Care Quality Commission

Creedy Number 1 Limited

Creedy House

Inspection report

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Date of inspection visit:
21 March 2018

Date of publication:
30 April 2018

Ratings

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

Summary of findings

Overall summary

This inspection was completed on 21 March 2018 and was unannounced.

Creedy House 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.

Creedy House is a large, detached premises situated in a residential area in Littlestone-On-Sea. The service was divided into two areas: The House which accommodated people requiring nursing as their primary need and The Lodge where people living with dementia had their bedrooms.

There was a manager at the service, who was in the process of applying to be 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.

At our last inspection we recommended that the provider ensured that quality and safety checks included observation of staff practice to see that it reflects care plan guidance and consistently minimises risks to people. At this inspection we found that these had not been implemented. Risks had been identified, however, action had not always been taken to minimise the risk from occurring. People had fallen and displayed behaviour that challenged. Although the manager had identified these as risks, there was a lack of guidance for staff regarding how to support people to prevent these from occurring. Incidents had not always been appropriately documented or analysed to look at the reason why they occurred.

One person had displayed behaviour that challenged and an identified reason for this was a possible urine infection. Staff had not tested the person's urine to see if this was the reason for their behaviour and if they required antibiotics. Some people had Deprivation of Liberty Safeguards (DoLS) in place, and conditions on these DoLS, had not always been complied with. Staff did not always work consistently across organisations, meaning necessary referrals to healthcare professionals were not always made. Other health care needs such as pressure areas, support with catheter care and diabetes were managed well.

At our previous inspection we recommended that the provider introduced a dependency tool to calculate the number of staff required to support people. Although this had been introduced the manager was unable to show us how the number of staff required had been calculated. People and their relatives told us they sometimes had to wait to receive support. Staff were busy and although we observed some kind and caring interactions, staff were task focused. Some staff did not treat people respectfully and we observed staff moving people in wheelchairs abruptly, without telling them what was about to happen.

At our last two inspections we identified that recruitment checks were not always completed and staff had

not been recruited safely. At our last inspection we made a recommendation for the provider to consider using a recruitment checklist to ensure that all areas were addressed for every applicant. This had been introduced and staff were recruited safely.

At our last inspection we highlighted that there were no pictorial menus available for people living with dementia. Pictorial menus could assist people with dementia to make meaningful choices about what they wanted to eat. These were not seen to be in place during the inspection. People had enough to eat and drink and when they required specialist diets, were supported to eat and drink safely.

At our previous inspection we recommended that the provider increased oversight of the service's complaints process to ensure it was suitably robust. Although improvements had been made the manager did not record all actions taken as a result of a complaint which impacted on learning from them in the future.

Checks and audits were completed by a representative of the provider and the manager, however, these had not identified the issues we found during this inspection. People, their relatives, staff and other stakeholders had been asked their views on the service. Responses had been collated, however, some areas of improvement, such as a lack of staffing at weekends had not been addressed. The provider had failed to meet all of their regulatory requirements as there had not been a registered manager at the service for over two years.

The manager had worked with other organisations, including the local safeguarding team when incidents had occurred at the service. We spoke with staff and although they knew about different types of abuse and how to whistleblow they did not always recognise that incidents between people could also be types of abuse.

There was an activities co-ordinator in place at the service, however, the manager told us that they wanted to develop the activities on offer at the service. They recognised that this was an area for improvement.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The provider's vision included, to, 'Build confidence and promote an independent lifestyle for all of our residents.' Staff and the manager shared this view of the service and people and their relatives had been involved in planning their care. People's care plans contained information regarding how they wanted to be supported. There were plans in place regarding how people wanted to be supported at the end of their lives.

Medicines were now managed safely, and people received all of their medicines and creams as required. Staff had received training and told us they felt well supported by their line manager.

The service was clean and people were protected from the spread of infection. Checks had been completed on the environment to ensure it was safe. The service had been adapted to meet people's needs and there was additional signage in place to assist people living with dementia.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. CQC check that appropriate action had been taken. The manager had submitted notifications in an appropriate and timely manner and in line with guidance. The manager had displayed the rating from our last inspection in the entrance hall of the service and the provider had ensured that the rating was displayed on their website.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks had been identified but not always mitigated.

There was a lack of oversight of accidents and incidents which limited opportunities to learn from them.

Staff did not always recognise that incidents between people could be instances of abuse.

People and their relatives told us there was not always enough staff. Staff were recruited safely.

Medicines were managed safely.

The service was clean and people were protected from the spread of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Conditions on people's Deprivation of Liberty Safeguards (DoLS) had not always been adhered to.

Staff had not always taken action to assist people with their healthcare needs. Referrals had not always been made to necessary healthcare professionals.

Staff did not use a pictorial menu, as recommended at our last inspection. People had enough to eat and drink.

People's needs had been assessed and staff received necessary training and support to carry out their roles effectively.

The environment was accessible and had been adapted to meet people's needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Although we witnessed kind and caring interactions staff were task focused in approach.

Staff were not always respectful to people.

People and their relatives were involved in planning their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The provider had not implemented an effective overview of complaints, to aid learning.

People and their relatives told us that the range of activities could be more varied.

People's care plans contained information regarding how they wanted to be supported.

There were plans in place regarding how people wanted to be supported at the end of their lives.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager in post.

The provider was not meeting all of their regulatory responsibilities and ensured compliance with all of the fundamental standards and regulations.

Checks and audits had not identified the issues we found at this inspection.

People and their relatives had been asked their feedback on the service, but this had not always been acted on.

The manager had worked in partnership with other organisations.

Care Quality Commission

Creedy House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 21 March 2018 and was unannounced. Three inspectors, a specialist nurse advisor and an expert by experience carried out the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider completed 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. We looked at the previous inspection reports and any 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 the manager, the area manager and the owner of the service. We spoke with two nurses, one senior care staff and three carers. We looked at six people's care plans and the associated risk assessments and guidance. We looked at a range of other records including two staff recruitment files, the staff induction records, training and supervision schedules, staff rotas and quality assurance surveys.

During our inspection we spent time with the people using the service. We spoke with 10 people and five relatives. We observed how people were supported and the activities they were engaged in. Some people were unable to tell us about their experiences of care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the service. One person said, "Yes I feel safe here thank you, very safe." Another told us, "I do feel safe now...I have to totally rely on them [staff] to do anything really…so I am definitely in the right place now to be looked after." A third person said, "My room is very comfortable and safe, and it is my home now." A relative told us, "I do know [my loved one] is safe here and I don't have to worry."

Although people felt safe, we found some concerns regarding risk management and staffing levels, which left people at risk of harm.

At our previous inspection staff had not always followed guidance in people's care plans regarding how to minimise risks to people. One person was not supported to consistently use their pressure relieving equipment and one person was not supported to move safely in their wheelchair. We recommended that the provider ensured that quality and safety checks included observation of staff practice to see that it reflected care plan guidance and consistently minimised risks to people. At this inspection, we found that pressure relieving equipment was being used correctly and staff supported people to move safely. The head of care completed 'sit and see' observations on staff practice. Although risks relating to people's care and support had been assessed action had not always been taken to mitigate these risks and reduce the chances of them happening again.

One person had fallen seven times in January and seven times in February 2018 . The person had sustained skin tears from falling. Although staff had recognised that the risk of the person falling was high, and the manager had applied for additional funding for one to one staffing, this had not yet been put in place. The person had a low bed and there was a pressure sensor by the person's bed which should have alerted staff when the person stood up. During the inspection the person fell. The pressure sensor had not activated and staff told us, "The mat should go off, but we think [the person] can step around it." No further action had been taken to minimise the risk of falls to the person. We discussed our concerns about the person's falls risk with the manager and one to one staffing was put in place for the rest of that day.

Some people could become anxious or confused and displayed behaviour that staff found challenging. Although these behaviours had been identified, there was little guidance for staff regarding pro-active strategies to prevent a behaviour from occurring. An incident had occurred at the service on the day before the inspection, which had placed people at risk of harm. A similar incident had occurred previously and staff had identified that there was a risk it may occur again. The person's care plan showed that staff were aware of the risk, but the actions taken to reduce the risk were, 'Ensure [person's] whereabouts is known' and 'Staff to observe discreetly.' No consideration had been given to ways of reducing the risk of the behaviour occurring or understanding why it was being displayed.

Staff told us about another incident the day before when a different person had also displayed behaviour that challenged. We asked to see the documentation regarding this and no accident or incident form could be produced. After the inspection we were sent an accident form which stated, 'On completing personal

care this morning [person] bit my left forearm.' The person's care plan stated that any incidents of challenging behaviour should be, 'documented on ABC charts' and this had not been done. An ABC chart is a way of mapping behaviour that challenges, and requires staff to record what was happening before, during and after an incident. This helps to identify any triggers for behaviours and ways of reducing the chances of them occurring.

Any accidents, such as falls were documented by staff. The manager reviewed each accident and completed some analysis, such as who was involved, where and at what time. However, there was not a complete record of what conclusion had been reached, any action that had been taken and if it had been successful.

The manager understood their responsibilities regarding safeguarding and had reported concerns to the local authority safeguarding team when necessary. Staff had received training on safeguarding and were able to tell us what action they would take if they saw unexplained bruising or needed to whistleblow. However, some staff did not recognise that if incidents occurred between people, this too could be counted as abuse. When an incident had occurred the day before the inspection staff had not recognised that this was a potential safeguarding issue. When it was brought to the manager's attention they did understand that this was a potential safeguarding issue, and took the necessary action.

The provider had failed to ensure that action had been taken to mitigate risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

At our last inspection we recommended that the provider introduced a dependency tool to determine the number of staff required to meet people's needs appropriately. At this inspection, the manager had used a dependency tool to calculate the number of staff required, however, they had not recorded their calculations in a formal way, to show how the number of staff needed was determined. As a result we could not be confident that changes in people's needs for care would quickly be identified and reflected in staffing levels in the service.

The manager told us that nine care staff in the morning and eight care staff in the evening were required to meet people's needs, and this was over what the tool had recommended. However, staff duty rotas for March showed that this number of staff had not always been available. People and their relatives told us they sometimes had to wait to receive support. One person said, "There always seem to be enough staff on duty, until I need something…then I have to wait while they deal with other people first and if I'm uncomfortable then that can be upsetting." A relative told us, "I think that (my relative) is safe here but the staff don't come as quickly as I would like when I call the bell for them and I know sometimes they are left wet because their skin is bad and very sensitive
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During the inspection, there were eight care staff on duty in the morning, staff were busy and the support we observed was not person centred. Staff were kind to people, but focused on tasks they needed to complete including getting people up and dressed or giving them lunch. People had to wait to be supported, and one person had an unwitnessed fall.

The provider had failed to ensure there were enough staff to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

At our last two inspections we identified that recruitment checks were not always completed and staff had not been recruited safely. At our last inspection we made a recommendation for the provider to consider using a recruitment checklist to ensure that all areas were addressed for every applicant. This had been introduced. Staff had provided a full work history before starting employment. Further checks had been

completed including gaining two references, photo identification and Disclosure and Barring Service (DBS) criminal records check. The DBS helps employers make safer recruitment decisions. Nurses Personal Identification Number (PIN) were checked to make sure they registered with the Nursing and Midwifery Council.

At our previous inspection prescription creams had not always been managed safely. Creams had been stored where people had access to them and people had not always received their creams as prescribed. At this inspection, improvements had been made. People's creams were stored securely and records showed they had been applied as and when people needed them. One person told us, "They bring my medicine to me which makes me feel much easier and safer and I don't have to worry." A relative said, "[My loved one] can't organise their own medicines. They are brought to them here in their room and someone always makes sure they take them."

There were appropriate systems in place for the ordering, storage, administration and disposal of medicines. Medicines were stored securely and at a safe temperature. Some medicines had specific storage and administration requirements, and systems were in place to manage this. We observed staff giving people their medicines and they ensured this was done safely. Medicine administration records (MARs) were fully completed. Some people had medicines on an as and when basis, for example for pain relief or anxiety and there was clear guidance in place regarding when these medicines should be administered and how much.

Some people received their medicines covertly, meaning they were administered without the person's knowledge. This had been appropriately assessed and the decision had been made involving medical professionals and people's loved ones. Advice had been sought from a pharmacist to ensure medicines were given in a safe way.

Staff completed checks on the environment to ensure people were kept safe. There was a fire risk assessment in place; shortfalls identified during the assessment had been completed. Weekly checks were completed to check that the fire alarms were working and fire doors shut. Records showed that some staff had attended fire drills, however, there was no time recorded for the drill, so it was unclear if a fire drill had been completed at night. There had been no analysis of how the fire drill had gone and if any changes that needed to be made to rectify shortfalls or that every staff member attended a drill. This is an area for improvement. Each person had a personal emergency evacuation plan (PEEP) in place. Each plan had information about a person including mobility and communication, so that they could be supported to leave the building safely in an emergency.

Water temperatures were checked weekly to ensure they were at a safe temperature to reduce the risk of scalding. There were environmental risk assessments in place and checks such as legionella had been completed and action taken to rectify any shortfalls. Equipment such as hoists were serviced regularly to ensure they were safe for people to use.

The service was clean people were protected from the spread of infection. One person told us, "My room was cleaned this morning and it very nice really." A relative said, "My [loved one's] room is always clean and comfortable whatever time of day I arrive, and I come every day." Staff used appropriate personal protective equipment and had been trained in infection prevention and control.

Requires Improvement

Is the service effective?

Our findings

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 procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The manager had applied for DoLS for people who lacked the capacity to consent to staying at the service. However, conditions on people's DoLS had not always been followed. Some people's DoLS had been authorised on the condition that referrals to medical professionals such as physiotherapists or the falls clinic were made. These referrals either had not been made or had not been followed up by the service to ensure people received the support they needed.

The provider had failed to ensure that conditions on people's DoLS had been followed, ensuring restrictions were appropriately authorised. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Staff showed an understanding of the MCA and offered people choices throughout the inspection. For example, people were offered choices between different drinks and where they wanted to spend their time. A relative told us, "They always ask [my loved one] how they would like things done, even though they don't really answer any more." When decisions needed to be made on people's behalf best interest meetings had been held, involving people's loved ones and other relevant professionals.

People did not always receive the support they needed to manage their healthcare needs and lead healthier lives. Following an incident staff had failed to check if one person had a urinary tract infection (UTI). The person's care plan stated that if they displayed certain behaviours this could indicate that they had a UTI. An incident had occurred the day before the inspection, and no one had tested to see if the person had a UTI. A relative told us they too had concerns that sometimes staff did not identify if their loved one had a UTI, saying, "I feel the staff usually know what they are doing but I do worry that sometimes (my relative) may have a UTI and it is not picked up." We spoke with nursing staff during the inspection and they told us they would check if the person was experiencing a UTI.

Staff did not always work consistently across organisations. Referrals to healthcare professionals had not always been made as needed. One person had fallen repeatedly. Staff had referred them to the falls clinic in January and the person had been discharged. They had fallen an additional seven times in February. Another referral had not been made. Another person had experienced 'hallucinations' and although it had been advised that they were referred to the mental health team for input, this had not been done.

The provider had failed to ensure that people's healthcare needs were managed safely. This was a breach of

Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Other healthcare conditions were managed effectively. Some people were living with diabetes and epilepsy and there was clear guidance for staff on how they should support people. People's blood sugar levels were tested regularly and when they were too low or too high staff took appropriate action.

Some people had a catheter in place. A catheter is used to empty the bladder and collect urine in a drainage bag. There was clear guidance in place for staff regarding how to support people with their catheter care, including when to change people's catheters and bags. Fluid charts were used to document the person's fluid intake, and a national screening tool (GULP) was used to ascertain the person's risk of dehydration.

At our last inspection we highlighted that there were no pictorial menus available for people living with dementia. The manager at the time told us these had been ordered. During the inspection staff did not use any form of pictorial menu. Staff told us they were in the process of producing pictorial menus and were seen to be taking pictures of people's meals to use as part of this work. A relative commented, "There is quite a good choice of food and usually something that [my loved one] can enjoy, although they now do not understand the choices when asked." A pictorial menu would assist people with dementia to make choices about what they want to eat.

Food appeared appetising, and people we spoke with told us they enjoyed what they ate. One person said, "I quite like the food, it is quite good really." Another told us, "I can ask for something extra to eat or drink if I feel like it and they will always bring a cup of tea if I want one" A relative said, "[My loved one] is happy with the meals and always keen to finish it up." Some people had been assessed as being at risk of choking and there was guidance in place from a speech and language therapist regarding how their food should be served. Throughout the inspection we observed staff following this guidance, and people were supported to eat and drink safely.

People's care had been planned and delivered to ensure their clinical needs were met. When people moved into the service the manager or a senior member of staff completed an assessment, clearly outlining the person's needs and involving them and people important to them. Tools such as Waterlow assessments (to assess the risk of people developing pressure areas) and a malnutrition universal screening tool (MUST) had been used to identify people who required more support. Some people were living with healthcare conditions such as diabetes or epilepsy and staff were aware of best practice guidance from the National Institute of Clinical Excellence (NICE) and other sources.

The manager had identified that staff had not been receiving one to one supervision as often as the provider's policy required to discuss their practice and any development needs. The manager had taken action to ensure that all staff had received at least one supervision so far this year and plans were in place for staff to receive further supervision and a yearly appraisal.

Records showed and staff told us that they received training appropriate to their role. All staff completed essential training including safeguarding, moving and handling and mental capacity. Training was completed on line and face to face. There were three staff who trained moving and handling trainers and assessors, this meant that staff competency was continuously assessed. We observed staff assisting to move people safely throughout the inspection. Nurses completed additional training such as verification of death to ensure they were able to fulfil their role.

The manager and deputy manager had arranged to receive clinical supervision from an outside consultant and would use this to inform their supervision of the nursing staff. The manager checked and recorded the nurse's competencies to administer medicines and complete clinical tasks on a yearly basis. Additional training and supervision was arranged if needed to ensure staff were competent. Competency assessments of care staff had just started and were being completed for all care staff in a variety of subjects.

New care staff completed an induction including shadow shifts with experienced staff to learn about people's choices and preferences. Staff who did not already hold a qualification in social care completed the Care Certificate, this is an identified set of standards that social care workers adhere to in their daily working life.

The service had been adapted to meet people's needs. There was a separate dementia suite which was housed on the ground floor. Hallways were wide and accessible and people were able to move freely around this area. There was a lift to allow people with additional mobility needs access to the first floor. Bedroom doors had been painted in different colours to help people to identify which was there's and a photograph of the person had been placed on their bedroom door to further assist them. Toilet and bathroom doors had clear picture signage and were painted a separate colour to differentiate them from bedrooms.

Requires Improvement

Is the service caring?

Our findings

Staff were kind to people, and we observed numerous caring interactions. However, staff were task orientated and told us they were, 'busy' and 'stretched at times.' As such, they did not always have the time to provide compassionate, engaging care. One relative told us, "Staff are job orientated and they can't spend much time with [my loved one] to enable them to catch up with what is going on." One person said, "The staff just get the job done that is pretty much it." Another person said, "They [staff] know what they are doing but I would say they are not very cosy with it." A third said, "I don't get rushed but usually they just come in do their jobs and leave me."

A staff member told us, "We spend all morning getting people up and dressed. Once you have done that you have lunches. It feels like a conveyor belt." When we arrived at the service at 9am most people in 'The Lodge,' the dementia area of the service were still in their rooms and not out of bed. At 11am three people were engaged in an activity in the lounge, throwing hoops on a large inflatable. The activities co-ordinator had been present throughout the morning and spent time talking with people in their rooms. However, staff told us that it was difficult to ensure that people were up and able to participate in activities in time.

Relatives commented that as staff did not have time to spend with people, they felt their loved ones could be lonely at times. One relative told us, "I think that [my relative] does get a bit lonely, but then, the staff are all very busy aren't they." Another relative said, "[My relative] is sometimes left in his room for long periods and has no interaction with anyone."

At lunchtime we observed a staff member moving a person's chair backwards, again, without explaining to the person what was about to happen. A senior member of staff witnessed this incident and spoke with the staff member to inform them this was not appropriate. Both of these people were living with dementia, and may have been confused or distressed by these sudden movements.

From April 2016 all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively. There was information regarding the AIS displayed throughout the service. Information about people, such as their care plans were stored electronically and staff were able to access them on hand held tablets with a small screen. This information could be printed off and shared with people and their families. However, no consideration had been given regarding how to ensure this information was accessible to people living with dementia or who may be confused. .

The provider had failed to ensure that people always received person-centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People told us that staff were kind and friendly. One person said, "The staff are kind to me. The staff are friendly and if I am scared they talk to me." Another person said, "I like the staff here, they are friendly and look after me." A third told us, "I find the staff very courteous and friendly."

People and their relatives were involved in planning their care. One relative told us, The staff often ask if there is anything [my loved one] would like done differently or if there is anything they can get to make them more comfortable." Some people required support to make their needs known, and either an advocate or their relatives helped them to do so. An advocate is someone who supports a person to make sure their views are heard and their rights upheld.

People's rooms had been decorated and people were encouraged to bring their own things with them, to make it feel homely. One person said, "I have my own belongings in my room. I like my own things to make me feel more at home." A relative told us, "We have tried to make it homelier by bringing in some trinkets and photographs to put up."

People's privacy was respected. Staff knocked on people's doors before entering and waited to be invited inside. Relatives confirmed they felt staff respected their loved ones privacy saying, "We do get privacy when I am here, and I think that the staff do really respect the people that live here." And, "Whoever is charged with looking after [my relative] manages to make sure they retain what little dignity they have left."

People were encouraged to be as independent as possible. People's care plans described what people could do for themselves, and staff told us they encouraged people to do as much as possible for themselves. One relative told us, "The staff are so patient with them and help them to wash and do as much as possible for themselves."

Visitors and relatives were always welcome at the service. One relative told us, "They are lovely people that work here and keep an eye on me too not just [my loved one] because they live here. When I was late the other day they called to make sure that I was alright and that nothing had happened to me."

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we recommended that the provider increased oversight of the service's complaints process to ensure it was suitably robust. Complaints were not recorded accurately or collated to enable the manager to look for trends or patterns or ways of reducing them from occurring. At this inspection the manager recorded complaints and investigated them following the provider's policy. The manager completed a complaint action form, giving details of the action they had taken and who they had contact with. The complainant was kept informed of the progress of the complaint and received a letter explaining the outcome of their complaint.

However, the action that had been taken to stop the incident happening again and any improvements that had been made had not always been recorded. For example, one letter stated, 'We have looked at our practice and made some changes which will provide a better service to our residents and families.' The manager told us that training had been given around the documentation of accident forms to make them more specific following the complaint. Laminated documentation had also been placed in each staff room detailing how to correctly complete accident forms and actions to take. However, this had not been recorded or checked to see that the training had been effective. Without accurate records there was still a risk that learning from complaints may not be effective. This was a continued area of improvement.

The manager told us that they wanted to improve the activities that were offered at the service. During the inspection people were given the opportunity to play an inflatable 'hoopla' game and musical bingo. In the morning, not everyone in the dementia suite was up and able to participate in the activity offered. Relatives commented that there was a lack of engagement for some of their loved ones, saying, "There is not much for them to take part in activity wise and I would like to see them more active." "They do not find very much to join in with activity wise here, but then I don't think they ever would have done." And, "I think they need to be busy and I do find them just sitting in their chair a lot."

Staff had recently started using an electronic care planning system and were in the process of transferring information over from people's paper records. Some people's care plans were detailed and accurate. However, others required updating and did not always reflect their needs. Some people had broken skin that required treatment. Although this was being monitored and they were receiving the correct support their skin assessments stated there was no broken skin. People were using specialist equipment to help keep their skin healthy, but again, this was not listed in their care plans.

Staff had taken action when one person living with diabetes had shown signs of hyperglycaemia. This is a situation where the body's blood glucose has increased significantly, and can lead to further deterioration. The person's doctor prescribed new medication which staff administered. However, this was not reflected in the person's care plan for medication, nor in their daily records of care.

When people displayed behaviour that challenged there was a lack of person centred guidance regarding how to support them to remain safe and calm.

The provider had failed to ensure that records regarding people's care and support accurate and up to date. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us they had been involved in planning their loved one's care. They told us, "We have been kept in full control of [my relative's] care plan in as much as we often discuss what it's content is and if we feel anything should be altered." "I am often approached by staff to ask my opinion and to ask if we would like anything changed or added to help." And, "We often go through the care plan together."

People's preferences and life history were included in people's care plans and staff knew people well. One relative told us, "The staff are very good at humouring [my loved one] and doing things for them just the way they like them done. For example, they are a stickler for organisation and likes their cupboard kept just so and they are very good at keeping the meticulous order when putting laundry back in." Another relative said, "The staff are very good at chatting with him and all remember his likes and dislikes."

There were plans in place regarding how people wanted to be supported at the end of their lives. Some people had do not resuscitate orders in place and these were seen to be accurate and reviewed when people moved into the service. Nursing staff were trained in using specialist equipment to administer emergency medicine to help people to remain as pain free as possible at the end of their lives. If required, people were referred to specialist palliative services for additional support. We observed that medicines required to support people at the end of life were at the service, were stored safely and were available when needed. Staff monitored people, they recognised when people were becoming frail and liaised with the GP to ensure that people received the care and support they needed. The GP reviewed people's medicines to ensure that they remained appropriate. Staff were aware and the care plan had information on people's cultural and spiritual needs regarding their end of life care. Staff told us that if relatives wanted to stay with their loved ones this would be arranged.

Inadequate

Is the service well-led?

Our findings

The service had been without a registered manager for over 800 days. Although managers had been appointed to the service, none had registered with the Care Quality Commission. Since our last inspection a new manager, who had previously worked at the service as the Clinical Lead had taken up post. They were currently in the process of applying to be registered.

People told us that the new manager was approachable, and they would go to them if they had any issues. One person said, "I can always speak to the manager without a second thought." A relative told us, "Yes I can speak to the manager, that is not a problem." Throughout the inspection people and their relatives approached the manager, greeting them warmly.

We found that suitable arrangements had still not been made to ensure that the service reliably met regulatory requirements by learning, innovating and ensuring its sustainability. Previous recommendations had not been met. At our previous inspection we recommended that the provider expanded their audits and management checks to include all medicated items, observation in relation to risk mitigation and complaints recording. At this inspection, although we found an improved picture regarding the management of prescribed creams, we found ongoing concerns regarding risk management and complaint recording. We found additional concerns regarding the number of staff available and the fact that care appeared task focused. The provider and manager's checks and audits had failed to identify these concerns.

Although some accidents and incidents were recorded we identified incidents when people had displayed behaviours that challenged that were not recorded appropriately to enable the manager or provider to analyse what had happened. The manager told us that they would be made aware of major or unexplained incidents of behaviour that challenged but not low level or expected behaviour. The manager did not have oversight of all incidents of behaviour that may challenge. We would expect a provider to be able to analyse all incidents to identify why they had occurred and what steps could be put in place to prevent them from occurring in the future. Staff did not always recognise potentially abusive incidents between people.

The manager completed audits on all areas of the service including care plans and infection control. The audits had not consistently identified shortfalls that were found at this inspection, particularly regarding the guidance available for staff to manage risks effectively. The manager told us that they randomly chose three care plans to audit each month, they did not have a system. We discussed the shortfalls found with the manager and they told us that they would now audit the care plans where people's care needs had changed to ensure that the care plans were up to date and provided the necessary guidance for staff.

Once audits had been completed they were sent to the operations director who produced a report monthly, with analysis and actions that needed to be completed. The manager recorded the actions required, who was allocated to complete them and recorded when they had been completed.

The operations director completed monthly visits on behalf of the provider to monitor the quality of the service. However, the care plans looked at were also adhoc, and there was no systematic plan in place to

pick up the gaps that we had identified regarding people's changing needs. A report was produced with actions that needed to be completed, these were checked at the next visit to ensure they had been completed. For example, action had been required on updating a person's care plan regarding the assessment for bed rails, this was checked at the next audit and noted as completed.

Quality assurance surveys were sent to people, relatives, staff and stakeholders such as GP's. The service had not received any response from stakeholders. The responses from people and relatives had been recorded and analysed, the provider had produced a 'What we will do' list. This included promoting more group activities and purchasing name tags for people's clothes. The manager told us that more activities was an area that they were working on. However, there had been no check to ensure that the provision of name tags had worked and that this had reduced the number of clothing items being lost. A relative told us that laundry was an ongoing issue at the service, saying, "One of my biggest irritations is the laundry here, (my relative's) clothing never gets back to them even with these clear and large labels on the front, and the washing is dreadful." Some responses in the survey highlighted shortfalls that we found at inspection, such as staffing levels at weekends and this had not been addressed in the analysis.

Staff attended regular staff meetings, there were general staff meetings and smaller meetings for different groups of staff such as nurses and senior carers. Staff were reminded of their roles and responsibilities and were encouraged to express their views and any concerns that they may have. The provider and operations director attended general staff meetings to hear staff concerns and views. When staff had raised concerns, it had been recorded what the manager or provider had said they would do but this had not been followed up and the outcome recorded. For example, staff stated that they were running out of supplies such as wipes and gloves, the manager said they would increase the amount ordered. Although more supplies had been ordered, this issue was not mentioned in the minutes of meetings that followed. The manager told us that staff had not mentioned this since, but they had not checked that the problem had been resolved. Staff had asked for a 'standaid hoist' for the 'House' unit and this had been provided, but again had not been recorded to show that action had been taken.

Resident and relative meetings had been arranged but were poorly attended. The meeting held in November 2017 only four relatives had attended and the next one was cancelled as no relatives attended. The manager had another meeting planned the week following the inspection but had not considered other ways of getting people and relatives involved other than meetings.

The provider had failed to establish and operate systems to assess, monitor and improve the quality and safety of the service and mitigate risks. They had failed to hold an accurate and contemporaneous record regarding each person. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's philosophy and values included, 'Build confidence and promote an independent lifestyle for all of our residents.' 'Provide a safe, warm and friendly environment.' And, 'To put our residents at the heart of everything we do.' Staff echoed this vision, telling us they wanted to, "Give people as much freedom as they can."

The manager had worked in partnership with other organisations, such as the local safeguarding and commissioning teams. Healthwatch had completed a recent visit to the service and the manager had been involved in pre-meetings with them, to understand their role. People and their relatives had fed back that they were happy with the new manager at the service.

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. This enables us to check that appropriate action had been taken. The registered manager was aware that they had to inform CQC of significant events in a timely way and had done so.

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 judgements. We found the registered manager had conspicuously displayed their rating on a notice board in the entrance hall 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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that people always received person-centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that action had been taken to mitigate risks. The provider had failed to ensure that people received support to manage their healthcare needs safely.

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 provider had failed to ensure that conditions on people's DoLS had been followed, ensuring restrictions were appropriately authorised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure that records regarding people's care and support accurate and up to date.

Regulated activity	Regulation
	The provider had failed to establish and operate systems to assess, monitor and improve the quality and safety of the service and mitigate risks. They had failed to hold an accurate and contemporaneous record regarding each person.
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were enough staff to meet people's needs.