New Century Care (Borough Green) Limited

Westbank Care Home

Inspection report

64 Sevenoaks Road
Borough Green
Kent
TN15 8AP

Tel: 01732780066
Website: www.newcenturycare.co.uk

Date of inspection visit:
29 January 2016
01 February 2016

Date of publication:
29 March 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Westbank Care Home provides accommodation along with nursing and personal care for up to 40 older people. One wing of the service was closed for refurbishment at the time of the inspection. This inspection was carried out on 29 January and 1 February 2016. It was an unannounced inspection. There were 24 people using the service.

We had received information of concern about the service from a number of sources prior to the inspection.

There was not a manager in post who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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. A manager had been appointed to the service in December 2015, but they had not yet applied to CQC to be registered.

At the last inspection on 24 March 2015, we asked the provider to take action to make improvements in respect of dignity, consent, governance, records and staffing. An action plan was not sent to us by the date we required when we published the final report. An action plan was submitted in July 2015 when we requested this again. The final date the registered provider had set for compliance with the breached regulations was 30 September 2015.

At this inspection we found that the registered provider had failed to make or sustain the required improvements they had outlined in their action plan.

People had not always been safeguarded from abuse or harm whilst using the service. Systems in place to reduce the risk of harm had not been effective. The risks to the welfare of people and the safety of staff had not been appropriately managed or reduced. People were at risk of developing pressure wounds and dehydration due to a lack of effective systems for reducing these risks. One person was at risk of choking and guidance to minimise this risk had not been followed.

There were insufficient numbers of suitably skilled and experienced staff deployed in the service to meet people's needs. This meant that people waited unreasonable lengths of time for care and for their meals. Staffing numbers on occasions during December 2015 were seriously below the number required to keep people safe in the service.

Staff did not receive adequate induction or training to ensure they were competent in providing safe and effective care to people. The registered provider had not ensured that systems for the regular supervision of staff were effective to ensure they were meeting people's needs.

Whilst we saw some examples of caring and compassionate staff we found that people were not always treated with respect or their dignity and privacy maintained. Staff were unclear how to respond

appropriately to people who were confused or had memory loss.

People did not always receive a personalised service that reflected their needs and preferences. People were not supported to get up at a time they wanted. A lack of directive care planning meant that people's needs were not always met.

There was a lack of effective leadership of the service. Audits and quality monitoring systems had not identified shortfalls in the provision of safe and effective care and plans to make improvements, following our last inspection, had not been successful.

People did not consistently have their nutrition and hydration needs met. People did not always have their health needs met in a timely way. People did not have care plans in place to enable them to improve their mobility and independence. We have made a recommendation about this.

Recruitment procedures were robust to ensure that people were suitable to work in the service.

People were provided with information about the service provided and were signposted to other services available to them.

People's medicines were managed safely. A policy for the management of medicines was not available. We have made a recommendation about this.

People lived in a clean environment and systems were in place to reduce the risk of the spread of infection. The premises was under refurbishment to modernise the service taking into account the needs of the people who used the service, including those living with dementia.

People were supported to make decisions about their care and treatment and had their rights under the Mental Capacity Act 2005 met. People were only deprived of their liberty in line with the law.

People knew how to make a complaint. People's views were sought through residents and relatives meetings and an annual survey, but the registered provider had not considered alternative and creative methods to seek the views of people with limited verbal communication. We have made a recommendation about this.

You can see what action we have told the registered provider to take at the back of this 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.

Following the inspection of this service we continue to liaise with the local authority who is working closely with the service to ensure people's safety.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not adequately safeguarded from the risk of abuse or harm.

Risks to individuals had not been appropriately assessed and reduced. People were at risk of dehydration, choking and the development of pressure wounds.

There were insufficient numbers of suitable staff on duty in the service to safely and effectively meet people's needs.

People were supported to manage their medicines in a safe way.

People were protected against the risk of acquiring an infection in the service.

Is the service effective?

Inadequate

The service was not effective.

Staff were not appropriately supervised to ensure they were competent in providing safe and effective care to people. Staff were not provided with adequate training appropriate to their roles.

People were not always referred to healthcare professionals promptly when required to ensure their needs were met.

People did not have their nutrition and hydration needs adequately met.

The registered provider was meeting the requirements of the Mental Capacity Act 2005.

The premises were maintained and improvements were underway to ensure they met the specific needs of people using the service.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with respect and they did not consistently have their dignity and privacy maintained.

Some staff knew people well, but information about their backgrounds, personality and interests was not used effectively when planning their care.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs were not always met. People did not receive a personalised service that reflected their needs and preferences.

People knew how to complain and people's complaints were taken seriously and acted upon.

Is the service well-led?

Inadequate

The service was not well-led.

The registered provider had not ensured a culture in the service that reflected the principles of person centred care.

The registered provider did not have effective systems in operation for checking and improving the quality and safety of the service. There were shortfalls found in this inspection that had not been identified through the registered provider's quality monitoring systems.

The registered provider had not ensured accurate and complete records were maintained.

Westbank Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was carried out 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 was carried out on 29 January and 2 February 2016 and was unannounced. The inspection team consisted of three 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 looked at records that were sent to us by the registered manager and the local authority to inform us of significant changes and events. We reviewed our previous inspection reports and sought feedback from the local authority commissioning service and the safeguarding team. We reviewed the providers action plan from July 2015 to see what improvements they told us they had made.

We looked at eight people's care records. This included assessments of needs, care plans and records of the care delivered. We observed to check that people received the care and treatment agreed in their care plan. We reviewed documentation that related to staff management and two staff recruitment files. We looked at records relating to the monitoring, safety and quality of the service and sampled the services' policies and procedures.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with twelve people who lived in the service and four of their relatives to gather their feedback. We reviewed comments and feedback sent to the commission and the service to understand people's experience of the care provided. We spoke with the manager, the area manager, the lead nurse, two nurses and five members of care and domestic staff. We also obtained feedback from health and social care professionals involved in the care of people using the service.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living in the service. One person said, "'I feel safe, I can call the buzzer at night if I need to and someone comes. They have a team of people on at night.' Another person told us, "I'm very happy with the care. I feel safe and cared for." These people's positive views did not reflect our findings that people were not always kept safe.

People and their relatives told us that there were frequent changes in staff working in the service and some people said there were not always enough staff. One person told us, "There have been days when they are really short staffed, I know lots of staff have left." Another person said, "There's a mix of staff all the time, it's because of the money" and another said, "They change a lot, the staff don't stay." Relatives fed back in a relatives meeting, and in discussions with our inspection team, their concerns about the high turnover of staff and frequent shortages of staff. People were aware there had been recent changes to the management of the service.

Although people told us that they felt safe in the service we found that the service had not always taken appropriate action to ensure people were protected from harm and abuse. The local authority safeguarding team had recently concluded an investigation into alleged abuse that had taken place at the service. The investigation concluded that neglect, in relation to ensuring one person was sufficiently hydrated, had taken place. There were also investigations underway into a number of other allegations of abuse including a full establishment safeguarding review for the service. The local authority had agreed actions with the registered provider in response to the concluded safeguarding investigation, but we found that the required improvements to ensure people were not at risk of dehydration had either not been made or sustained.

Fourteen care staff were employed in the service and ten had completed training in safeguarding people from abuse. The staff we spoke with understood the process for identifying and reporting abuse and for contacting external agencies if they had concerns about people's welfare. Staff understood their responsibilities to report any concerns about abuse and were confident to do so. However, staff had not recognised that neglect was taking place because a person was not having their need for adequate hydration met. Staff and the manager had not recognised this or reported it appropriately. All staff said they had opportunities to raise concerns in the daily handover meeting for each department. Three of the four nurses employed had completed training in safeguarding. The nurse in charge of the service on the first day of the inspection had not completed training in safeguarding. They understood the requirement to report a safeguarding concern and told us they would report this to the manager, but were unclear on how to report in the absence of the manager. This meant that safeguarding concerns may not always be reported in a timely way.

The service provided a work experience placement for students aged 16-19 from a local school. At the time of the inspection students were working in the service carrying out domestic duties. Teachers were present, but were not always in the same area of the service as the students. This meant that students, who had not undergone vetting procedures, were unsupervised in the service. We saw that a student was vacuuming a corridor outside people's bedrooms. People were in bed and had their bedroom doors propped open.

Adequate supervision arrangements were not in place to ensure people were kept safe.

Two people's records we looked at contained a blank property list. They had not had an inventory of their belongings recorded when they moved to the service. Staff were unclear about the procedures for ensuring people's money and personal belongings were kept safe. We had received information of concern prior to the inspection about the way in which people's money and belongings are safeguarded in the service.

People were not always appropriately protected from harm and abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had not managed risks to individuals' safety and welfare appropriately. Records showed that the provider assessed people's nutritional needs and where people had been assessed as being at risk of dehydration a monitoring chart for their fluid intake had been introduced. However, this had frequently not been completed accurately and on a number of occasions the total fluid intake at the end of the day did not reach the amount the person's record said they required. One example was for a person whose record stated they required in excess of 1500mls of fluid per day, but had received less than 900mls on some occasions and as low as 300mls on other occasions. The records did not show what action had been taken in response to this low fluid intake on these occasions and care and nursing staff were unclear about what steps had been taken. One person had seen their GP about their low fluid and food intake, but a care plan to address this had not been agreed or recorded. The nurse in charge arranged for a further visit from their GP during the inspection as the the inspectors raised concern about the person's welfare. During the morning of the inspection on both days we found that people who were in bed had drinks placed out of their reach. Staff confirmed that one person required their drink to be kept out of reach as they were likely to knock it over or throw the cup on the floor. The person's records did not demonstrate they had been offered or provided with any fluids between 5pm the previous day and 10am that morning. People's relatives raised concern in a recent relatives meeting about people being provided with tea and not given help to drink it before it was removed by other staff. The risk of people becoming dehydrated was not effectively managed and minimised.

People at risk of developing pressure wounds did not have a care plan in place that gave staff clear instruction about how frequently they should be repositioned. Staff told us they repositioned people every four hours, but we found this had not been assessed on an individual basis as part of their care plan. The records showed that some people had gone for longer than four hours without being repositioned. Staff told us that this happened on occasion when they were busy and could not get to people in time. Some people had pressure relieving equipment in use, such as air flow mattresses. The inflation of the mattresses are required to be set according to the person's weight. The weight based setting had not been calculated for some people and for others had not been reviewed when their weight had changed. Staff did not know how to check that the mattresses were set or operating correctly. Staff were required to complete a check of the setting each hour when they checked on people who remained in bed. We asked two care staff and a nurse to show us what they were checking when they made the recorded entry on the chart. We were told that they recorded the same setting as it had been recorded on previous days and times on the form. Staff were not able to show us how to check the correct setting for the person. Staff knew to report any areas of redness to a nurse and they said that the nurses were responsible for dressing any broken areas of skin. We were told that two people had pressure wounds at the time of the inspection. One nurse had completed training in pressure area prevention and three in wound care. We saw one person who had slid down in their bed as the head of the bed had been raised. This meant their feet were pressed against the footboard of the bed which could cause pressure damage to their skin. A visiting healthcare professional also raised this as a concern during the inspection. A person's records showed they were assessed at being at 'very high risk' of skin breakdown and pressure wounds. They had been offered the use of an air mattress, but had declined.

The person's care plan did not sufficiently detail what other action staff should take to minimise the risk of pressure wounds developing. The risk of people developing pressure wounds was not effectively managed.

During the inspection we were told by one staff they sustained a burn during lunch preparation. When the inspector asked if they had reported this the staff were not clear about the procedure for doing so, but said they would speak to the manager. In another incident during the day a person hit out at a staff member and when we asked staff if they would complete the accident and incident record they were again unclear about the procedure for this. This meant that staff may not always be completing records of accidents or incidents appropriately to allow the registered provider to take appropriate action to minimise the risks to the safety of people and staff.

One person had been identified as being at risk of choking when eating. The speech and language therapy team had assessed the person and advised they receive a soft diet and be supervised throughout meals. This information had not been included in the care plan, which recorded that the person required their food to be cut up only. We asked the kitchen staff what their understanding of the person's needs was and they told us they needed meats blending only. We saw that the person was provided with a meal that included green beans that were served whole. The person did not have staff present with them whilst they ate their meal and they were alone in their room. Guidance from health professionals had not been followed which placed the person at risk of choking.

Staff were unclear about how to safely move one person. The person's care plan recorded that they required a 'stand aid' hoist for transfers, however we saw two members of staff attempt to stand the person without the use of any equipment. The staff were unable to do so and therefore sought advice from the nurse in charge who told them to use a full body hoist. One member of staff went to find a different sling to the one the nurse provided with the hoist and when asked why they told us they preferred to use that sling with everyone. The sling size had not been determined based upon the person's weight or height. The inconsistency in the care plan for the safe moving of this person placed them and staff at risk of injury.

The risks to individuals' safety and welfare had not been assessed and managed effectively. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The premises were safe for people to use. Risks to the safety of people and staff had been assessed and action taken to minimise these. Action had been taken to improve the safety of areas of the service when necessary, such as fitting hand rails in bathrooms and covering radiators. Equipment, such as hoists and wheelchairs, was maintained in good order and had been checked and serviced at appropriate intervals to make sure it was safe to use. Risks within the premises had been identified and minimised to keep people safe.

At our inspection on 24 March 2015 we found the registered provider was in breach of the regulations relating to the provision of adequate staffing numbers to meet people's needs. They sent us an action plan stating they would be compliant with the regulations by August 2015. At this inspection we found that they continued to provide insufficient numbers of staff to meet people's needs. The registered provider used a dependency assessment tool to establish how many staff were required to meet people's needs. Whilst we saw that, at the time of the inspection, the assessed number of staff were provided this was not sufficient to ensure that people's needs could be met in a timely way. We saw that, on the first day of our inspection, some people did not receive help to wash and dress until 12.10pm. We asked staff why this was and we were told that it was the soonest they could get to those people. People had been asked, as part of their care plan, what time they preferred to get up, but this had not been followed in practice. We raised the issue with the manager who said they were aware of the problem and were working with staff to speed up the process

for providing personal care in the mornings. On the second day of our inspection the manager advised they had spoken with staff to ensure that everyone, who wanted to, must receive their personal care by 11.00am. We found that this had been achieved, but staff told us they had struggled to do so and did not have time to do more than provide basic care to people on that day.

At our previous inspection we found that people waited an unreasonable length of time to receive their meal once the meal service had begun. The registered provider told us in their action plan that this would be addressed through the recruitment of more staff by August 2015. At this inspection we found that people were still waiting for long periods of time for their meals to be served. Some people in the dining room did not receive their meal until 25 minutes after others and some people who remained in their bedroom did not receive their meal until 40 minutes after the meal service had begun. At the start of meal service there were three members of staff in attendance and the manager went to find the remaining staff to help serve the meals.

Records showed that there were serious shortfalls in the provision of adequate staffing over the Christmas period 2015. The staffing assessment tool determined that 2 nurses and 5 care staff were required between 8am and 2pm and 1 nurse and 4 care staff between 2pm and 8pm each day. Staffing was below the required numbers on 8 out of 9 days between 25 December 2015 and 2 January 2016. On 25 December 2015 staffing levels were seriously below the required number with only 1 nurse and 1 care staff between 2pm and 4.20pm. Further staff arrived at the service between 4.20pm and 5.30pm, but they still remained below the required numbers for the remainder of the day. We asked the manager how they had ensured people were safe and received effective care during this period of time and we were told that the nurse and care staff worked together to check each person in rotation, but did not provide personal care during this time. Records for two people showed that during the day on 25 December 2015 they remained in bed for most of the day and received only basic care and safety checks. The other 7 days where there were staff shortages the staff numbers were reduced by one to two care staff per shift. Additionally, there was no domestic staff on duty on 26 or 27 December 2015. The manager told us that there had been a number of unauthorised absences from work and agency staff had not been available to cover.

There were insufficient numbers of staff deployed in the service to keep people safe and meet their needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider followed robust procedures for the recruitment of new staff. The staff files we viewed contained included interview records, references and a disclosure and barring check. Gaps in employment history were explained. All staff received a basic induction and shadowed more experienced staff until they could demonstrate a satisfactory level of competence to work on their own. They were subject to a probation period before they became permanent members of staff. Disciplinary procedures were followed if any staff behaved outside their code of conduct. This ensured people and their relatives could be assured that staff were of good character and fit to carry out their duties.

People's medicines were managed so that they received them safely. The service did not have a policy for the administration of medicines available for staff to follow. The manager advised this was under review for the organisation. However, nursing staff had received appropriate training and the manager had made checks of their competence to administer medicines safely. The lead nurse ensured all medicines were correctly ordered and received, stored, administered and recorded. We saw nursing staff administering medicines and accurately recording when people had taken these. The pharmacy supplier had conducted an audit in January 2016. The manager had agreed to complete the arising actions by 19 February 2016, but had not yet written an action plan. People were protected by effective systems for ensuring they received

the medicines they needed at the right time and in a safe way. We recommend that the registered provider make available to staff an up to date medicines policy that reflects guidance from the royal pharmaceutical society.

People lived in a clean environment. People and their relatives told us that the service was kept clean. Staff were employed in housekeeping roles to ensure that areas of the premises were cleaned on a daily and weekly basis. The service held a policy on infection control and practice that followed Department of Health guidelines and helped minimise risk from infection. Staff had a thorough understanding of infection control practice and understood the importance of effective handwashing in reducing the risk of infection. Staff told us they used disposable gloves when providing personal care to people and we saw that staff obtained these before providing care. Staff understood and followed safe procedures for managing soiled laundry and clinical waste. This meant that people's risk of acquiring an infection was reduced.

Inadequate

Is the service effective?

Our findings

People and their relatives told us that staff employed permanently by the registered provider understood their needs, but most people commented that frequent changes in staff and the provision of agency staff meant that they were often cared for by staff that did not know them well or understand their needs. One person said, "Permanent staff know what they are doing, agency staff often don't seem to."

Residents said the food was mostly good, but some people commented that it was not always served at a suitable temperature.

People felt that the nurses responded to their health needs and enabled them to see health care professionals when they needed to. One person told us, "The staff got me the doctor last week as I had a chest infection and he came within an hour." Another person said that the optician visits the service regularly and they had recently received a new pair of glasses following a visit. One person's relatives told us that they had been waiting a long time to see a physiotherapist, but they felt the delay was not with the service, but with the community team.

At our inspection on 24 March 2015 we found the registered provider was in breach of the regulations relating to the training and support provided to staff to enable them to meet people's needs. They sent us an action plan stating they would be compliant with the regulations by August 2015. At this inspection we found that they continued to provide insufficient numbers of staff to meet people's needs. Staff had not received an appropriate induction into their roles. We were shown a basic induction that staff undertook to familiarise themselves with the service and the policies and procedures. We noted that a staff member who was currently on induction had completed the induction in one day. When we asked the manager if they felt this would be in sufficient depth we were told this was not in line with their expectations and should be completed over a longer period to allow the staff member to read and understand the policies. We asked to see the induction records for the agency staff working on duty on the day of the inspection, but these were not available. Staff told us that they had shadowed more experienced staff for their induction to the service, however one staff said this had been cut short due to staff shortages. The registered provider had not yet implemented the Care Certificate, which was introduced in April 2015, or a suitable alternative that meets the required standards. The care certificate is designed for new and existing staff and sets out the learning outcomes, competencies and standard of care that care homes are expected to uphold. An inconsistent approach to induction for new staff mean that people could not be assured that staff would work to the same standards when providing their care.

There was a programme of staff training in place. We asked the manager to provide us with a copy of an accurate record of the staff training provided and we were sent this by email to review. Staff training records showed that there were gaps in the provision of training for staff, for example, of the 29 staff employed in all roles by the service only 16 had completed health and safety training. 14 care staff were employed in the service. Only seven had completed a dementia awareness course and none of the staff had completed the Dementia advanced course that was provided by the registered provider. Staff told us that over half of the people that used the service were living with dementia in the advanced stages of the disease. Staff

commented that much of the training provided was using an e learning or workbook platform and that they had requested further face to face training to ensure they could fully understand the training subject, for example in respect of safeguarding training. Neither of the two cooks had completed the required food safety qualification. One nurse had been employed since October 2015, but had not yet completed any training relevant to their role including safeguarding, health and safety, fire safety and safe moving and handling. There was no record provided that showed this training had been completed in a previous role. Only one of the four nurses employed had completed training in pressure area prevention and we found that two people had pressure wounds in the service at the time of the inspection. Only two nurses had completed training in care planning and all the care plans we saw lacked sufficient detail and instruction for staff to follow to meet people's needs. Only three care staff held a relevant qualification in health and social care. The manager told us that more staff would be starting qualification this year and further training courses, including dementia, would be provided.

Staff did not receive adequate supervision in their roles to ensure they were skilled and competent to carry out their roles. The action plan sent to us by the registered provider stated that all staff would be having a six weekly supervision session with their manager by July 2015. We found that supervisions had been completed inconsistently with eleven care staff having no supervision since September 2015.

Staff were not provided with the induction, training and support they needed to ensure they could deliver safe and effective care. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 24 March 2015 we found the registered provider was in breach of Mental Capacity Act 2005 (MCA). They sent us an action plan stating they would be compliant with the regulations by August 2015. At this inspection we found that they had met the regulations and were following the principles of the MCA. 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. Staff were trained in the principles of the MCA and these were applied in practice. We saw that staff sought and obtained people's consent before they helped them. The care staff and nurses were clear about what to do if people refused care or treatment. When people had been assessed as not having the mental capacity to make specific decisions, a recorded meeting had taken place with their legal representatives to decide the way forward in people's best interest. This ensured people's rights to make their own decisions were respected and promoted when applicable.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest. The registered provider had considered the least restrictive options for each individual. This ensured that people's right to liberty were protected.

People had not always been provided with food and drinks that were appropriate or in sufficient amounts to meet their needs. People had an assessment of their nutritional needs, but their needs were not adequately planned for and met. Some people had drinks placed out of their reach and one person was provided with food that placed them at risk of choking. People were offered a choice of meals, although they were required to make their choice several days in advance on occasions, which may not always meet the needs

of people with memory problems. The manager advised they had identified this and was arranging for choices to be offered on a daily basis. Nursing staff were responsible for making sure people had enough to eat and drink and checking that daily recording charts were completed accurately. One nurse told us that often there were gaps on the charts and if this happened staff were spoken with about it. We found that people at risk of dehydration were not always provided with sufficient amounts to drink to meet their needs. People did not always have their nutritional and hydration needs met appropriately. We have addressed this under the management of risks in the section titled 'Is the service safe?'

People were supported to see health professionals, although we found that there had been some delay in referring people who were at risk of dehydration. A chiropodist visited every six weeks to provide treatment. An optician visited people upon request. People were involved in making decisions about their health, but did not always have their health needs met in a timely way, for example in respect of adequate fluid intake. We have addressed this under the management of risks in the section titled 'Is the service safe?'

We found that people's care plans relating to their mobility focused on staff moving the person and lacked information about how to ensure they retained their own mobility as far as possible. We did not see anyone being encouraged or supported to mobilise during the inspection. One person had a care plan for gentle exercises that were to be done on a daily basis by staff. This had not been done and staff we spoke with were unaware of this need. We recommend that the registered provider review individuals' mobility care plans to ensure that people are encouraged and supported to mobilise in a way that meets their needs.

The premises was under refurbishment to modernise the service taking into account the needs of the people who used the service, including those living with dementia. The registered provider had consulted with a specialist design company when devising the refurbishment plans. Staff told us they were looking forward to the completion of the redevelopment work and said that they, people and relatives had been involved in choosing the décor.

Requires Improvement

Is the service caring?

Our findings

People and their relatives were positive about the caring attitude of the staff. One person said, "Staff are very caring" and another said "Staff are much kinder here than in other homes I have seen." Most of the residents reported that they were treated with kindness, respect and compassion. One person reported they had not received compassionate care from one particular member of staff, but said that they had reported this and the matter had been resolved.

Staff that were in permanent roles and worked regularly in the service knew people well. However, there was a high turnover of staff and vacancies that were filled by agency staff. Where possible the manager had tried to use regular agency staff, but this had not always been possible. Staff and people told us that the high use of agency staff was challenging as they did not know people well and it took time for them to become familiar with people, their needs and their preferences. We found that information about people's lives and history was not used to develop the care plans. The activities coordinator said work on family histories was an area for development and had been discussed at their supervision.

At our inspection on 24 March 2015 we found the registered provider was in breach of the regulations relating to dignity and respect. They sent us an action plan stating they would be compliant with the regulations by June 2015. At this inspection we found that they continued to fail to ensure that people were consistently treated with respect and dignity. We saw examples of caring and compassionate staff practice, but we also saw a number of examples of staff practice that did not demonstrate these values.

During the first day of the inspection an inspector heard a member of staff shouting through kitchen hatch to staff in kitchen, "Couldn't give a damn today" and "They should have thought about this, it's cross contamination". This was within hearing of people who used the service. Staff frequently referred to people by their room numbers rather than their names. They referred to people that required assistance to eat their meals as 'feeds'. Staff were heard to speak to and about people in a patronising and undignified way, for example "Have you been a good girl today", "Be careful of him he's challenging", "He's in a bad mood" and "Thirsty girl aren't you." These examples did not demonstrate that staff treated people with respect.

We observed the way staff conducted their work was not always sensitive to the needs of people. Some people were sat in front of a television whilst another staff coordinated a singing group, other staff were shouting to another staff member and another staff came in and started vacuuming. This made it difficult for people to hear the television. A care staff said "Let's have some music on" and turned the television off without asking if people minded. Staff appeared to take the decision and there was no discussion with people. An inspector noticed a repeated humming noise coming from one person's room which was because their music CD had got stuck. Staff walking by did not notice or investigate this until the inspector raised it with them.

People's privacy was not consistently maintained. Records were stored in a nursing office which was unlocked during the day. A student on a work placement was vacuuming a corridor outside people's bedrooms whilst they were in bed in their night clothes with their door propped open. We overheard a

discussion about people personal care needs which took place in the hearing of other people. One staff asked person about their 'sticky eye' in front of other people.
People were not always treated with respect or their dignity and privacy maintained. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed some elements of good practice for example, staff ensured that people's bedroom doors were closed before providing personal care. Some staff demonstrated kindness and warmth towards people and staff were patient when providing support. Staff knew whether people preferred a male or female carer for their personal care and made sure this was supplied.

People were provided with information about the service provided and were signposted to other services available to them. They were given a brochure that contained information about the services provided and how to make a complaint if they needed to. There was a notice board for people's use that included current information about the menus, activities, events and local services. However, information was not in always provided in appropriate formats, for example staff said people living with dementia would benefit from choosing from a pictorial menu and that others would benefit from information in large print. We recommend that the registered provider review the format of information provided to people to ensure it meets people's communication needs.

Inadequate

Is the service responsive?

Our findings

People and their relatives told us that the service was responsive to their needs, but that they did not always have their care provided at the time they wanted. Examples, were given where people wished to get up earlier than they had been able to due to a lack of availability of staff.

People did not always receive a personalised service that reflected their needs and preferences. Each person's needs had been assessed before they moved into the service. This included their needs in relation to their personal care, safety, mobility, skin integrity, nutrition, health and personal preferences. This information had not been used to deliver personalised care. People's care plans included information about their preferences, for example what time they liked to get up and whether they preferred a bath or shower, but their preferences had not always been met. People were not always supported to get up and receive their personal care at the time they had said they preferred in their care plan.

On the second day of our inspection one person refused personal care until 11.30am, when a care staff from another part of the building was available to provide the care. Staff told us they knew the person would often only accept care from this particular member of staff. This had not been recorded in their care plan or taken into account in the staff deployment for that day to enable the preferred member of staff to be made available to help at the time they preferred.

Staff told us, and we saw, that they did not have time to spend time talking with people other than during the provision of personal care. Records did not indicate how staff reduced the risks of social isolation to those who spent much of their time being nursed in their rooms. We asked staff how they reduced this risk and they told us that they chatted to people when they provided their personal care and checked upon them hourly. We saw that the checks made were brief and staff had limited time for social interaction. Staff confirmed they did not have much time to interact with people outside of direct care tasks. During the first day of the inspection we saw that three people who used a wheelchair were positioned in front of the television in the lounge and were not moved or subject to more than passing interaction from staff for more than two hours.

One person's medicine profile did not indicate that they frequently declined their medicines. The person's medicines care plan stated that they were compliant with taking their medicines at the last evaluation on 28 December 2015. There was no guidance in the care plan for staff to follow, if they declined their prescribed medicines, to ensure their ongoing health needs were met. This meant that the person may not have received a consistent and responsive approach from staff to ensure they were referred to their GP if they continued to decline their medicines.

Staff had not completed the advanced dementia training, provided by the registered provider. Staff were unable to demonstrate that they understood how to meet the specific needs of people living with dementia, for example how to respond when people were distressed, agitated or confused. We saw that staff were inconsistent in their responses when people were disorientated in their reality or frustrated and the care plans lacked guidance for staff in providing appropriate responses. For example, some staff told us that, in

the case of one person who was crying out for their mum, that they explained to the person that their mum was no longer around, whilst others said they distracted the person and moved the conversation on. This inconsistently in approach did not ensure that people's emotional needs were met in a personalised way.

The service did not always respond in a timely way to changes in people's needs. A person who had been frequently refusing to eat and drink had been seen by their GP, but had not improved and a follow up appointment had not been made in a timely way. The nursing staff arranged for the GP to visit during the inspection when we raised concerns about the person's welfare.

People had not been consulted about their hobbies and interests and did not have an individual plan, as part of their care plan, for ensuring that they were occupied in the way they wished and that their social needs were met. There was a programme of activities during the day, although at the time of the inspection the activities did not reflect the scheduled activities displayed on the activity board. This can cause confusion for people living with dementia.

Staff told us, and records showed, that one person frequently became aggressive with staff and placed themselves and others at risk of harm. The person's care plan did not give staff clear information about how to respond to this behaviour that challenged the service. Staff told us they left the person if they refused care or became aggressive, but that this had not always been possible before an incident occurred. Records showed that a member of staff had been hit by the person, resulting in the need for medical attention. Other records showed frequent incidents of the person hitting out at staff. There was a lack of clear and directive guidance for staff to respond in these situations, other than a recorded instruction for staff to remain calm and leave the room. The person's care plan had not been reviewed following the incident that had resulted in staff injury. There was no record to show what action had been taken to keep the person and staff safe. The person's care plan did not demonstrate that the reasons for the challenging behaviour had been assessed to allow staff to provide an appropriate response. The person was labelled by staff as 'challenging' and some staff told us they avoided working with the person where they could. This meant that the person did not have their needs met in a sensitive or personalised way, ensuring the safety of them and staff.

People did not always have their needs met or receive a personalised service that met their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's views were sought through residents and relatives meetings which were held quarterly and an annual survey was sent to people's relatives or representatives. Records showed that people were asked about their views of the care, the range of activities and the quality of the food. Some people were unable to contribute to the meetings and surveys, due to limited communication or understanding. Whilst the views of their relatives had been sought the registered provider had not considered alternative and creative methods to seek the views of the person themselves. We recommend that the registered provider seek advice about the use of alternative ways to seek feedback about the service from people with limited verbal communication.

People knew how to make a complaint and most said they would speak directly to the nurse in charge or the manager. The provider had a formal complaints policy and procedure. The complaint procedure was displayed in the reception area, but was in small print only and not easily accessible to people living in the service. Complaints had been recorded and responded to within an appropriate timeframe. We recommend that the registered provider make the complaints procedure available in alternative formats suitable to people's communication needs.

Inadequate

Is the service well-led?

Our findings

People and their relatives told us that there had been frequent changes to the management of the service. One person said "The home has been very unstable, I hope that will settle with a new manager." Another person said, "I have met the new manager, who seems very nice, but they do not seem to keep managers so we will have to wait and see." People said they felt they could contact the manager at any time to discuss any concerns. One person said "All in all it is a very good home."

There was a new manager in post who had not yet applied to be registered with CQC. The previous registered manager had left the service in August 2015. An interim manager worked in the service until a permanent manager was recruited in December 2015.

At our inspection on 24 March 2015 we found the registered provider was in breach of the regulations relating to the monitoring and improving of the quality and safety of the service. They sent us an action plan stating they would be compliant with the regulations by September 2015. At this inspection we found that they had continued to fail to ensure that systems for monitoring and improving the safety and quality of care were effective. The registered provider had not successfully made the required improvements from the last inspection or had not sustained the improvements made.

Audits and quality monitoring systems had not been effective in identifying issues with the culture of the service particularly in respect of the approach of staff. An audit of the philosophy of the service, carried out the day before the inspection, had not identified that staff were not working in a way that reflected the values of the organisation or that demonstrated respect for people.

There was a lack of effective leadership of the service. Staff and people were uncertain about the future of the management of the service. However, staff said they felt supported by the new manager and said the manager was making positive changes to the workforce. One staff told us, "I think X [the manager] is right for this place, if anyone can drag us up from the gutter she can". The nurse in charge of the service on the day of the inspection did not know if there were any agency staff working in the service on that day, which meant that they could not be sure that the staff caring for people were skilled or supported adequately. There were agency staff working in the service that day. The deployment of the staff in the service was disorganised resulting in people not receiving personal care until lunchtime and people waiting for 40 minutes for their meal to be served.

Accurate and complete records had not been maintained to ensure that people received the care they needed and that changes in their needs were acted upon quickly. For example, records about the fluid intake for people deemed at risk of dehydration were frequently incomplete or had not been reviewed at the end of the day to ensure an adequate fluid intake had been provided. This meant that nursing staff did not have accurate information to enable them to be response to changes in people's needs or wellbeing.

Some people's care plans were not updated to reflect changes in need at the time of the change. For example, one person had a chest infection, but this was not included in their care plan so that staff knew

what action to take to aid their recovery. The prescribed antibiotic treatment had not been included in the care plan. The equipment and method used for one person to move them had changed and this had not been reflected in their care plan. As a result staff were unclear about the safest way to move the person, placing themselves and the person at risk. There was inconsistent guidance for managing the risk of choking during eating for a person. There was a lack of clear and directive written guidance for staff to follow to minimise the risks of aggressive behaviour in respect of one person. Some writing in the care plans and the daily records was either illegible or difficult to read. This meant that nursing staff, the manager and registered provider would not be able to use the information to act upon changes in need or to evaluate if the person's needs were being met.

The nominated individual raised concern with us during the inspection about insufficient feedback received from the GP following a visit to a person. They arranged for the GP to call back to provide a clearer plan of care to meet the person's needs. However, we found that the nurse who had received the initial feedback from the GP had not recorded what information had been given and had not challenged a lack of information at the time of the GP visiting.

The above examples are evidence that the registered provider had not ensured the systems and processes for monitoring and improving the quality and safety of the service were effective. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had not consistently notified the Care Quality Commission of any significant events that affected people or the service. They had failed to inform us of the serious shortages of staff during December 2015, particularly on 25 December 2015. This was a breach of Regulation 18 of the Care Quality Commission (registration) regulations 2009 (Part 4).

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider had not consistently notified the Care Quality Commission of any significant events that affected people or the service. Regulation 18 (1)(2)(g)(i)

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not ensured that people's needs were met or that they received a person centred service. Regulation 9 (1)(a)(b)(c)(2)(3)(a)(b)(d)(i)

The enforcement action we took:

We issued a warning notice to the registered provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had not ensured that people were treated with dignity and respect or that their privacy was maintained. Regulation 10 (1)(2)(a)

The enforcement action we took:

We issued a warning notice to the registered provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured that people were protected from the risks on unsafe or inappropriate care or treatment. Regulation 12 (1)(2)(a)(b)

The enforcement action we took:

We issued a warning notice to the registered provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had not ensured that appropriate and adequate steps were taken to

	keep people safe from the risk of abuse or harm. Regulation 13 (1)(2)(4)(c)(d)(6)(a)(b)(c)(d)

The enforcement action we took:

We issued a warning notice to the registered provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not ensured that effective systems were in operation for monitoring and improving the quality and safety of the service. Regulation 17 (1)(2)(a)(b)(c)(f)

The enforcement action we took:

We issued a warning notice to the registered provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had not ensured sufficient numbers of qualified and competent staff were deployed in the service to meet people's needs. Staff were not provided with adequate induction, training and supervision to ensure they could provide safe and effective care and treatment. Regulation 18 (1)(2)(a)

The enforcement action we took:

We issued a warning notice to the registered provider