation to the frequency of supporting the person to change their position to reduce the risk of developing a pressure ulcer. However this guidance was not being followed in practice.

This was an ongoing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were still not being supported safely in relation to their nutrition. Some people were on food monitoring charts and staff told us they tried to complete these throughout the day and did not wait until the end of their shift before completing the records. However we looked at records on the day of our visit and saw that staff had not recorded what people had eaten until the end of their shift. This posed a risk that records may not be accurate with what people had actually eaten.

People were not always protected from the risk of weight loss. There was uncertainty about two people who were at high risk of weight loss and had lost weight. We saw the manager undertook a monthly weight analysis to assess any weight issues; however the analysis did not always lead to the required actions being taken. For example we saw from the weight analysis that the manager had determined one person needed to be weighed weekly instead of monthly due to an increased risk. The manager had recorded this in the evaluation of the person's nutrition care plan but the care plan had not been updated to show the person now needed to be weighed weekly. We spoke with the senior staff member who was responsible for planning the weekly weights and they were unaware this person required weighing more frequently. We found this was the case for another person who was also at risk of weight loss. Their care plan detailed they needed to be weighed weekly, however this was not being done and the senior staff member responsible for people's weights was unaware of this need.

This was an ongoing breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that the manager had made applications for DoLS for several people since we last inspected the service. We looked at one of these applications and found that it had not been completed accurately. The person who had the tilt chair, which was being used to keep the person safe and stop them from slipping out of the chair, had a DoLS application lodged with the local authority. The manager had recorded on the DoLS assessment that a MCA had been completed in relation to this chair but we found this was not the case. This meant the local authority would not have accurate information to enable them to decide the priority of assessing this person.

We observed staff supporting people in a safer way than we had at our previous inspection. The manager told us they had needed to go back to the drawing board with regard to staff training. Although staff had previously completed e-learning courses, considered as mandatory by the provider, they had not been required to achieve a certain pass mark to show they had learnt from the course and to apply this in the work place. Staff had therefore been required to retake these courses and achieve a set pass mark. The manager said they had identified five key courses that all staff were required to complete by the end of the month. The manager told us they were also introducing more face to face training as well as individual coaching when on shift and were planning to stagger training throughout the year so that all training courses did not require a refresher session at the same time. Staff had also attended a training session on fire safety the day prior to our visit and told us they felt training had improved.

Records showed that one person needed their food to be pureed due to a risk of choking and when we observed lunch being served, we saw this was given in line with guidance in their care plan and the person was supported to eat their meal. Records also showed that people's nutritional risks were assessed regularly.

Staff we spoke with were aware of the specific diet one person required due to a health condition and the reason for this and were aware of health professional's recommendations about the most effective and safest way to support the person with their nutrition. We observed the person at lunchtime and saw that staff followed the advice given in relation to the person having a special diet. Staff we spoke with were aware of the support other people needed to eat their meals. We spoke with the cook and they were aware of people's diets in relation to health conditions and had information on how to add extra calories to people's meals where this was needed due to poor nutritional intake.

Records showed that when people were ill and needed to see a GP that staff contacted the GP in a timely way. There was also evidence of staff seeking advice from other health professionals such as the district nursing team and the occupational therapist. The manager told us that there was a weekly 'ward round' carried out by a health professional to give guidance and support to staff in relation to people's health care needs. Records and discussions with staff showed that staff had recently been praised by this visiting health professional in relation to how they had supported one person with their needs in relation to management of pressure ulcer healing.

Staff we spoke with were able to provide an overview of people's health conditions and the support needed with these. They were aware of potential risks and what monitoring was carried out as well as what action they would need to take in the event of a health emergency. Staff were also able to describe the support they gave to a person to manage a physical need they required staff to undertake and told us they felt confident in supporting this person.

Requires Improvement

Is the service responsive?

Our findings

When we inspected the service in April and October 2016 we found there were improvements needed in relation to people having their support needs assessed and planned for to ensure they were cared for safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this visit we found that some improvements had been made in relation to how care was assessed and planned for some people, however further improvements were needed.

Records showed that risks in relation to people's care and support were still not being assessed and planned for safely. The manager told us they had commenced a complete re-write of the care plans for each of the eight people who used the service. However three people still did not have the new care plans in place at the time we visited, although the manager told us that these were in progress. We looked at the new care plans and found that although people's needs had been assessed and planned for, they still did not always meet the current needs of people who they were written for.
We looked at the care plans of two people who were at risk of weight loss and despite them having one of the new format care plans, which had been re-written to ensure their care was assessed and planned for. Both people had care plans stating they needed to be weighed weekly but this was not happening in practice. One of these people also had a care plan in place which detailed they needed to be encouraged to sit on a pressure relieving cushion due to a risk of developing a pressure ulcer. We saw the pressure relieving cushion was in a storage room and the manager stated that the person generally refused to sit on the cushion and so staff were advised to try and encourage the person to do so and if they refused to place it in the store room. However on the day we visited the person was not sitting on the pressure cushion, we did not observe staff attempting to encourage the person to do so and when we asked a member of staff if the person should be on a pressure cushion they said they were not aware of one. It was unclear if an alternative method of reducing the risk of the person developing a pressure ulcer had been investigated. This put the person at risk of developing a pressure ulcer.

We looked at the care plan of one of the people who did not yet have one of the new style care plans in use and saw that although some new information had been added, such as information about the diet the person needed to reduce the risk of choking, the care plan was not up to date with their current needs. There was a plan in place, written in December 2016, which detailed recommendations from the Speech and Language Team (SALT) on how to minimise the risks. This included the food the person should eat and how staff should support them. However records showed there had been telephone contact with the SALT team since then as staff had been concerned about how the person was drinking fluids. The SALT team had given advice to staff on a method to try and this had been recorded in the evaluation but had not been added to the person's care plan. We observed staff were not following the guidance in practice. There was also a care profile in place, which was out of date in relation to the person's current needs. For example the profile stated the person was on a normal diet when in fact the person was at high risk of choking and was on a pureed diet.

Some areas of this person's care plan had not been updated since May 2016 and did not fully reflect their current needs. For example, there was no information relating to the person's history of in relation to urine

infections. Prior to our visit the manager had informed us this person had developed an infection in their urine. Despite this, the person's care plan had not been updated to include information guiding staff on how to reduce the risk of a further infection or how to recognise the symptoms of the person having another infection. Additionally a tissue viability nurse had assessed this person and deemed them to be at high risk of developing pressure ulcers and there was a record in the care plan asking that staff reposition the person one to two hourly during the day. The care plan written by staff detailed the person needed to be repositioned four hourly, which conflicted with the health professionals recommendations. Following our visit the manager told us they had investigated this and were unsure of who had made this change or why.

We looked at the care plan for a person, who did not have a new care plan in place, and saw it still did not contain enough information for staff to enable them to recognise when their health condition was deteriorating. This person had been hospitalised previously when their health condition had deteriorated and at that time health professionals raised concerns about the lack of knowledge and information for staff on how to monitor this condition and support the person safely. Despite this, the care plan in place still did not give staff guidance on how to recognise the person's condition was deteriorating.

This was an ongoing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us staff were being encouraged to read the new care plans as they were implemented for people and staff we spoke with confirmed they had read most of the care plans. Staff told us the new care plans were an improvement and said they provided the detail of how people needed to be cared for. A senior member of staff told us the new plan format was, "better organised and easier to read and understand."

We saw the new care plans that were in place for some people were much more detailed in relation to each aspect of people's care and support needs. There were clear plans in place guiding staff in how to support people with communication and where people sometimes communicated through their behaviour there was clear guidance for staff about how to support the person. Where people were at risk in relation to mobility, falls and developing pressure ulcers there were detailed plans in place for each area of need. We saw that the new care plans in place contained detailed information in relation to health care support informing staff how to recognise the health condition was deteriorating and how they should respond. These also linked to other aspects of people's care and support and how their health conditions might affect them. For example one person who lived with a dementia related illness sometimes communicated through their behaviour. There was a detailed plan in place guiding staff on how to support the person and this included the affects their health condition might have on their behaviour. The care plan of one person stated they needed equipment in place to minimise the risk of them developing a pressure ulcer and we saw the equipment was in place and was being used correctly. This person also needed specialist equipment for a health condition and we saw this was being used as intended.

The new care plans were person centred in that they described people's preferences in relation to how they would like to be supported. The plans detailed people's likes and dislikes and gave details of their life history and any achievements.

Staff were not consistently responsive to people's needs and did not always consider their choices and preferences about how they spent their time. We observed one person was enjoying listening to music and was singing along to one of their favourite artists in the lounge. A member of staff turned the music off and put the television on without asking the person and another member of staff challenged this and said, "[Person] was enjoying that." However the member of staff continued to put the television on and did not

put the music back on.

Another person spilled their cup of tea on their clothing and dropped their cup and the same member of staff said to the person, "We will have to go and change you now. What a mess you have made of yourself [person's name]."

One person who lived with a dementia related illness had a care plan in place which stated they could sometimes display behaviour which may challenge staff if they did not feel included in what was happening in their surroundings. The plan stated if this was ignored the person's behaviour may escalate. We observed the person sitting at a dining table and staff were nearby. The person was repeatedly saying, "Can someone help me, can someone come" and staff did not respond to this. Eventually the person screamed out loud to get attention and staff responded to this. This could have been avoided if staff had responded to the person's initial requests.

One person needed a member of staff to assist them to eat and we observed a member of staff doing this. However they twice left the person mid-meal to answer the telephone and the doorbell without providing explanation to the person.

Other than these examples we observed staff were more responsive to people's needs and requests than they had been at our previous inspections. We saw examples of staff being attentive and engaging in a more meaningful way with people.

At other times staff spoke with people or gave some other acknowledgment as they passed them. We saw staff providing appropriate reassurance which included holding hands or other gentle physical contact.

The manager told us that activities were still being implemented in the service and that staff were being encouraged to provide activities based on what worked well for individuals. We saw there had been some improvements in relation to people having more access to activities and meaningful tasks and there were further improvements planned. The manager had trialled 'doll therapy' for one person who lived with a dementia related illness and had told us this had been successful and had a positive impact on the person reducing their distress and making them more accepting of care and support from staff. We observed this to be the case and saw the person benefited from this throughout the day. Staff also used this as a distraction technique whilst supporting the person, due to a history of resisting personal care, and we observed this was successful on a number of occasions.

We saw staff spending time with together with people who used the service playing games and chatting. For example we saw that one person was clearly enjoying playing dominoes with staff. Staff had placed a smart phone on the table and were playing the person's favourite music for them. This had a positive impact on the person and they were smiling and happy, performing actions to the music and singing along. Another person enjoyed talking part in household tasks and we saw this was documented in their care plans and observed that staff had tasks organised for them to take part in such as folding clothes into a washing basket.

Staff we spoke with told us of recent activities and said they provided these when people wanted them such as dominoes, skittles, sing a long, hand massages and nail painting. They told us they had tried playing bingo but this had not gone down particularly well. They told us they recorded any activities people got involved in and we saw records which confirmed this. There were photographs on the wall of the service showing activities people had recently been involved in such as, cake baking, drinks in the garden and flower arranging. Visits from the mobile library had also been implemented.

People could be assured that concerns they raised would be listened to and acted on. The manager told us there had only been one verbal complaint, which had only recently been raised and they had arranged to speak with the person raising the concern before they recorded this in the complaints log. Following our visit the manager informed us they had now spoken with the relative raising the concern and had also received concerns from a second relative and that these were being investigated. There was a complaints procedure in the service and staff we spoke with were aware of the procedure and their role in recording any concerns received and communicating these to the manager.

Inadequate

Is the service well-led?

Our findings

The last two inspections undertaken at this service, in April and October 2016 resulted in concerns being found in a number of areas of safe care delivery. At both inspections we found there were improvements needed in relation to the provider's lack of effective systems in place to monitor the quality and safety of the service. This had led to negative outcomes for some people who used the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had issued us with an action plan prior to our inspection in October 2016 and we had found during the October 2016 inspection that the actions stated in the plan had not led to all of the improvements being made. Despite the action plan stating the provider would have a robust quality assurance toolkit in place to ensure the safe and effective running of the service of the service and to provide ongoing monthly auditing of the entire home by 16 June 2016, this had not been achieved.

We found during this visit that there had been improvements in relation to how the quality of the service was assessed and monitored but further improvements were still needed.

There had not been a registered manager in post since September 2015. A new manager had been recruited since we last inspected and they told us they had started the process in order to become registered with us. We will continue to monitor this.

The consultant who was engaged to support the provider to make improvements when we last inspected the service was no longer in post. The provider had engaged a new consultancy agency in November 2016 to support them in implementing an effective system to assess, monitor and bring about the improvements required. We found this had been successful in some areas, however we found that some improvements had not yet been made. The manager told us that improvements were not as advanced as they would have liked and this was in part due to difficulties with recruiting staff. They told us that each area of improvement was slow as when they looked into the area of need it was like 'peeling the layers off an onion' and starting everything from new.

Actions planned to improve the quality and safety of the service had not always been completed in the timescales specified by the provider. Following the October 2016 inspection new consultants acting on behalf of the provider gave us an extensive action plan detailing what improvements they would make and by when. They communicated with us on a regular basis and gave updates on their progress with the action plan. We measured this action plan against what we found during this visit and although some areas had been addressed, as detailed in the plan, others had not.

The consultants had stated in the action plan that a quality assurance programme would be implemented by 25 November 2016. We looked at this programme and found that systems to assess, monitor and improve the service had been implemented; however these were not yet fully effective and robust in bringing about the improvements needed to ensure the safe running of the service. The manager told us that they recognised there needed to be further work to establish these systems. This meant there was an ongoing risk that issues related to the safety and quality of the service may not be identified.

The consultant told us in the action plan that by 18 November 2016 systems would be implemented to ensure that all incidents which required a safeguarding referral would be processed. The manager had made a safeguarding referral and had notified us of a medicines error during that time, however we saw there had been an incident in the service on 31 December 2016 and this had not been investigated to ascertain if the information needed to be shared with the local authorities safeguarding adult's team. This ongoing failure to identify incidents which required further investigation meant that action was not always taken to reduce the likelihood of further incidents and placed people at continued risk of harm.

The consultant told us in their action plan that by 25 November 2016 they would have completed a comprehensive review of all care files to ensure up to date MCA/Best interest decisions were in place. They updated their action plan on 7 November 2016 recording that all MCA and best interest's decisions had been completed. However when we visited, we found there was still not a MCA in place for the person who we raised concerns about at our inspection in October 2016 in relation to the use of a 'tilt chair.' Best interest's decisions had not yet been recorded for any MCA completed for other people who used the service. This meant that there was still a risk that people's rights under the MCA may not be protected.

Swift action was not always taken in response to known issues. The Nottingham Clinical Commissioning group (CCG) had undertaken an infection control audit on 16 November 2016 and had submitted a report to the provider detailing what action needed to be taken to improve the infection control risks in the service. Following the visit by the CCG the consultant updated their action plan stated that actions would commence with immediate effect. Despite this we found that not all of the actions had been addressed. For example the audit had identified that some areas of the service were not clean and hygienic, we found this was still the case when we visited. The audit also identified that some areas of the service were not included in cleaning schedules; during our visit we found that no action had been taken to address this.

Systems and processes in place to assess and improve the quality of the service were still not always effective in bringing about improvements. There were catering and dining audits being carried out and we saw from a recent audit that actions for improvements had been recorded. Although we saw some of these actions had been completed, such as the purchasing of new knives and chopping boards, there were others which had not. For example the audit stated that allergen information needed to be taken out of a folder and displayed in the kitchen as the assistant cook had not known about the information. We checked this and saw the information was still in the folder. The audit included the facility for scoring the quality of different areas of catering and dining, however on the audit undertaken in November the scoring had not been recorded and some areas of the audit had not been covered at all. There was also the facility to record the overall score to enable the provider to assess if the service was improving in relation to catering but this had not been completed on the audit. This was identified through the manager's monthly audit and the manager told us they had addressed this with the catering staff. However the catering audit carried out in December 2016 still did not contain the required scoring. This meant the audit was not being used as intended and was not fully robust in bringing about improvements.

Some audits had not been completed in full which meant that issues related to the safety of people's care and support had not always been identified. In order to try and improve the quality of care planning there had been an audit of care plans carried out; however the audit only covered the care plans of four people. The manager said this was because clear themes had been identified and a decision made to implement new care plans for all eight people. This meant there was a risk that individual areas of need for the remaining four people could be overlooked whilst the new care plans were being implemented and we found this had been the case for some people. For example we reviewed one person's care plan that had not been recently audited. During previous inspections we identified concerns about the management of a health condition and the quality of care planning and recording related to this for this person. During this

inspection we found that their care plan had not been updated to include information about the risk associated with their health. This ongoing lack of information placed the person at risk of their health deteriorating.

In addition to this the care plan audits were not always effective in improving the care and support people received. We saw the audit carried out on one person's care plan had identified an inconsistency with the care plan stating the person needed to sit on a pressure cushion due to the risk of developing pressure ulcers, but that staff had said the person did not sit on one. When we visited it was still unclear what was being done to manage this risk. The care plan still stated the person should be encouraged to sit on a pressure cushion but we saw the person was not sitting on one and a member of staff on duty told us they were unaware of the person having such a cushion. This inconsistency put the person at risk of developing a pressure ulcer.

Accurate, up to date records of support provided were not always kept and this put people at risk of receiving inconsistent, unsafe support. We saw records such as 24 hour monitoring records which were not being completed as intended and contained frequent gaps. In some cases these records were not dated to show which day the records had been written. We looked at medicines records and found there was an inaccurate recording. A record kept for one person showed the person had run out of one of their medicines on 31 December 2016 but their medicine administration record showed the medicine was still being administered until 6 January 2017. This lack of clarity in recording made auditing the medicines difficult and did not show a clear picture of when the medicine had run out. Furthermore, incident records were not always completed in full to show what action had been taken following the incident and on one occasion a care worker had completed the section of the record which was intended for the manager. Audits of the service were sometimes not dated or signed to provide a record of when or by whom they had been undertaken and some audits, such as the catering audits had a lack of dates for actions to be completed.

Systems and processes in place to ensure the cleaning of the service were not effective and this had not been identified in a timely manner by the management team. For example, cleaning records kept by the night staff had not been completed since November 2016 and records showed equipment such as hoists and wheelchairs, which were included on night time cleaning rotas, had not been recorded as having been cleaned since June 2016. This resulted in us finding dirty equipment such as wheelchairs and hoists. We spoke with a member of staff who informed us that, they and the manager, had picked up issues relating to this the day prior to our inspection. Given the duration that this had been an issue it should have been identified sooner. This demonstrated that governance systems were still not effective in swiftly identifying issues and did not give us confidence in the provider's auditing and quality assurance.

Given the service's history of non-compliance with legal requirements, the slow pace of improvements made and the continued issues identified in relation to quality assurance and governance we were not assured of the long-term sustainability of the improvements made or the ability of the provider to ensure consistently good practice over time.

This was an ongoing breach of Regulation 17of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager was transparent and honest with people involved in the service about the improvements which were needed. People who used the service, their relatives and staff working in the service had been informed of the issues, of inspections undertaken by external professionals and what improvements were needed. This was also shared with the staff team at regular intervals. The manger had held two staff meetings since starting work in the service. Records showed the meetings had given staff feedback on

recent inspections and the action plan that had been put into place. The manager shared details about planned improvements in relation to the environment and new systems to be followed, such as introducing person centred care plans. Staff were being encouraged to 'play a part' in making the changes and improvements. This included fulfilling their responsibilities to complete training and taking part in a new keyworker system. Staff spoke positively about the manager and felt they were doing a good job. Staff told us they felt comfortable to approach the manager felt listened to. They said this was the view of all the staff who were also happy the manager had taken on the role. A senior staff member told us, "The home has got so much better, it is more relaxed and organised." They also said that any issues that arose were "sorted out" and that they were now so much stronger as a team. Staff recognised that there was still more progress need.

People who used the service and their relatives had been given the opportunity to have a say about the quality of the service via a satisfaction survey. Records showed that the results of these were mainly positive. The manager had also provided relatives with dates for relatives' meetings for the next year and the first one was due to be held the day following our visit. One topic that had been planned for discussion was decision making and how people who may not have the capacity to make decisions should be supported to do this. The manager sent us the minutes of this meeting once it had taken place and we saw that the planned discussion about decision making had gone ahead. Relatives had been given the opportunity to have a say about the quality of the service during the meeting and the minutes showed relatives had commented favourably about the new management structure and said they felt that although there were issues with communication from staff they felt there had been improvements in the service in the last month.