Rosemere Care Home Ltd

St Claire's Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

St Claire's Care Home provides care and support for up to 39 older people. There were 24 people living at the service at the time of our inspection. People cared for were all older people; most of whom were living with dementia and some who could show behaviours which may challenge others. People were living with a range of care needs. Some people needed support with all of their personal care and some with eating, drinking and their mobility needs. Other people were more independent and needed less support from staff.

St Claire's Care Home is a large house, previously arranged as three attached houses, now converted to a single property. People's bedrooms were provided over four floors, with a passenger lift providing stair free access. There were communal sitting rooms and a communal dining area. There was an enclosed area of garden at the front of the property.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We carried out an unannounced comprehensive inspection of this service on 27, 28 and 31 October 2016 and St Claire's was rated 'Requires Improvement' and 'Inadequate' in the 'Safe' domain. There were breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. We issued requirement notices relating to safe care and treatment, staffing, need for consent, premises and equipment, person centred care and good governance. We asked the provider to take action and the provider sent us an action plan. The provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. We undertook this inspection to check that they had followed their plan and to confirm that they now met legal requirements. The provider had not met the previous breaches of regulations and further breaches were found.

Risks relating to people's care and support were not always assessed or mitigated. Staff told us and we observed that some people could become distressed and display behaviours that challenged. This was not always documented and there was no guidance for staff on how to prevent this from happening. Accidents and incidents were not investigated or analysed to look at ways of reducing the risk of them happening again.

The environment was not always safe. At our previous inspection we asked the provider to make improvements to the physical appearance of the service and although work had started, it had not been completed. There was no action plan or schedule of works to show how or when the improvements would be finished. A fire safety assessment had identified that the external fire escape was unsafe but this work had not been prioritised. The service smelt of cat urine. Professionals told us they had raised this with the registered manager before our inspection, but no action had been taken to improve the odour.

Staff did not know how to recognise and respond to abuse. Staff had documented that people had unexplained bruising and skin tears and although the registered manager told us they had, 'checked these out' there were no records of these checks. People were unable to confirm these checks had taken place, as they were living with dementia.

People told us that staff were kind and caring, but that they had to wait to receive support. Staff had not been deployed effectively and people were left waiting at lunchtime. They did not always receive the assistance they needed to eat effectively. There was a task led culture within the service. Staff were busy and did not have time to deliver person-centred care.

There were no dementia specific activities and people told us that they were bored. People who were unable to leave the service without staff assistance told us they missed going out and were not supported to go to church or practice their faith.

Staff had met with their line manager to discuss their practice and received some basic training. However, there was no training in topics specific to people's needs such as epilepsy or skin care. There was a lack of guidance for staff on how to support people with their health care conditions and when to seek medical assistance. People were at risk of receiving inconsistent care.

The provider and registered manager did not have oversight of the service. They had sent us an action plan following our last inspection and this had not been adhered to. The provider did not carry out regular audits or checks to ensure the service was being run safely. The registered manager told us they had stopped checking and sampling people's care plans because they, 'knew they needed to be updated.' People, their relatives and other stakeholders had not been asked their views on the service since our last inspection.

People's relatives spoke positively about the care people received and said they were always made to feel welcome at the service. The registered manager greeted relatives warmly and everyone told us they were a visible presence within the service. There had been no complaints since our last inspection.

Medicines were now managed safely. There were appropriate arrangements in place for the ordering, storing, administering and disposal of all medicines.

The registered manager had notified us of important events that had happened within the service and staff were recruited safely.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. These safeguards protect the rights of people using services by ensuring that if there were any restrictions to their freedom and liberty, these had been agreed by the local authority as being required to protect the person from harm. The registered manager had applied for DoLS when necessary. People were supported to make day to day choices about their lives, such as what they ate and where they spent their time.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant

improvements within this timeframe.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks relating to people's care and support had not been assessed or mitigated.

The environment was in need of repair and there was no plan in place to prioritise what work needed to be completed.

Staff did not know how to recognise or respond to abuse.

Staff were not always deployed effectively and people had to wait to receive support. Checks were carried out on staff before they started work.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not received training in topics relating to people's needs.

People did not always receive the support they needed to eat effectively.

Staff had made referrals to health care professionals but their advice had not been documented.

People were supported to make decisions about their lives. Any restrictions had been imposed lawfully, and the registered manager had applied for Deprivation of Liberty Safeguards.

Is the service caring?

Inadequate

The service was not caring.

People told us that staff were kind and caring, but they were lonely as staff were too busy to spend time with them.

The provider and registered manager had shown a lack of

respect for people in failing to address the issues we highlighted at our previous inspection.

People's relatives had been consulted on changes made to people's care and support.

Is the service responsive?

Inadequate

The service was not responsive.

People told us they were bored and there was a lack of activities to keep them engaged.

Care plans lacked the level of detail to ensure people received consistent support.

There had been no complaints since our last inspection.

Is the service well-led?

Inadequate

The service was not well-led.

The provider and registered manager did not have oversight of the service. They had not completed checks or identified the issues we highlighted at this inspection.

The provider and registered manager had not complied with requirement notices issued at our last inspection and there were continued breaches of the regulations.

People, their relatives and other stakeholders had not been asked their views on the service since our last inspection.

Staff focused on tasks that needed to be completed, rather than on people.

The registered manager had notified CQC of important events that had happened within the service.

St Claire's Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This inspection took place on 30 August 2017 and was unannounced. The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection we looked at previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with 12 people using the service, two relatives, the provider, the registered manager, a team leader and four members of staff. We observed staff carrying out their duties, communicating and interacting with people. Some people were unable to tell us about their experience of care at the service so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at seven people's care plans and the associated risk assessments and guidance. We looked at a range of other records including three staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance surveys and audits.

After the inspection we spoke with the local safeguarding and commissioning teams to share our concerns.

We last inspected St Claire's Care Home in October 2016 when six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. At this inspection we found that the provider and registered manager had not made the necessary improvements and there five continued breaches and

two new breaches of the regulations.

Inadequate

Is the service safe?

Our findings

People said they felt safe living at the service. One person told us, "The girls all know what they are doing and are more than helpful. [Staff member] will go out of her way to help and reassure me when I am worried and in a dither and really takes their time as I can panic." Another person said, "I am safe here, I don't have any worries" A third told us, "Yes we always feel safe, I just have to press the red button and someone comes."

Although people told us they felt safe we found concerns regarding risk management and the environment, which meant that people were not as safe as they should be.

At our previous inspection people were at risk of unsafe care and treatment because risk assessments did not always record sufficient measures required to keep people safe. People had fallen and action had not been taken to reduce the risk of this happening again. There was little use of assistive technology such as bed, chair or floor pressure monitors which may have alerted staff to the unsupported movement of people. Accidents and incidents were not investigated or reviewed to ensure necessary changes were made to people's support.

At this inspection one person's care plan had been reviewed and re-written, however, no action had been taken to ensure staff had the guidance necessary to support the other 22 people living at the service. People were still falling and there was still a lack of guidance for staff to follow to ensure people were supported effectively to reduce the risk of them falling again.

There had been occasions when people displayed behaviours that may challenge. There was a risk that they may hurt themselves or other people. There were no step by step guidelines in place to explain to staff how to support people in a way that suited them best. There was a risk that staff would be inconsistent in their approach and the risk would not be reduced.

Throughout the inspection we observed one person becoming distressed. They were shouting at staff and batting their hands away when staff were trying to assist them. Staff told us this person regularly became distressed and disliked being assisted with their personal care. One member of staff told us, "I have never known anything like it. [The person] will throw us around and hit us. I am sure it doesn't say that in [the person's] care plan. I used to write details in their daily notes, but now I don't, I think they just think that is who they are." The person's care plan did not contain any information on how to support them with their behaviour or how to reduce the risk of physical aggression towards staff. We reviewed the person's daily notes and there was no mention of the distress or aggression that we had witnessed. Without accurate records of incidents they could not be collated or analysed to identify why they had occurred and if anything could be changed to prevent them from happening again.

Staff had documented that they had caused a 'skin tear' on another person when assisting them with personal care as the person had, 'fought back.' The registered manager had not reviewed or analysed this incident. We discussed the incident with the registered manager and they told us that the person could

regularly 'tense' during personal care, and they believed the skin tear would have been an unavoidable accident. Staff confirmed that the person could sometimes 'stiffen' when they were assisting them. Although this was a known risk when assisting the person it had not been assessed and there was no guidance for staff on how to minimise the risk of them causing another injury to the person.

The provider and registered manager had failed to ensure that risks relating to people's care and support had been assessed and mitigated. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager showed us their 'compliance tracker' spreadsheet. This listed key environmental safety checks, such as emergency lighting and smoke alarms. There was a record of the frequency at which the checks should be conducted, the dates serviced or inspected and whether or not it was 'in compliance as of 17/08/2017'. The information shown was not accurate or sufficient. For example, the fire risk assessment carried out in December 2016 was highlighted green to denote compliance. However, the report identified a large number of shortfalls some of which had not been addressed. This included, '1st floor fire escape stairs. Hazard: Stairs are too slippery to use' and 'Rear fire escape. Hazard: Stairs are too slippery and dangerous to use'.

Another report dated 12 July 2017 had been produced following an inspection of the ground floor external fire escape. This noted concerns of 'significant corrosion' and 'surface rust'. There was a risk that people and staff may not be able to leave the building safely in the event of an emergency. We raised these concerns with the fire office after the inspection.

There was a lack of infection prevention and control measures. There was a strong smell of cat urine throughout the service. The new toilet in the basement had no soap, paper towels or bin in it. The second communal toilet in the basement did not contain paper towels. The communal bathroom in the basement also had no paper towels. The bath was cracked making it prone to trapping dirt. The clinical waste bin was full and there was a strong smell of faeces. Poor hygiene and infection control not only places people at risk but did not make some parts of the service a pleasant place to be We raised this with the registered manager and they immediately made staff empty the clinical bin.

The provider and registered manager had failed to ensure the environment was safe. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in October 2016 water temperatures were not safely regulated and arrangements were not in place to safeguard against the risks of Legionella. Safety testing of portable electrical appliances (PAT) had also lapsed. At this inspection water temperatures had been taken regularly to make sure the water was at a safe temperature. The thermostatic water mixer vales had been checked to ensure they were working correctly. In addition to the annual Legionella test two further independent surveys had been completed and corrective action taken to mitigate the risk of Legionella. PAT testing had now been completed. Safety checks on equipment and the environment including gas safety, emergency lighting, lifts, hoists and the bath hoist had been completed.

At the last inspection in October 2016 the provider had not ensured the premises were properly maintained. Decoration through most communal areas required attention, walls on the top floor were water stained or bare plaster following a water leak and corridors, particularly on the ground floor required decoration as most painted woodwork was chipped and exposed bare wood. We asked the provider to take action. The provider sent the Care Quality Commission an action plan; however this did not address all of the shortfalls that were identified. At this inspection a small number of improvements had been made, however we still

found areas where the premises were not properly maintained.

Since the last inspection in October 2016 new carpets had been purchased and fitted to the basement corridors and the toilet and dining room had been renovated. The kitchen had been refurbished and was awaiting installation of a cooker hood before it was functional. A 'make shift kitchen' was being used as a short term interim measure.

Work had started on the ground floor, however this had stopped at the time of the inspection. Staff told us there was only one maintenance person and they worked across the three services owned by the provider. Two people's rooms had recently been flooded and the maintenance person was working on these as a priority so that people could move back into them. The ground floor remained as we found it at the previous inspection with chipped paint and exposed woodwork, paper peeling and in a general state of disrepair.

The action plan sent to CQC by the provider noted 'The maintenance plan has been reviewed and updated'. We asked to see this. There were two maintenance plans one of which had been provided to the local authority. Neither of these were dated and neither showed what action needed to be done, who would carry out the work and when it would be completed. The provider agreed they needed to have a more robust, comprehensive, working document to monitor the maintenance work that needed to be done.

Maintenance had still not kept pace with the rate of wear. When carried out, maintenance was still completed reactively with little evidence of forward planning. The provider had not ensured the premises were properly maintained. This was a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection there were no systems in place to assess the number of staff necessary to provide support. There was no post for a deputy manager or administration support, although historically there had been. Staff identified that there were busy times during the day when people required additional support and at times people had to wait.

At this inspection the registered manager used a dependency tool to calculate the minimum number of care hours required and to inform their decision on how many staff were needed to keep people safe and meet their needs. The most recent calculation dated 9 August 2017 identified 12 people having a high level of dependency, five having a medium level and six were classed by the registered manager as low level.

During the day three staff were deployed on the ground floor and one on the first floor. The registered manager told us that when needed staff supported each other. There were four care staff on duty during the day and three at night. In addition there was a cook, a kitchen assistant and a person completing laundry tasks. There was still no deputy manager or administrative support. We asked the registered manager how many people needed the support of two staff to help them move safely and they told us, "Roughly ten people". When two staff were supporting one person with their mobility or personal care needs this left only two staff to observe, care for and support 22 people who lived over three floors.

We observed and people told us they sometimes had to wait to receive support. One person told us, "Usually help will come quickly but sometimes in the day they are slow, usually at meal times really, so I suppose that is to be expected." Another said, "The staff sometimes come quickly but they can take their time if they are tending to someone else." A third person told us, "No one can really spare the time for a chat, this is the longest chat I have been able to have for days, can you stay longer?"

Some people required support from staff to help them eat their meals and staff provided this support.

However, we observed people struggling to eat their meal without support of staff. There was not enough staff deployed to give people their meals at the same time and to provide people with the support they needed in a timely manner.

The provider and registered manager had not ensured there were sufficient numbers of staff deployed. This was a continued breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not know how to recognise and respond to abuse. Although staff had received safeguarding training they were unable to tell us what they would do if they had safeguarding concerns. We spoke with the four staff on shift on the day of the inspection. Three of the four staff were unclear about what process they should follow if they witnessed or suspected abuse. Staff appeared confused and initially did not even say they would report their concerns to a senior member of staff. After much prompting they agreed they should inform their senior or a manager. However, three of the four were unable to tell us where they should go outside of the service if they suspected abuse and were concerned that action was not being taken. One member of staff told us, "I do not know where to go outside [of the service.]" We told another staff member that they should report safeguarding concerns to the local authority safeguarding team or whistleblow to the Care Quality Commission and they said, "I did not know that."

Staff documented when they found unexplained skin tears or bruising on a body map. We saw multiple body maps where people had sustained injuries and the cause was unknown. We discussed this with the registered manager and they told us they had, 'looked into' each of these injuries and 'checked people' when these had been reported to them. These checks had not been recorded anywhere and people were unable to confirm if they had occurred. We informed the local authority of these concerns after the inspection.

The registered manager and provider had not protected people from the risk of harm and abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection medicines were not managed safely. People did not always receive their medicines as prescribed. Staff did not document where they applied people's medicine patches and did not always document when they applied people's prescribed creams. Action had not been taken when medicines were stored at an unsafe temperature and staff had not always documented when they had opened liquid medicines. At this inspection, improvements had been made.

People told us they received their medicines safely. One person told us, "My medicine is brought to me to take." Another person said, "We don't keep any medicines in our room but then I feel safer knowing that it is all organised for me." There were appropriate arrangements in place for obtaining, recording, administering and disposing of prescribed medicines. Staff were trained in how to manage medicines safely and were observed by senior staff a number of times administering medicines before being signed off as competent. Medication Administration Records (MARs) were fully completed, showing people received their medicines as and when they needed it. Staff documented where the applied people's medicine patches to ensure the site of application was rotated regularly to protect skin integrity. Staff documented where and when they applied people's prescribed creams.

Some people had medicines on an as and when basis (PRN) for pain relief. There was clear guidance in place so staff knew when people might need these medicines and how much they should take. Staff dated creams and liquids when opening so they knew how long they had been in use and if they were still safe for people to have. Staff took fridge and room temperatures and action was taken if they were outside of a safe

temperature.

We checked three staff files to make sure proper pre-employment enquiries had been carried out. Recruitment checks were completed to make sure staff were honest, reliable and trustworthy to work with people. Information had been requested about staff's employment history and any gaps in people's employment were discussed at interview. Two references were obtained, including from the last employer and proof of identity was provided. Disclosure and Barring Service (DBS) criminal record checks were completed for all staff before they began working at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff files included checks to make sure the staff had the right to work in the UK. Staff files were kept securely in a locked office.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in October 2016 the provider had not ensured staff received appropriate induction training. The provider had also not ensured staff received appropriate and effective supervision to meet the requirements of their policy. We asked the provider to take action. The provider sent the Care Quality Commission an action plan. At this inspection a number of improvements had been made. However, there was still a continued breach of a regulation.

Staff completed an induction when they started working at the service. New staff were working on the Care Certificate, an identified set of standards that social care workers adhere to in their daily working life. They shadowed experienced staff to get to know people, their routines and their preferences.

Staff told us they had completed training. The providers and registered manager had not checked staff understanding of the content of the training. We asked staff what they would do if they saw abuse take place and who they would report it to. Three of four staff we asked were not able to tell us who they should contact.

The registered manager had recorded on the training schedule that 9 out of the 18 care staff had not completed training about the Mental Capacity Act. They had also recorded that not all kitchen and domestic staff had completed training about safeguarding people and three care staff were overdue with their refresher training for this. Six care staff had completed training to inform them about diabetes. There was no training about other health risks such as epilepsy or pressure areas. The registered manager and maintenance person's training had not been recorded at all. Most staff had completed training about supporting people living with dementia.

The registered manager told us that the dementia training covered behaviour that could be challenging, however, we observed incidents where people became distressed and staff did not record this. Staff lacked insight in how to respond and prevent incidents such as this.

The providers visited the service to carry out 'sit and see' observations of staff. They checked staff engagement and interactions with people to make sure people were being treated with kindness and compassion. Although these observations had been completed they had not picked up on the lack of interactions we observed. We observed that staff were busy but moved people safely and reassured them when they became distressed. They did not have time to engage fully with people.

The provider and registered manager had not ensured staff had received training in topics specific to people's needs. This was a continued breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt supported by the registered manager. Staff said they met with the registered manager for one to one supervision meetings. Records showed these were being completed and the registered manager told us they were continuing to increase these in line with the provider's policy of every eight

weeks.

The registered manager carried out 'spot checks' to check the competency of night staff. This time was also used to meet staff on a one to one basis to review their work, agree future targets and discuss any training, support and personal development needs.

People told us they regularly saw health care professionals. They said, "The district nurse comes round and the doctor too and if the dentist is needed they come to us." "Yes a doctor can be called whenever they are needed or a nurse." And, "They [staff] will ring my GP for me if needed and I sometimes go to the surgery to pick up my prescription because I can walk there." Staff had taken action and sought advice from healthcare professionals when people were losing weight.

Although people had access to health care professionals staff did not have the guidance necessary to support people with their health care conditions. Some people were living with unstable health care conditions such as epilepsy, and regularly experienced seizures. There was no information in people's care plans regarding the support they needed to manage their epilepsy effectively. There was no guidance regarding what a person's seizure may look like or what action staff should take. Some members of staff were able to tell us what a person's seizure may look like and when they should call for medical assistance, however, others could not. Staff had not received training in epilepsy, meaning this risk was further increased.

The provider and registered manager had failed to ensure staff had the necessary skills and guidance in place to support people with their healthcare conditions. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoke positively about the food they were offered. One person told us, "The food is good and we can ask for something different and it will be made for us." Another person said, "The food is very good."

The registered manager told us that only one person used the dining room for their meals. During the inspection staff did not offer people the choice of where they would like to eat and if they would prefer to eat together in the dining room. Meals were given to people in the communal lounges or in their bedrooms.

Some people needed assistance to eat their meals. Whilst staff were providing this support other people's meals stayed on a trolley with a metal cover over the individual plates. They were not kept on a hot plate to make sure they stayed warm. One member of staff told us, "They [people] sometimes have their meals going cold. There is not a heated trolley."

People were not always given the assistance or equipment to be able to eat their meals effectively. At lunch time one person was given their food on plate. This food had been pureed. The person was unable to get the food from their plate into their mouth and the majority landed on their knee or on the table. Staff did not assist the person at any time. We discussed this with the registered manager and no consideration had been given to providing this person with a plate guard or independence aid, to enable them to eat their meal with ease.

The provider and registered manager had failed to ensure people were able to receive food in a way that met their individual preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

At our previous inspection, the provider and registered manager had not applied for DoLS for everyone whose liberty was restricted and who could weigh up and agree to the restriction. The registered manager had now applied for DoLS for everyone who lacked capacity to consent to restrictions. Some DoLS had been authorised and any conditions on these DoLS had been adhered to.

The registered manager had assessed people's capacity to make a variety of decisions, including if they were able to consent to care and for staff to hold people's medicines. People were able to make day to day choices about what they wanted to eat and wear. Staff asked people what they would like to drink. One member of staff told us, "For the ones that can I ask people what they want, and listen to their answer. But we can also tell by people's facial expression. I still give people a choice even if they can't speak and tell me what they want." Mental capacity training had been booked for all staff after the inspection.

Inadequate

Is the service caring?

Our findings

At our previous inspection we described care as 'functional.' Staff comforted people who were calling out or distressed and provided personal care as needed, however, staff rarely had time to meaningfully engage with people outside of the functions of care delivery. We identified this as an area for improvement. At this inspection we found no improvements. People told us that staff were kind and caring but did not always have the time to stop and talk with them. Comments included, "There is no one to talk to, I do get so lonely, so very lonely." "The staff are really very good but are always in a rush and don't have time to sit and chat." And, "There is no one to talk to, that is the worst part of getting old."

People also told us that they were bored and the lack of interactions impacted on their emotional well-being. One person said, "They are all very kind here and friendly too but I wish I could just escape sometimes and have a bit of chat and a life. I sometimes just feel I am waiting to die but then I wake up again and again and I am still here." Another person said, "The staff are so kind and will be friendly but it is not like they can take the time to have an intelligent chat like we are." Some people were unable to tell us about their experiences but we observed people being left for extended periods of time without any interaction. Staff did stop and speak with people when they called out or appeared distressed.

The service was dirty and smelt of cat urine. Professionals told us that they had raised the issue of the bad smell with the registered manager before our inspection, but nothing had been done to improve the environment for people. The local authority safeguarding team visited the service after our inspection and found that the smell still remained. This lack of action, and the fact that the provider and registered manager had not acted on the concerns raised at our last inspection regarding the environment indicated that people were not always treated with respect.

People's bedrooms were clean and tidy and people were able to bring photographs and belongings with them from home. However, people told us they were not always happy with the décor of their rooms. One person told us, "The decoration is all decided before we move in and it doesn't look that cheerful does it?" The provider's handyman was in the process of fixing some people's rooms after they had been damaged by a flood.

People told us they were encouraged to be as independent as possible. One person told us, "I do all my own personal care but if I need help it is always possible to ask." However, due to the lack of staff people were sometimes left in an undignified manner when they were unable to independently clean or wipe their faces. We observed some people being left with food and saliva on their chins.

The provider and registered manager had failed to ensure people received care that was personalised and reflected their needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives we spoke with were positive about the care that people received. They told us they were always made to feel welcome and were kept informed about any changes to their loved ones care. One relative

said, "We can come and see [our loved one] whenever we want. There aren't any restrictions."

People and their relatives were involved in planning their care. People told us they had been asked about the care and support they required. One person said, "Yes we discuss what care I need but my daughters can deal with that I don't need to be involved" Another person told us, "I do discuss my care but nothing needs to get changed."

Some information was displayed in an easy to understand format, so people were able to make choices about their lives. Staff showed us pictures of home cooked meals that were provided at the service. People were shown these pictures when deciding what they wanted to eat each day.

People's privacy was respected. We observed staff knocking on people's doors before entering. When we asked staff questions they answered in a quiet voice or shut the door to ensure other people were unable to hear what was being discussed.

Inadequate

Is the service responsive?

Our findings

At our previous inspection there was a lack of activities specifically for people living with dementia. At this inspection, people told us that they were bored and there was a lack of activities to keep them engaged. People said, "There is nothing to do day in day out." "I would love to get out and about but I can't on my own so it has become impossible and I am basically trapped. It is no one's fault but that is my life." "I get up I the morning and wait to go to bed in the evening. Nothing in between."

Some people were able to leave the service independently. One person visited the pub regularly with their family and another person visited a local day centre. However, people who required assistance to leave the service were unable to go out when they wanted. One person told us, "I don't get out and no one takes me out either." Another person said, "We can't go out as there is no one to take us." And, "We don't get out because it is impossible on our own."

The provider and registered manager had not employed an activities co-ordinator and no one had responsibility for activities. There was a board in the lounge where the activities that were meant to be happening each day was displayed. Although 'arts and crafts' was written on this board for the day of the inspection people were not consistently engaged in activities.During the morning of the inspection someone visited the service to give people a hand massage. For the rest of the inspection people remained sitting in their chairs with little or no meaningful interaction from staff. There were no activities taking place except for a member of staff colouring in at a table with one person. Most people sat in the lounges and dozed on and off in their chairs for the duration of our visit. One person told us, "I am not sure if anything does get planned, does it? I don't see much of it if it does."

Relatives told us that they enjoyed attending events at the service. One person told us, "They do sometimes throw a party for a special occasion and then it can liven up a bit."

No one had moved into the service since our last inspection. Previously we identified that people's care plans did not contain the necessary detail to ensure people received consistent support. At this inspection one person's care plan had been reviewed and re-written, however, no action had been taken to ensure staff had the guidance necessary to support the other 22 people living at the service.

Care plans were not personalised with detailed information about people's personal care routines or how they needed assistance to move. When people had been assessed as requiring the use of equipment such as a hoist and were unable to weight bare there were no step by step instructions to guide staff on what to do. Some people were living with dementia and were unable to tell staff their routines or how they preferred to be assisted. This placed people at risk of not receiving consistent care.

People's care plans did not contain information regarding their hobbies and interests. One person told us that attending church was important to them, but there was no provision to ensure they were able to continue to practice their faith. They said, "I used to go to church but there is none of that anymore." The provider told us that they had arranged for a vicar to visit someone on end of life care. The registered

manager acknowledged that work needed to be done to ensure guidance for staff was more person centred and people's preferences were reflected within it.

The provider and registered manager had failed to ensure that people received care that met their assessed needs and preferences. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a complaints policy in place and there had been no complaints since our last inspection. The policy was not displayed in a format that was easy to understand for people. This was an area for improvement. Relatives we spoke to were positive about people's care and support, even though we identified concerns. One person said, "I really wouldn't think anyone would be afraid to ask anything of the staff they are always there for us."

Inadequate

Is the service well-led?

Our findings

People told us that they liked the registered manager and they were a visible presence within the service. Comments included, "One hundred percent, [the registered manager] is my friend not just in charge. She is a diamond." "She is not just the boss but she is our friend." "She will always help if she can and I would say she usually can." "She is interested in us and I would say she is interested in what we want."

Although people and their relatives were positive about the registered manager we found continued shortfalls in the way the service was run and serious concerns regarding risk management, the environment and staff understanding of safeguarding.

We last inspected St Claire's Care Home in October 2016 when six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. We identified breaches relating to safe care and treatment, premises and equipment, staffing, person-centred care, good governance and need for consent. We asked the provider to take action and the provider sent us an action plan. The provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. The action plan stated that the service would be compliant by May 2017. At this inspection, we found five continued breaches of the regulations and two new breaches of the regulations. The provider had not complied with their action plan.

The provider and registered manager had failed to identify the shortfalls at the service and rectify them through regular, effective auditing. At this inspection no improvements had been made regarding the governance and oversight of the service

The provider had not implemented agreed actions from the action plan they submitted to CQC, telling us how they would become compliant with the regulations. They had told us, 'Providers audit will be devised and implemented by 31st May 2017.' Although the provider visited the service regularly, they did not complete any audits or checks when they were present. They had no form of formal oversight over the service.

The registered manager ensured checks were completed on some key things, such as, fire safety equipment, hot water temperatures and medicines. However, the provider did not take prompt action to resolve concerns that were identified. When shortfalls were identified these had not all been addressed and action had not been taken. Some concerns had repeatedly been brought to the provider's attention. For example, there were a large number of outstanding actions from fire reports. Reports completed by the provider following the audits did not detail any actions needed, prioritise timelines for any work to be completed or record who was responsible for taking action.

Other checks such as those relating to staff competency and records kept relating to people's care and support had not been completed. The provider and registered manager had failed to identify staff's lack of knowledge regarding reporting safeguarding concerns. The registered manager told us they knew that people's care plans needed updating, so they had not completed any sampling or checks since the last inspection.

Records were not comprehensive and although the registered manager told us they had 'checked people' when staff reported unexplained skin tears or bruising there was no record of these checks or investigations. The provider had noted in their action plan that 'analysis of accidents and incidents and a report compiled to demonstrate that appropriate action has been taken has been updated'. We asked to see this. The registered manager was unable to provide any overview of accidents and incidents in the service. They told us they had not reviewed people's falls since April 2017 and had never analysed incidents that occurred within the service.

During this inspection we asked the registered manager and provider to show us their updated action plan from our previous inspection. They were unable to produce this. The provider had not continued to monitor the shortfalls identified and ensure that the appropriate corrective action had been taken.

The provider had a range of policies and procedures in place that gave guidance to staff about how to carry out their role safely. These had recently been updated and rewritten. At the time of the inspection these had not been shown to staff. The registered manager did not know how they were going to ensure staff read and understood the new policies.

Although records were stored securely to protect people's confidentiality when we asked for any information it was not immediately available and records were disorganised. Some accident and incident forms were in the registered manager's office whilst others had been placed in people's files without review. There were no systems and processes in place to ensure that records were reviewed and filed accurately or easily accessible.

The registered manger told us that no formal feedback had been sought from people or their relatives since our last inspection. Questionnaires had been sent out before our last inspection, but no action had been taken to discuss the concerns that we had raised subsequently or what improvements people and their relatives would like to see.

The provider and registered manager had failed to establish and operate systems to assess, monitor and improve the quality and safety of the services provided and failed to maintain accurate and complete records. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had worked at the service for a number of years. They told us that they had been 'unaware' of requirements regarding legionella testing highlighted at the last inspection. We asked them how they kept their knowledge and understanding up to date. We asked if they participated in any local care home forums or used resources provided by reputable sources, such as Skills for Care. They told us they did not.

People told us that staff were kind and caring, but that they were 'busy.' We observed staff stopping when people called out when they were in distress but they were unable to spend time with people and provide person-centred care. Staff focused on tasks that needed to be completed, rather than on people as a result.

It is a legal requirement that a provider's latest CQC inspection report rating 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. The rating was not displayed at the service. We discussed this with the registered manager and they told us they were 'unaware' of the need to display their rating. The rating was immediately printed out and displayed on a notice board in the entrance hall. The provider had not displayed the rating for the service on their website.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had submitted notifications to CQC in an appropriate and timely manner and in line with guidance.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider and registered manager had failed to ensure people were able to receive food in a way that met their individual preferences. The provider and registered manager had failed to ensure people received care that was personalised and reflected their needs. The provider and registered manager had failed to ensure that people received care that met their assessed needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Maintenance had still not kept pace with the rate of wear. When carried out, maintenance was still completed reactively with little evidence of forward planning. The provider had not ensured the premises were properly maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider and registered manager had not ensured there were sufficient numbers of staff deployed. The provider and registered manager had not ensured staff had received training in topics specific to people's needs.

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 The provider and registered manager had failed to ensure that risks relating to people's care and support had been assessed and mitigated. The provider and registered manager had failed to ensure the environment was safe. The provider and registered manager had failed to ensure staff had the necessary guidance in place to support people with their healthcare conditions.

The enforcement action we took:

We issued a Warning Notice and asked the Provider to become compliant by 27 October 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered manager and provider had not protected people from the risk of abuse.

The enforcement action we took:

We issued a Warning Notice and asked the Provider to become compliant by 27 October 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager had failed to establish and operate systems to assess, monitor and improve the quality and safety of the services provided and failed to maintain accurate and complete records.

The enforcement action we took:

We issued a Warning Notice and asked the Provider to become compliant by 27 October 2017.