Eastgate Care Ltd

Canal Vue

Inspection report

107 Awsworth Road
Ilkeston
Derbyshire
DE7 8JF

Tel: 01159791234
Website: www.eastgate-care.co.uk

Date of inspection visit:
13 March 2018

Date of publication:
27 April 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 13 March 2018. At the last inspection there were regulatory breaches in safe care and treatment, recruiting fit and proper persons and good governance. At this inspection there were still regulatory breaches in these areas and further breaches in other regulations. Following the last inspection on 8 June 2017, we asked the provider to complete an action plan in July 2017 to show what they would do and by when to improve the key questions of safe and well led to at least good. They had not met the actions on this plan and had been in breach of regulations and rated as requires improvement at the past three inspections. At this inspection the overall rating for this service is Inadequate which means it will be placed in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures

Canal Vue is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care is provided in one building across three floors. There are communal living areas and dining areas on each of the floors. The home provides accommodation and nursing care for up to 70 people who are living with dementia. There were 58 people living at the service when we visited; although two moved out on the day of inspection.

There was 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 2008 and associated Regulations about how the service is run.

We found that risk was not managed sufficiently to ensure that people were kept safe. Plans were not followed to ensure that people received safe care. Risk was not reviewed when people's needs changed to

prevent further harm; for example, from falls. When people's behaviour put themselves and others at risk of harm staff did not always respond and there was not always detailed plans to direct them how to. Medicines were not always managed and administered to ensure that people had them as prescribed. Records which were in place to support the care people received so that staff understood what they needed to do were not always up to date or clear.

Staff did not always recognise and report any suspected abuse. The provider did not always learn from when things went wrong to ensure that action was taken to avoid it happening again. They did not ensure that staff understood how to avoid further recurrence.

There were not enough staff deployed to meet people's needs and this meant that people did not always have their dignity respected. Staff did not always recognise when dignity and privacy was compromised for people living at the home. Safe recruitment procedures were not followed to ensure that staff were safe to work with people.

At the previous three inspections we have found that staff needed additional support and training in understanding the needs of people living with dementia and at this inspection we found that this had still not been provided. It meant that they did not always respond to people consistently to ensure that they reduced their distress.

Quality improvement systems were not effective in highlighting and addressing concerns. This meant that concerns around infection control, medicines management and falls were not actioned sufficiently and lessons were not learnt when things went wrong.

At the previous two inspections we found that the Mental Capacity Act 2005 (MCA) was not fully embedded and we found that this was still the case at this inspection. Some people had safeguards in place which staff were not aware of and the conditions had not been met to ensure they were legal. Safeguards had not been considered for others who required them because there were restrictions on their liberty. Therefore, people were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice

Care plans were not always up to date or regularly reviewed for people to ensure that staff had relevant information to assist them to support people. This included plans for people who were at the end of their life. Some care plans were not followed as required to ensure that people had their healthcare needs met. People were also not always supported to have enough to eat and drink. They did not always have enough stimulation and engagement in activities.

We found that the provider did not always respond to complaints in line with their procedure. They did not always respond to feedback from staff about the quality of the service. Notifications of incidents and events were not always made in line with their registration.

Families were welcomed to visit without restrictions.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.
People were not provided with safe care and treatment because risk was not fully assessed or plans were not followed. Medicines were not effectively managed to reduce the risks associated with them. People were not protected from the risk of abuse because the safeguarding systems were not thorough. There were not enough staff to meet people's needs safely and safe recruitment procedures were not followed. The risk of infection was not always adequately controlled.

Is the service effective?

Inadequate

The service was not effective.
Staff did not have the skills and training to support people effectively. When people were not able to make their own decisions this was not always assessed to ensure the decisions were made in their best interest. People's health needs were not always met and plans were not followed. People did not always receive the support to eat and drink what they needed. The environment was not always suitable to meet people's needs or not used effectively.

Is the service caring?

Requires Improvement

The service was not consistently caring.
People's dignity and privacy was not upheld. Their choices were not always respected. Families were able to visit when they wanted to.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.
People did not always receive care that met their needs and preferences. Their care records were not always up to date or accurate. There were not always enough activities provided to engage them. Complaints were not always managed to ensure that they were responded to and that people were happy with the outcome.

Is the service well-led?

Inadequate

The service was not well led.

The systems in place to monitor and drive quality improvement were not effective in implementing change. The provider had not made the required improvements since the last inspection. They did not always respond to feedback about things that needed to be improved. They did not notify us of all incidents that they are required to.

Canal Vue

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by feedback we received from others which indicated potential concerns about the management of risk and ensuring consent, as well as how complaints were managed and responded to. This inspection examined those risks.

This was an unannounced inspection which took place on 13 March 2018. It was conducted by two inspectors, an expert by experience and a specialist adviser. An inspection manager was also present for part of the inspection and for feedback meetings with the provider. The specialist adviser was a nurse with expertise in dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We received feedback from the safeguarding team and from the community healthcare team prior to the inspection to inform our plan. On this occasion we did not request a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. However, on the day of inspection we gave the provider the opportunity to share this information

We used a range of different methods to help us understand people's experiences. People who lived at the home had varying levels of communication. We spoke with seven people and also observed the interaction between people and the staff who supported them throughout the inspection visit. We also spoke with four people's relatives about their experience of the care that the people who lived at the home received.

We spoke with the registered manager, the deputy manager, two nurses, three senior care staff, five care staff and one domestic member of staff. We also spoke with four visiting health professionals. We reviewed care plans for nine people to check that they were accurate and up to date. We also looked at the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to

drive improvement. For example, we reviewed audits and quality checks for falls medicines management, fire risk assessments, health and safety checks and infection control. We also looked at four staff recruitment files and staff rotas.

During the inspection we asked the provider to send us an urgent action plan within twenty four hours in relation to specific areas of concern, which they did. After the inspection we requested further information about staff training, complaints management, people living at the home and the dependency tool used which were provided within the set timescales.

Inadequate

Is the service safe?

Our findings

At our last inspection we found that risk was not always managed to protect people from harm, and there was a breach of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection we found that improvements were still required in the areas we identified. We also found further concerns and additional improvements were required to keep people safe.

People were placed at risk of harm because the plans in place to protect them were not followed. One person had been assessed as needing to be checked every half hour so that staff could ensure that they didn't require personal care and that their pain was managed. On two occasions on the day of inspection we found them in distress and in need of personal care and support. The person had been left for over one hour longer than their planned monitoring checks. When we spoke with the registered manager about this they told us that one of the reasons for the regular checks was to reduce the risk of these situations happening. Another person had a health condition which required regular attention. They should have had dressings to their legs changed every two days. They told us that they had last had them dressed when they attended a hospital clinic four days previously. They said, "I keep having to ask for things; for example, reminding them about my dressings". We reviewed records and found that the dressings had never been changed every two days and on two occasions there had been a five days gap. This was not sufficient to maintain their health and the management of their health condition as prescribed by the specialist clinic at the hospital.

Some people behaved in a way which could cause themselves or others harm. We saw that one person was distressed on several occasions and demonstrated this by hitting a wall. Staff did not attend to this person on two occasions and we had to ask them to support them. When we asked one member of staff about this they said, "They always do that". A relative we spoke with who also observed the behaviour said, "That person does do that for quite a long time". This demonstrated to us that this behaviour was accepted and that staff did not always recognise how to support this person. Another person was upset and walking up and down the corridor wearing their coat and asking to go home. Again staff did not always interact with the person but accepted the behaviour and walked past them. This person's plan stated, 'Distract [name] before they become fixated with going home'. And 'Staff to reassure [name] at all times'. Therefore, this person's plan was not followed to ensure their anxiety and distress was reduced.

Lessons were not always learnt when things went wrong to reduce the risk of recurrence. We reviewed how many falls people had sustained and noted that there had been 31 in February 2018 and 35 falls in January 2018. There was no information about what action had been taken following the analysis of these falls. This put people at continued risk of falls. For example, one person had eight falls in January and February, one of which resulted in serious injury and hospital treatment. We observed this person attempt to stand from a chair using their walking frame to assist and support their weight and they were unsteady. We were concerned that they may fall and called staff to assist. A staff member attended and straightened the frame and then left the communal room. The person then walked across the room unsupported on their tip-toes. We reviewed their risk assessment which said that they should be supported by one member of staff when mobilising with a walking frame. This had not been followed. The risk assessment had also not been

reviewed or amended since their serious injury. When we spoke with the staff member they told us that their mobility could be impaired on some days since the injury and so they occasionally supported the person to move with a hoist. This had not been risk assessed for this person. This meant that they were at increased risk of falls because they were not supported in line with their risk assessment and their risk assessment did not reflect their current needs.

When equipment was used to reduce the risk of falls we saw this was not always used correctly. For example, another person was sitting in chair in their bedroom and we saw that they had a sensor alert mat placed near their bed, but not by the chair they were sitting in. Sensor mats are used to alert staff if people who are at risk of falls are mobile so that they can assist or observe them. We asked a member of staff if this person should have the alert mat beside them and they responded that it should and moved it into place. This showed us that the actions put in place to reduce falls were not always followed correctly and were therefore not effective.

Other risks had not been considered or followed. We saw that one person knew the code to open a locked door in a corridor so that they could get to their room. We looked at their care records and there was not a risk assessment in place for this. When we spoke with the registered manager they told us that the risk was reduced because this door had a different code to other doors in the home. We found that this was incorrect and that this code was the same for all internal doors including those to the stairs. Therefore, the risk to this person and others living on the same floor was not suitably managed to ensure that they were safe and unable to access unfamiliar areas of the building which could cause them harm.

Plans which were in place to respond to emergencies were not always accurate. One person's emergency plan stated that they could be 'assisted once standing to walk'; however, the person was now transferred using a wheelchair. Another person's emergency plan was completed in June 2015 and had not been reviewed since and their needs had changed during that time.

The systems and processes in place to manage medicines were not adequately followed and this exposed people to risk of harm. We saw some people were given their medicines and were not monitored to ensure they had taken them. For example, one person was given some medicine and we saw it fall out of their mouth onto their clothing. They found it and returned it to their mouth. There were no staff available to support them or monitor this. We checked their records and saw that they had been assessed as not having capacity to manage their own medicines. A second person was also assessed as not being able to manage their own medicines and requiring staff support. Again, we saw that their medicines were left in a pot on a table beside them and they were left to take them on their own. This was not in line with the assessed risk and meant that they may not have taken the medicines prescribed for them.

People were at increased risk of harm when medicines were administered because staff did not comply with national guidance [National Institute for Healthcare and Excellence (NICE) 'Medicines management in care homes']. We saw that the medicines cabinet was left open on three occasions while the staff member administered medicines. There were eight people in the room at the time so there was a risk that they may have accessed medicines which could cause them harm. We also saw a second staff member carry medicines for two people at the same time. This increased the risk that they may administer the wrong medicine to them.

When people were prescribed topical creams records were not maintained to evidence that they had been administered. For example, one person was assessed as being at high risk of skin damage. They were prescribed two topical medicines. One was to use 'as needed' and there was no record that this had been administered. The other was last recorded as administered over three weeks ago. We reviewed topical

medicines for a further two people and found no record of administration for them either. This meant that we could not be assured that people were receiving their prescribed medicines to reduce the risk of harm.

When people required additional medicine to assist them to reduce their anxiety there was limited guidance to explain to staff when this might be needed. Some guidance was completed but only described to administer the medicine 'when agitated' which is not enough detail to ensure that staff have a consistent approach and only administer this medicine when it is needed. Other people did not have any guidance in place.

Some of the medicine administration record instructions were handwritten and only had one signature. This is also not in line with national guidance. All of these risks showed us that medicines were not managed effectively to keep people safe.

Measures were not always taken to ensure that the risk of infection was managed and reduced. For example, at 5.00pm we saw that one person's bedding was unclean and due to the nature of this could spread infection. Also, in a communal bathroom there were toiletries and hair accessories. A member of staff told us, "We keep these here as spares in case people run out". This may increase the risk of infection if people used the same items and they were not stored securely as required.

This evidence represents an ongoing breach in Regulation 12 of the Health and Safety Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always enough staff available to meet people's needs safely. We saw that when people were distressed or required personal assistance there were not always staff in the vicinity. We had to intervene and find staff to support people on several occasions. For example, one person asked to us to find staff to change their clothing. Another person asked us to switch their light on when they were sitting in the dark. When one person was upset we asked staff to assist them. Two people stopped us in the corridor and asked us to help them to go to the toilet and we had to ask staff to support them. On another occasion one person who was sat in a communal area asked for assistance to go to the toilet. There was only one member of staff in the area monitoring fifteen people. They told the person that they could not go because they needed to wait for another member of staff. The person asked twice more and was distressed. We saw it was 10 minutes before they were assisted to go to the toilet.

One person we spoke with said, "When I need help I can never get it and I end up waiting a long time. This has led to me being incontinent. A relative we spoke with said, "I don't think there are enough staff". One health professional who was visiting a person told us, "I have requested a drink for this person and we have been waiting for 40 minutes for the staff to return".

We spoke with staff about the staffing levels and they all expressed their concerns. One staff member said, "I don't think there are enough staff and it means we can't get to people on time; for example, people are falling". When we asked this member of staff if the day of inspection was a 'usual' day they said, "No, today was quite quiet. It is often worse than this". Another member of staff said, "There are not enough staff and it means the level of care has suffered". A third staff member said, "At times we let people down with the level of care because we are so busy".

We were told that that the staffing levels had been reduced from the day before the inspection visit because some people funded by the health authority for nursing care were moving. On the morning of the inspection the numbers of people had not reduced. The registered manager told us that six people they thought would have moved had in fact been delayed and were now due to leave on the following day. This meant that the

provider had already reduced the staffing numbers before the expected people had left the service.

We reviewed the dependency tool used to plan staffing levels. We saw that it was completed on 15 February 2018 to determine the staff required to meet the needs of 58 people. It was not amended prior to reducing the staffing levels on 12 March 2018. The dependency tool stated that there should be 15 care staff on duty for 58 people and on the day of inspection there were 12 care staff to support 58 people. This is below the assessed numbers that were needed to meet people's needs safely in the dependency tool. After the inspection we asked for some more information about people who would be leaving the home. We saw that two people had already left and this meant that the number living at the home had been 60 but this was not reflected in the dependency tool. This meant that we were not confident that the provider was accurately assessing people's dependence and needs and planning staffing levels to accommodate that.

This evidence represents a breach in Regulation 18(1) of the Health and Safety Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found a breach in Regulation 19 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 because safe recruitment procedures were not always followed to ensure that staff were suitable to work with people. At this inspection this had not improved. We reviewed recruitment files and found that some staff had previous convictions. The provider had not completed a risk assessment to ensure that there were measures in place to protect people from the increased risk of harm. In addition, references were not always received from the previous employer in line with best practise guidance so that the provider could make a judgement about the character of the new employee.

This evidence represents an ongoing breach in Regulation 19 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014

People were not always protected from abuse because there was not a full understanding of safeguarding procedures. We saw incidents recorded of aggression between people who lived at the home which had not been reported as safeguarding concerns and no action had been taken to protect the people from one another. For example, one record reported one person hitting another in the face. This was not reported to managers or the safeguarding authority. Records for another person evidenced unexplained bruising and another was an altercation with another person. Again, these had not been followed up as safeguarding concerns. When we spoke with one member of staff they described other instances of people's behaviour causing harm to others. They were unclear about the records they should complete for this. We reviewed people's care plans and incident records and could not find all of these incidents recorded. They told us they would tell a senior member of staff or a nurse about their concerns but there was no record of this. They did not recognise the incidents they described as safeguarding concerns. This demonstrated to us that there may be further incidents which were not identified as safeguarding and therefore no action was taken.

Action was not always taken after safeguarding concerns were raised to ensure that the risk of recurrence was reduced. One visiting healthcare professional told us that they had raised concerns about one person's care with a senior member of staff on duty. However, on subsequent visits they had found the same concerns and we saw records that confirmed this. In addition, another member of staff told us, "We have not been told the outcomes of safeguarding investigations; we don't get a follow up from anyone or any learning from it". This demonstrated to us that the provider did not take adequate steps to protect people from potential and ongoing abuse or harm.

This evidence represents a breach in Regulation 13 of the Health and Social Care Act 2008. (Regulated

Activities) Regulations 2014.

Staff were provided with protective equipment which we saw used when they were assisting people which meant that they were meeting hygiene standards. The home had a rating of 4 from the food standards agency which demonstrated that systems were in place to manage hygiene in the kitchen and around food.

Inadequate

Is the service effective?

Our findings

At our previous two inspections we found that there was not enough training and support for staff to understand how to support people living with dementia. At each of these inspections we received assurances from the provider that the need for this training was recognised and that it was planned. At this inspection we found that this had still not taken place and we saw that staff did not always demonstrate the skills required to support people users living with dementia. For example, one person became distressed and anxious about wanting to go home and a member of staff said, "You will have to talk to your family about that". This caused more confusion for the person. Other people were confused or distressed and we heard staff give different advice and responses to them rather than a consistent approach. One relative we spoke with told us, "I don't think the staff are skilled in supporting people with dementia and they can be a bit short with people". One healthcare professional we spoke with said, "The interactions between staff and people don't demonstrate an understanding of dementia".

We spoke with staff about their understanding and the training they received. One staff member talked to us about how some people's behaviour could cause harm to them and others. They told us they had not seen any plans to help them to understand how to support people and they had not received any training in supporting people who are living with dementia. We reviewed the training matrix and saw that staff were provided with 'Dementia Awareness' training on a one day course which also included pressure care, privacy and dignity, equality and diversity and Mental Capacity Act 2005. The registered manager confirmed that there had been no recent or more detailed training in dementia care.

This evidence represents a breach in Regulation 18(2) of the Health and Safety Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 provider had not considered all restrictions for people nor applied for all necessary DoLS. For example, when we discussed whether one person required a DoLS we were told by the registered manager that they did not because they were compliant with their medicines and understood why they were living at the home. However, when we reviewed their capacity assessment it stated that they did not have the capacity to understand about the front door being locked. This demonstrated to us that the registered manager had not considered all of the reasons someone may need a DoLS and the distinction between compliance and understanding the reasons for medicines, in order to consent to them. Other

DoLS had been authorised with conditions which must be met for them to satisfy the requirements of the MCA. We found that staff and the registered manager were not aware of all of the conditions and had not met them. Furthermore, staff were not able to explain about people's capacity to make decisions nor did they know who had a DoLS authorised. There had been previous safeguarding concerns at the home which related to whether people had the capacity to consent to treatment and if they did not who could consent on their behalf. Therefore lessons had not been learnt from this to ensure that staff did not make these errors again.

This evidence represents a breach in Regulation 11 of the Health and Safety Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always have their healthcare needs met. We saw that one person had diabetes which meant that their blood needed to be tested to monitor it. There was a hospital recommendation that this should be completed four times per day. This recommendation was only met on three days out of the thirteen that we looked at. This was not in line with their care plan and put the person at significant risk of harm; particularly as on one of the three occasions it was measured the fourth reading required an intervention to manage the condition and raise the person's blood sugar.

Another person had diabetes. They told us that they wanted to lose weight and so they were not eating one of their meals each day. We saw that they did refuse a meal on the day of inspection. Records confirmed other occasions when they did not eat this meal. There was not a referral to other healthcare professionals to support them with their desired weight loss. There was no review of their diabetes management to consider the impact the alteration on their diet could have on their condition.

We spoke with some healthcare professionals about working with staff from the home to meet people's needs. One told us, "It is sometimes hard to find out what care people have received. There are often agency nurses who are not as familiar with people". Another health professional said, "The information in people's records is not detailed enough". This meant that the handover of information between staff was not always sufficient to meet people's needs.

People did not always have enough to drink. One health professional alerted us to the fact that the person they were visiting was showing signs of dehydration. They did not have any drinks in their room and the professional had needed to request some. They told us that this had previously been a concern and we looked at records and saw that they had made the same request on three previous occasions. Another person spilt their drink before having any of it. Staff took the empty cup away and cleaned the floor but did not return to bring a replacement drink.

We could not be certain that food and fluid monitoring records were reliable. We observed that one person did not drink a cup of tea. When we reviewed their records it was written that they had drank 200mls which was not correct. Following observation we saw the record of what they ate was also incorrect.

The environment in one of the dining rooms was excessively hot. The staff working in the room discussed the heat and told us it was often hot. One member of staff told us, "It is so hot on this floor; we raise it all the time". We saw that the water cooler in this room was empty meaning people couldn't independently access drinks in an environment where they may need additional fluids.

People did not always receive adequate support to eat and drink enough. We observed mealtimes and saw that some people were not supported; for example, one person slept through most of their meal without interaction from staff. Another person required support to eat and this was provided by one member of staff

who then left the person mid meal. After a break of approximately five minutes a second member of staff assisted them. This meant their meal was interrupted and the support wasn't focussed on them because they were busy completing other tasks. We saw a third person spilling a drink and food when they were having a meal without support. When one member of staff saw this they intervened, took the spoon from the person and supported them to eat. They did not consider using adapted tableware so that the person could continue to eat and drink independently.

There was a choice of meals provided for people but not how it was presented. For example, there was a meat or fish choice and the staff who were serving it added sauces and gravy without asking people if they liked or wanted it. There was no written menu and when staff were serving one dish we heard them saying that they were unsure what the dessert was but they thought it might be peach. Therefore, they were unable to tell people what it was. When people were unable to make a choice verbally about their meal they were not assisted in any other way; for example, there were no picture menus.

The environment had been designed to meet the needs of people living with dementia when it was built. However, there were several rooms which were not in use. One relative we met with in an empty communal area told us, "This is a lovely room but no-one uses it. The doors (to outside) are always locked. I suppose that would mean extra staff if they used this room. It's a shame." We saw that up to fifteen people were sat in one communal space with no spare seats in the room when other people came in. However, a second communal space was not used. One member of staff said, "We need to be able to monitor people and there is no one spare to go there". In addition another relative said, "People get confused about which room is theirs and I think it might be because the doors are all brown. They used to have people's pictures on the doors but not everyone has now". This demonstrated to us that the environment was not always adapted to meet people's needs.

Requires Improvement

Is the service caring?

Our findings

Staff did not always recognise when peoples' dignity was compromised. We found one person asleep in another person's bed. When we spoke with a member of staff about this they said that they had been told this at handover by night staff but that they didn't want to wake the person as they could become aggressive when woken. They did not recognise the privacy of the other person and their right to their own room and bedding. Another person required assistance to go to the toilet and staff were not available to attend to them. We saw that they used the en-suite facilities of one bedroom and when we did find a member of staff to assist them they confirmed that they had used someone else's facilities.

Privacy was not respected when people had treatment for their feet. We saw that fifteen people were sat in a circle in a communal area. A healthcare professional was tidying away their equipment and we asked how many people they had treated. They told us that they had completed treatment on seven of the people in the lounge. A member of staff confirmed, "Yes, they do their feet in this communal area and they put a mat down on the floor to do it".

At other times privacy was not respected when staff spoke about people in public areas where other people could hear them. For example, they discussed when people required personal care with one another in communal areas and in corridors.

The importance of people's belongings was not always considered. We heard one person ask for their handbag three times during a meal. Staff responded to them that there bag was in another room and they would get it later. They did not consider the distress this was causing to the person nor how their dementia may impair their understanding of other spaces and times. On another occasion we helped a different person find their handbag when they were distressed and staff were not available to assist them.

Consideration was not always given to people's appearance and the importance of this for their dignity. We saw that when one person spilt their drink they were left in a damp, stained top and not supported to change. Another person was wearing odd socks and no shoes.

People's choices were not always respected to promote their independence. One person told us, "I wanted to lie on my bed but I was told I can't because it's too early". When people were distressed or upset staff were not always available to attend to them in a timely manner because they were busy attending to other people or tasks.

This evidence represents a breach in Regulation 10 of the Health and Safety Care Act 2008 (Regulated Activities) Regulations 2014.

We did see some kind interaction between staff and people and some people we spoke with said they found staff approachable and helpful. One person said, "I have a good rapport with them, they're friendly, sometimes I can be cheeky with them". Another person told us, "Yes I think they're kind and caring". However, there was often not an opportunity on other floors to develop these relationships because staff

were task focussed and did not have the time to spend with people.

People's families were able to visit without restriction. One relative we spoke with told us, "I visit very regularly and am always welcomed". We saw that relatives visited when they wanted to and that arrangements were made to take people out.

Requires Improvement

Is the service responsive?

Our findings

Complaints were not always managed and responded to thoroughly to ensure that lessons were learnt and that complainants were satisfied with the outcome. On the day of our inspection we saw that a family had put a notice on their relative's door to ask about missing items. We spoke with the family and they told us it was the second time that the items had been lost and replaced and they were concerned for their relative's wellbeing without them. They had raised these concerns with staff. When we spoke with the registered manager they told us they were not aware of this situation and it had not been reported to them as a complaint. This demonstrated to us that staff had not recognised and reported the concerns as a complaint and they were therefore not reviewed under the procedure. We reviewed complaints records on the day of inspection. We saw that one complaint had been received had not been investigated nor responded to.

We were contacted by some people's families about other complaints prior to our inspection. On the day of our inspection we were unable to fully review the provider's response to these complaints because the information was no longer kept at the home. We were forwarded the records of one after the inspection visit. We found that these complaints were not always fully reviewed nor responded to. Furthermore, additional concerns and complaints we were aware of had not been recorded under the complaints procedure so we could not consider the provider's response to these.

This evidence represents a breach in Regulation 16 of the Health and Safety Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always receive care that met their needs and preferences. When people were reaching the end of their life their care plans were not updated to reflect this. Staff told us how one person's health had been deteriorating over several months. We reviewed records and saw that they lost 11% of their body weight in one month and the staff member confirmed that they had reduced appetite. However, their care plan had remained the same and had not been updated to reflect their changing condition. They had been prescribed pain relief which would need to be administered by community district nurses. When we asked the staff member how they would monitor the person's pain they said, "We have Abbey Pain Scale, but are not using it". This meant that we were not assured that this person would receive their pain relief at the end of their life when they needed it. A second person was also identified to us as being considered to be near end of life and again their care plan had not been reviewed to reflect this. This demonstrated to us that the provider had not put care plans in place to monitor and respond to people's needs, particularly as they may not be able to communicate and may need to have rapid access to support if their condition changed.

Staff did not always know people well or what their needs were. We asked one member of staff what someone's name was and they were unable to tell us. Another member of staff took someone to the wrong room and said that they had made the mistake because the person had moved rooms. We later confirmed that the person had not changed rooms. We spoke with one person who told us that they liked to sit in their room and watch the birds because this had always been their hobby. When we asked staff what this person liked to do they did not know this and said that they sat staring out of their window. We went past another person who was in bed who called us to ask for assistance. We saw that the buzzer to call staff had been left

beyond their reach. We intervened and asked staff to meet the person's needs and move the buzzer to enable the person to be able to access it if they required further support.

Information available to guide staff in care plans was unclear and not accurate. For example, one person had a care plan which was written over one year earlier which stated they could do some of their own health management independently which was no longer the case. Another person had a care plan which ticked that they were 'low in mood' and 'happy and sociable'; so it would be difficult for staff to know how they were. A third person had previous pressure damage to their skin recorded but did not have any monitoring of their skin in place. One member of staff commented, "Some care plans have not been updated for six months. We have been trying to work on them and get them up to date in the past few months".

Records which were maintained were not always accurate or reliable. When we attended one person we saw that their daily records had not been completed for the last two allocated times. However, when we went back to the person later the records had been retrospectively completed. This meant we could not always be sure the daily records had been completed inaccurately.

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

People did not always have enough encouragement and interaction to engage in activities. There was an activities co-ordinator and people we spoke with told us that they enjoyed the activities they provided and that they were responsive to new ideas. However, on other floors people had less engagement and spent the majority of the day sat in communal areas or walking in corridors. For example, in one communal lounge people up to fifteen people were sat in a circle with a television on. At least five of these people would be unable to see it from where they were sat. Most of the rest did not seem to be engaged in watching it and either slept or sat passively in a chair. Staff had little time to speak with people on a one to one basis or engage them in individual activity.

Inadequate

Is the service well-led?

Our findings

At our last inspection we saw that the systems in place to measure and drive improvement were not fully effective and required improvement. At this inspection we found that the governance systems for assessing and monitoring the service were ineffective. We looked at completed audits and found that when areas were identified for improvement there was no action recorded to demonstrate that improvements had been made. For example, in infection control it was recorded that commodes were not free from rust. There was no plan or action recorded from this. When medicines stock were reviewed there were errors; for example for one person there were an incorrect number of medicines noted. However, no action was recorded. This did not assure us that people had received all of their medicines as prescribed because there were two additional tablets which had been recorded as administered. The governance of medicines did not ensure that people received safe care and treatment. There was no oversight of these audits by the provider to ensure that the noted discrepancies were actioned.

On the day of our inspection we raised the seriousness of our concerns with the provider and asked them to provide us with an urgent action plan within twenty four hours to assure us how they would meet specific people's needs. The action plan we received did not give us any assurances that the needs of these people could be met. In particular, it did not consider staffing levels, staff training and competencies, the safe delivery of peoples' care and treatment, management oversight, risk assessments, and reviewing peoples' needs and care plans.

After the last inspection in 8 June 2017 we asked the provider to send us an action plan which detailed how they would make improvements. At this inspection we found that they had not implemented the actions as stated. For example, the provider stated that all care plans and risk assessments had been updated and would be regularly audited. They remain in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and this is the third time in four inspections that the provider's recruitment procedures have not been sufficient. In addition, we found that the provider had not sustained improvements noted at the last inspection and we have renewed concerns around staffing levels and safeguarding.

When we spoke with staff they told us that they found the registered manager supportive. However, they also told us that they had raised concerns or asked for support and no action had been taken. For example, one staff member told us that they had requested additional training in dementia which had not been provided. Another staff member said that they had raised concerns about staffing levels and asked for people's dependency to be reviewed and this had not been actioned. A third member of staff told us that there was little or no learning given to staff as a consequence of safeguarding investigations. This demonstrated to us that the provider did not always listen and respond to feedback.

The overall rating for this service is Inadequate. Providers should be aiming to achieve and sustain a rating of 'Good' or 'Outstanding'. Good care is the minimum that people receiving services should expect and deserve to receive. The service has been rated as 'Inadequate' or 'Requires Improvement' on four consecutive inspections.

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

The provider had not informed us of all the incidents that they are required to under their registration with us. We found that there were two serious injuries to people which resulted in hospital treatment which we had not been notified of. In addition we had not been notified of all of the safeguarding concerns which the provider was aware had been raised. This meant that we would not be able to monitor and review the provider's response to such incidents.

This evidence represents a breach of regulation 18 of the Registration regulations (2009)

The provider had regular meetings with people and their relatives and we had mixed feedback about them. One person said that they enjoyed attending and felt able to give feedback. However, one relative said they did not always find them informative. People and relatives told us that they knew the registered manager and found them approachable.

There was a mixed response from other agencies about partnership work with the home. We had some feedback prior to the inspection visit which stated that communication and handover had improved. However, when we spoke with visiting professionals on the day of inspection they expressed frustration with staffing levels and finding information out about people. This demonstrated to us that there was not a consistent approach to effectively working in partnership with others.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed this in the home and on their website.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents Did not receive notifications for all instances that are required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of people was not always appropriate, met their needs or reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always provided with the consent of the relevant person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The systems and processes established to

protect people from harm were not effectively operated to keep them safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not always fully investigated nor proportionate action taken in response to any identified failures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not ensure that fit and proper persons were employed to support people living at the home.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People did not receive safe care and treatment which protected them from harm

The enforcement action we took:

We imposed urgent conditions that the provider must not admit any new without prior written agreement of the CQC. They must also report to the CQC weekly with assurance about staffing levels and their competence.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The systems and processes in place to ensure good governance were not sufficient or operated effectively.

The enforcement action we took:

We imposed urgent conditions that the provider must not admit any new without prior written agreement of the CQC. They must also report to the CQC weekly with assurance about staffing levels and their competence.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	The provider did not ensure that there were sufficient numbers of suitably qualified staff available to meet people's needs.

The enforcement action we took:

We imposed urgent conditions that the provider must not admit any new without prior written agreement of the CQC. They must also report to the CQC weekly with assurance about staffing levels and their competence.