Speciality Care (UK Lease Homes) Limited

Riverside Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection of Riverside Court took place on 17 and 24 April 2018 and was unannounced on both days. At the last inspection in March 2017 the home was rated requires improvement and had six breaches of regulations in dignity and respect, need for consent, safe care and treatment, safeguarding service users from abuse and improper treatment, good governance and staffing. Following the last inspection, we met with the provider and asked the provider to complete an action plan to show what they would do and by when to improve the five key questions to at least good.

Riverside Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Riverside Court accommodates 60 people across four separate units, each of which have separate adapted facilities. The home was divided into four units; Shannon unit was for people with nursing needs and living with dementia, Clyde unit was for people living with dementia and Trent and Avon units were for people who needed support with daily living activities, some of whom may be living with dementia.

There was no registered manager in post but a newly appointed manager had recently started at the home and was in the middle of their induction. They were in the process of being registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found serious concerns within the home. Staff were unaware of how to recognise or report safeguarding concerns and could not appreciate the support they were providing was, in some cases, increasing people's distress and sense of anxiety.

Risks were identified but then not managed to reduce the likelihood of harm for people. Staffing levels were not sufficient to ensure people had a good quality of life as many remained in their rooms all day with little, or no, interaction. In addition, a lack of continuity of staffing meant people did not know who was supporting them each day and some agency staff displayed little knowledge of how to support people safely or effectively.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice. Although progress had been made in regards to obtaining legal authorisations to deprive people of their liberty, people were not encouraged to take positive risks and many had unnecessary restrictions placed on them.

Medicines were recorded, stored and administered safely for the most part apart from the use of PRN, or 'as required', medication. We found two people where medication had been used to reduce their behaviour

which may be seen as challenging themselves or others rather than any evidence of positive behaviour management techniques. Staff appeared unaware of how to support people living with dementia effectively or safely, with minimum restrictions to their liberty.

Care records, although slightly more person-centred than found during the previous inspection, were large and often illegible, and staff readily admitted to not reading them as they did not have time to do so. Nutritional guidance was mixed and people did not have ready access to snacks and drinks throughout either day of the inspection.

We found the provider had not followed advice received from health professionals regarding suitable equipment to prevent pressure damage and other health-related issues. It was only on the second day of the inspection an order was put in for some equipment but this was not reflective of all people's needs.

People's privacy and dignity was not respected or promoted within the home. We found people's doors were wide open and no appropriate consent in place, and some staff also spoke openly about people's conditions while in communal areas.

We found some staff to be uncaring and very task driven, and for those who were more empathetic, were confounded by the over-use of agency staff who sometimes showed little initiative.

There was a lack of transparency and openness within the home's culture and people were not supported by well-managed staff. Although the new manager was on induction other senior staff were present on both days but did not acknowledge the concerns we found. Quality assurance was poor and did not provide sufficient confidence to evidence people were safe or well cared for.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, five of which were continuing from the previous inspection.

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.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were insufficient staff to meet people's needs safely, and risks were not always managed properly.

Medication was managed in accordance with requirements but there was inappropriate use of sedative medication for some people with more complex behaviour.

Some parts of the home were unclean as there was insufficient staff available to support this task.

Is the service effective?

Inadequate

The service was not effective.

People were not supported with nutrition and hydration sufficiently and staff displayed a lack of knowledge about to support people living with dementia.

There was little evidence of best practice, and advice from other health and social care professionals was not always followed.

Staff did not fully understand the implications of the Mental Capacity Act 2005 or its associated Deprivation of Liberty Safeguards.

Is the service caring?

Inadequate

The service was not caring.

Although some staff showed empathy, this was mostly lacking and some staff ignored people in distress.

There was no evidence of people's involvement in their care planning.

People's privacy and dignity were not respected.

Is the service responsive?

Inadequate

The service was not responsive.

Care records were comprehensive but not always reflective of people's needs.

People did not have access to person-centred care as most stayed in their rooms, with little stimulation or attempt at engagement.

Complaints were acknowledged and investigated.

Is the service well-led?

Inadequate

The service was not well led.

There was no evidence of clear direction or leadership within the home. Although the manager was new, there were other senior leaders who had knowledge of the service but this was not shared with staff.

Governance was ad hoc and had not identified the concerns we found.

Partnership working was poor as advice was not followed and there was little evidence of staff learning from incidents.

Riverside Court

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 17 and 24 April 2018 and was unannounced on both days. The inspection team consisted of four adult social care inspectors and one expert by experience on the first day. 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 expert's experience was in dementia care. ON the second day three adult social inspectors visited the home.

Before the inspection we requested a Provider Information Return (PIR) which was returned to us. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We checked information held by the local authority safeguarding and commissioning teams in addition to other partner agencies and intelligence received by the Care Quality Commission.

We spoke with 10 people using the service and eight of their relatives. In addition, we spoke with 16 staff including six care staff, two nurses, the maintenance man, a member of the domestic team, an activity co-ordinator, the deputy manager, the clinical lead, the quality manager, the manager and the operations director.

We looked at four care records including risk assessments in depth and other sundry records, three staff files including all training records, minutes of resident and staff meetings, complaints, safeguarding records, accident logs, medicine administration records and quality assurance documentation.

Inadequate

Is the service safe?

Our findings

At the last inspection we had concerns about how the provider was minimising risks for people, supporting people with their medication and managing infection control practice. During this inspection we found some improvements had been made with medication management but not in the other areas.

There were insufficient staff to meet people's needs safely or in a person-centred manner. Most people spent the day in their rooms, often in bed, with their doors open and staff periodically walked up and down the corridor looking in the rooms but did not always acknowledge them. People who were able to mobilise independently walked up and down the corridor without purpose and staff made little attempt to engage with them.

People told us they had to wait for staff. One person told us, "In general carers are good, never seems to be enough of them. I wait a long time sometimes; then, when they come they say they can't do 'owt as they're on their own and need to go get someone else." This person continued, "I'm not happy with the lack of staff, there's quite a few agency staff, quite a lot of changes." Another person stated after 10.15am, "They're a long time coming with my breakfast, my tea's cold."

Relatives we spoke with echoed these views with comments including, "Doesn't get enough showers; I've asked but they say they can't do it because there's not enough of them. I do it," "They're very good carers but there just aren't enough of them up here because of the numbers that stay in bed. There are a lot of agency staff especially at weekends," and "Same staff do tea trolleys, personal care and sometimes at weekends, they have to serve and wash up. Just over worked and work hard."

There was no nurse on the Shannon unit on the first day as they had rung in sick and so the deputy manager took this role. However, we did not see them assist with any care and support of people. This included lunchtime when staff were struggling to support people due to their complex needs. A nurse from another unit came and supported people with medication during the morning. This unit was also staffed with two agency care assistants and one permanent care assistant. A further care assistant arrived late morning and advised us they had been working in the kitchen until that point. This meant people were not receiving support from staff who knew them.

Staff told us they did not feel there were enough staff on duty and people could not be supported properly as they did not have time to engage and maintain their safety. The deputy manager explained each day was different so staffing levels were "sometimes acceptable". We were told by a member of the domestic team if cleaning staff were on leave or sick, this was not covered. The provider had an electronic staffing tool which allocated staffing hours but we noted the information entered did not accurately reflect people's dependency levels, thus distorting the amount of staff required to support people safely.

We looked at staffing rotas and found shifts were covered, but not all by permanent staff. We were assured by the operations director, agency staff who were employed knew people well but our observations did not match this view as we observed agency staff regularly being prompted by permanent staff as to who people

were and what tasks to undertake. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staffing was insufficient in meeting people's needs.

One person told us, "I'm as safe here as I was at my last place" and another said, "Yes I feel safe, I think they know how to look after me." However, this was not the case for everyone living in the home. We observed an incident between two people in the lounge on the Shannon unit; no staff were in attendance and two people hit one another. We intervened and supported one of the people away and pressed the call buzzer. One agency care assistant arrived who had been supporting another person in their room as the two other staff were otherwise occupied. We reported the incident to the two permanent care staff later in the day and spoke with the deputy manager who had not been informed this had occurred. This meant people were not being safeguarded from harm as staff seemed unaware of how to respond to and report the incident, and we did not see any checks made on the people concerned to ensure their safety and well-being. The incident was later reported inaccurately and no records were in either person's file by the second day of the inspection. This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as records were not accurately maintained.

People had risk assessments in their care files, however these were not always used to inform the care records. One person's record stated their falls risk score had changed due to a change in their medication in March 2018 and referenced a new care plan was required. However, there was no new care plan in the person's file and the effect of the medication change was not clear. Moving and handling plans stated specific equipment was in use but then not referenced in the 'safe system of work' nor in the risk reduction measures, which meant staff did not have correct guidance to follow. We noted some repositioning charts only had one signature when two staff should have been supporting. One person was deemed at low risk of choking and yet required thickener in fluids to prevent aspiration. Behaviour management plans for people with more complex behaviour were not thoroughly completed for staff to be able to respond to their needs appropriately. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risks were not sufficiently assessed.

Maintenance checks were completed as necessary on equipment and the premises, and records reflected these were current and regularly monitored with actions taken in a prompt manner. Fire drills also took place regularly and while we were present the fire alarm was tested in accordance with requirements. There were personal emergency evacuation plans (PEEPs) in people's files but one person's PEEP stated they required one-to-one support in the event of any evacuation as they were likely to abscond. The unit only had one member of staff on duty at night for a maximum of 15 people, so we could not determine how this would be achieved. When we checked the file kept for emergency evacuation we found this was not complete and meant not everyone in the home was accounted for.

We looked at the systems in place for the receipt, storage, administration and disposal of medicines. We saw temperatures of the clinical room where medication was stored and the medicine fridges were recorded daily and were within guidelines. Medicines were clearly recorded on Medication Administration Records (MARs) along with any medicines already in stock. This meant the MARS gave an accurate record of the amount of medicine available for each person. We checked a random sample of medicines and found the amounts available corresponded with the amounts recorded as received and administered. We also saw controlled drugs were appropriately stored and records were accurately maintained, which reflected stock levels. Where medicines were given covertly this was clearly detailed on a covert medication form kept with MARs with appropriate best interest decisions having taken place.

Topical medicines such as moisturisers or barrier creams were signed as administered on topical medication administration records (TMARs) kept in people's bedrooms. A nurse told us that creams such as

steroids which may be harmful if not used correctly were stored in medicine trolleys and applied by the person trained to administer medicines.

We saw protocols for medicines given on an 'as required' (PRN) basis were in place for some, but not all PRN medicines. For example protocols were in place for PRN pain relieving medicines such as paracetamol but were not in place for two of the random samples we checked of medicines prescribed to relieve anxiety or unsettled behaviours. We saw one person had been given their PRN medicine for four consecutive days because of unsettled behaviour. When we checked this person's daily records, we did not see any record of actions taken to try to support the person to settle before administering their PRN medication. We found another example of medication being used without any reference to other strategies being attempted first. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as medicines were not being used properly as a last resort to manage more complex behaviour.

Some areas of the home were untidy and unclean such as a bookcase which contained items of food. Cupboards contained random items such as a thermostatic radiator valve and deflated balloons. We saw this had been addressed by the second day of the inspection.

We looked at staff recruitment records and found appropriate checks had taken place. References were obtained and Disclosure and Barring Service (DBS) Checks completed. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

Inadequate

Is the service effective?

Our findings

At the last inspection we found concerns with a lack of staff induction, people being deprived of their liberty unlawfully and insufficient mental capacity assessments. We found continued evidence of lack of appropriate induction and training for staff, and further issues with mental capacity assessments.

Only one person we spoke with spoke positively of the food, saying, 'Food's alright, they do well with the food here." All other comments referred to drinks being cold and the food being mediocre.
We observed people left with breakfast in their rooms and no assistance offered by staff to eat or drink. On one occasion a person had lost their teeth which were under their chair and their full dinner plate was in front of them. We saw the care assistant come into the room, pick up the teeth leaving them on the side and take away the full dinner plate and the person's drink.

We did not see any drinks or snacks served to people throughout the morning despite asking staff on several occasions when they would be served, and people did not have access to water as they had no drinking glasses. People in the Shannon unit were taken to the dining room for lunch half an hour before any meals were served. One person shouted for food throughout this time. Meals were pre-plated in the kitchen and handed to staff saying who it was for. The meal looked appetising and was nicely presented. However, people were not offered a choice or assisted to make a choice as all meals were the same. People were not offered any juice to drink. Condiments were not available and when one person shouted out for salt, the care assistant went into the kitchen and returned with a salt grinder which they used to put salt on the person's meal. The person was not given the option of putting their own salt on. Nobody else was offered condiments.

There was an inconsistent staff presence in the dining room as staff were both serving people and supporting others in their rooms. We observed some people were struggling to eat as they were confused with their cutlery. We saw one person try to eat their meal with their fork handle and knife for some time until we brought this to staff's attention. Another person was asking for help throughout the meal without any being offered until a member of kitchen staff came to their assistance. The person continued to ask for help after the person left. We saw one person eating their meal in bed. They shouted to us and asked us to take their pudding away. We saw the pudding had bits of cabbage in it from the first course and some orange juice which had been on the person's over bed table. This meant the person had not been supported to eat their meal appropriately. This was reflected in Clyde unit where people were left unattended in the dining room and had to listen to some loud music. One person was denied a knife to eat their food as care records showed the person was prone to taking them and staff only allowed them a fork. This is a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the nutritional and hydration needs of people in the home were not always being met.

On the Trent unit five people attended the dining room, and six on the Avon unit meaning the majority of people remained in their rooms all day, often in bed as few people were supported to sit in easy chairs. However, organisation on these two units was generally better with staff clear about who they were supporting. There was a positive atmosphere and good levels of interaction between staff and people. Staff

were discreet and friendly, offering encouragement to eat and drink and prompting those people who needed it. One person complained the custard was too thin and so a new batch was made for them.

One person's care records stated they had lost 5kg in weight since their admission in February 2018. We saw the dietician had visited and advised the person required a fortified diet and should be given two fortified milk shakes each day. We looked at the person's fluid intake charts for the period 7 – 16 April 2018 and saw the person had been given only one milk shake during that time period. Food intake charts for this person showed they were not consistently offered snacks between meals and milk and gravy were frequently listed as fortified foods. In another person's record it was stated they had a particular condition where fluids needed to be encouraged. However, their fluid intake chart showed they had had an insufficient intake.

During the afternoon on the first day of the inspection on the Shannon unit we saw some people were served cake and drinks. We heard one person asking for cake but the agency care assistant told them they could not have it because they needed a pureed diet. We asked the care assistant about this because we had seen the person eat a normal diet at lunch. They went to check and on return said they could have cake with cream on. Had we not intervened this person would not have received cake because the member of staff was not aware of their dietary requirements. Advice from the Speech and Language Therapy (SALT) team was not integrated into care documentation which meant people could be at risk of the wrong diet. When we asked a care assistant about people's nutritional requirements they were not aware of the SALT advice.

People's healthcare needs were detailed within care plans and we saw records to show health care professionals had been involved in people's care as needed. One relative told us, "I know they're on the ball if medics are needed, they seem to get a quick response." However, we were concerned care plans were not always followed. For example, we saw a care plan had been developed for one person over two weeks prior to the inspection which stated the person had a scabbed area to their toe. The care plan said for this to be reassessed daily. We did not see any further mention of this within the person's care records and the care plan had not been reviewed. We also observed one person had removed their slipper and had a very red, sore looking area on their toe. We mentioned this to care staff who agreed it looked very sore but just put the person's slipper back on. When we checked the records the second day nothing had been recorded or any action taken. There was only reference to a small blister on the person's toe on 1 April 2018.

We saw a number of people were nursed in bed. When we asked the deputy manager about one person, they said they did not know why they were in bed because they 'hadn't worked the floor' for some time. They did not look at the person's care plan. We saw from the care plan the person was able to sit out for short periods but needed staff or family to be with them when they did this. We looked at the person's care records and could find only one occasion in the past two weeks of them sitting out of bed. Although people had been provided with appropriate pressure relieving mattresses, there was confusion within the care records and between staff as to what the correct settings were. This had been identified on the previous inspection. The provider responded on the first day of our inspection and recording had improved by the second day with a promise of supervisions for staff to ensure they all understood what was required.

We also found people had not been provided with equipment recommended by the Vanguard team. The Vanguard team exists to provide intensive support to care homes to prevent unnecessary hospital admissions. Some of these requests for the equipment had been made to the provider in August 2017. The provider responded to our concerns by ordering some equipment on the second day of the inspection but this meant other people had not been supported in the most appropriate or a timely enough manner. One person who was supposed to be wearing a palm protector due to their contracted fingers, was observed not to be on the second day of inspection. This is a breach of Regulation 12 Health and Social Care Act 2008

(Regulated Activities) Regulations 2014 as not all had been practicably done to mitigate risks to people.

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.

We found people who lacked capacity to make specific decisions had been assessed in accordance with the MCA. However, some of these contained multiple decisions and did not evidence involvement of relevant parties such as an advocate. Best interest meetings and decisions were recorded in relation to a range of areas where people lacked capacity to consent. This included receiving their medicines covertly (hidden in food) and restrictions such as sensor alarms to alert staff to their movements. However, one person's best interest decision referred to a discussion with their family member who was noted as being a Lasting Power of Attorney but no evidence was in the file to determine what authority they had or what they had specifically said.

We found not all capacity assessments were correct as some people were recorded as having capacity to make specific decisions when they did not. Equally, where people had capacity they were judged not to be able to make a specific decision even though the reason was a physical, rather than cognitive, impairment which is an inaccurate assessment. This is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as consent was not always obtained where people lacked capacity.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Most staff we spoke with were unaware who had a DoLS in place and therefore did not know if they were legally depriving someone of their liberty. We found DoLS had been applied for and conditions integrated into care plans more than during the previous inspection but our observations indicated people were being restricted in their day to day living as there was limited evidence of consent.

One person told us, "They look after us well in here; they seem to know what they're doing." However, our observations of people who were unable to verbalise their needs was different. Staff displayed little understanding of how to support people living with dementia effectively. One care assistant told us, "[Name] knows where their room is but they keep emptying their room and trying to move it to another." This person had only been admitted the week before and no signs were on their door to indicate which room was theirs. Staff's knowledge of how to support the person safely was limited; their methods included trying to get them to watch musicals or listen to Abba. We observed this person frequently try and leave the unit as they did not want to be there and were desperate to go outside. There was no evidence they had been supported to go outside over the previous week as staff told us the person was likely to abscond. One care assistant told us, "They try to escape" reinforcing the message the home was keeping people in.

We looked at induction records and found these were often incomplete. One care assistant told us they had supervision six-monthly which they said was time spent discussing training needs. Another care assistant who had started in February 2018 had not had a supervision despite having no experience of care. We saw supervision records were pre-determined topics with general guidelines for staff. We saw no evidence of observations of staff performance, or any reflection of what they did well or where they needed further

development.

Another care assistant struggled to remember any training they had completed in their four years at the home and told us they relied on knowledge from their previous job. Staff had access to e-learning which they completed in their own time. Training records showed staff had not completed all necessary training with 16% of care staff and 11% of nursing staff having expired training on their records. None of the training records we were given referenced any care relating to dementia awareness although the provider assured us training was being provided the week after the inspection visit to all staff. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff were not suitably skilled, competent or experienced.

The home had contrasting environments reflective of the quality of care provision in each. Signage was poor in the home and there was little in the way of personal effects to aid people's orientation Lounges were sparsely furnished. We noted the Shannon unit lounge had been re-painted on our second day but the TV was placed above three chairs where people were seated which meant it could not be used. Some puzzles placed on the wall were potential hazards for people as there were sharp edges.

Inadequate

Is the service caring?

Our findings

At the last inspection we had concerns about how people's privacy and dignity was being promoted as room doors were left open. We found this was still common practice on this inspection.

People told us, "In general, carers are good" and "Very good carers." However, we found mixed experiences of staff conduct and interactions. On the Trent and Avon units staff appeared more caring but on the Shannon and Clyde units staff displayed little understanding of how to support people with dementia effectively. A person newly admitted to the home was left to wander, constantly asking to leave, and staff did not provide reassurance or distraction to support this person. We observed staff leaving another person's room who had been shouting, and as they left the person asked for a drink but they were ignored.

Staff did not always treat people empathetically. One person who was very distressed was repeatedly told by a care assistant, "Don't cry" without any attempt being made as to find out the cause. When prompted by an inspector, the care assistant asked the person what was upsetting them but dismissed their response. Another person, who it was noted in their care plan reviews, was attempting to stand unaided, was told periodically to sit back down in their wheelchair by care staff. A further person was heard crying out when the tea trolley was moving around, and the care assistant responded to them, saying, "What are you shouting for?" They seemed unaware of how to support effectively and care records did not provide the necessary guidance.

We found a number of incidences where people's dignity was not promoted. We saw some people had not had shaves or their hair combed, and several people wore clothing which was stained. None of the people who were mobile on the Shannon unit wore socks, tights or stockings. When we asked the deputy about this they told us they all took them off, however we saw no attempts by staff to encourage people to wear such items. Two people were wearing odd slippers and female residents were not wearing bras. When we asked a care assistant about this, they told us this did not happen if a particular nurse was on duty. However, again they took no action to support people to change their clothing. We observed one person walking around the lounge with their trousers falling down and their buttocks and incontinence pad clearly visible. None of the staff who came in and out of the room attended to this.

People's oral care was neglected and hand hygiene was not promoted as many people had dirty nails. One person who struggled with verbal communication had not been provided with any alternative forms of communication to aid understanding.

Continence care plans and care records in people's bedrooms did not mention supporting people to the toilet but only mentioned checking and changing incontinence pads. We did not see any person supported to use the toilet during our time on either the Shannon or Clyde units which meant people's independence was not being encouraged, and daily records did not indicate this either.

We did not see evidence of people having been involved in their care planning but saw families had been involved in providing life histories wherever possible. However, we saw little evidence of staff's knowledge

about people's past to help provide effective support.

People in bed had their doors open and could be seen by anybody passing by. During the morning on the first day on the Shannon unit only two people came out of their bedrooms. None of the people who were unable to mobilise independently were supported to leave their rooms. When we asked staff about this, they told us it was 'their choice' however we did not hear any people being given this choice. A member of agency staff walked up and down the corridor with their hands in their pockets looking at people in their rooms but did not engage with people in any way. Although some people were calling out from their rooms, the member of staff did not respond to them. When asked by one inspector what were the plans for people that day, they did not know and explained they were "watching the corridor." During the afternoon we saw the same member of staff standing in the doorway to the lounge watching people but not interacting in any way.

When we asked the deputy manager why staff did not sit in the lounge and interact with people, they told us it was because it was "an EMI unit." 'EMI' (elderly, mentally infirm) is an inappropriate term used to describe people who are living with dementia and this comment did not promote people's dignity. We also found reference to this term in mental capacity assessments where one stated, "for [name] to reside in a secure EMI residential unit." The use of this term was common in the home and showed staff did not consider the impact of such terminology.

In one person's room we saw their family photographs were in the bottom of their bedside cupboard with toiletries stored on top of them. This demonstrated a lack of regard and respect for people's belongings. All the above examples are a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not consistently treated with dignity or respect.

We did see some caring interactions from one care assistant and we saw a nurse from another unit wish a person a happy birthday and give them a hug. In other units, staff did engage with people as far as time allowed but these were limited interactions.

We saw some care plans had details of people's preferences for their attire such as hair style and clothing preferences. One stated, "[Name] likes perfume but not sprays, so staff should put onto their fingers and then [name] will transfer to their skin."

Inadequate

Is the service responsive?

Our findings

At the last inspection we found issues with poor record keeping. During this inspection we saw attempts had been made to improve them but records were not always reflective of people's needs. We found the majority of care plans very difficult to read due to the handwriting of the staff who had written them. When we mentioned this to the deputy manager, they said "If you think these are bad, you should see some of the ones on other units."

Care records contained key information such as a person's preferred name and their keyworker, family and health professionals' details. People's needs with communication, mobility, falls, nutrition, personal hygiene, skin integrity, psychological wellbeing and activity preferences were recorded. However, records were not always accurate. One person's oral care assessment identified the person had no issues with swallowing nor any dexterity issues and yet in other assessments they were unable to use a call bell and had received SALT advice for a soft diet. In another person's falls assessment they were deemed high risk as they were mobile and incontinent but their pre-admission assessment and bowel assessment stated they were fully continent. Their mobility care plan stated they enjoyed walks around the garden but we could see no evidence these had taken place. One care assistant told us, "[Name] doesn't get to go out" but had no justification for this.

One care assistant told us, "We sometimes get time to read the care plan. The main bits we need to know, nutrition, moving and handling. You look at the most recent review to see current needs. We get an oral handover and the seniors will tell us about any changes in people." A communications book used on one unit provided basic reminders for staff such as filling in topical medication charts.

One care assistant spoke with us about how they knew a person was distressed as they starting singing a particular song but when we checked the communication plan to assist staff in how to support this person, there was no reference to this. In another person's falls care plan it stated their frame and sensor mat were to be close at all times. However, when we checked their room the frame was nowhere to be found. In a different person's dependency assessment it was noted they were 'physically aggressive' and yet there was no corresponding care plan in place to guide staff as to how best manage this person safely and with the least restriction.

Care records were large and difficult to navigate as although reviewed regularly, we found much of the current information was on the review form rather than integrated into the care plan which meant it was time consuming for key information to be found. One person was admitted to the home on the first day of the inspection but the pre-assessment information was sketchy and subsequent assessments did not provide sufficient detail. Two staff we spoke with admitted to not having time to read the care plans for people, preferring to rely on information from the handover. This meant staff did not have a rounded knowledge of people's needs as the handover focused on key events or incidents. This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as records were not always accurate or complete.

In the Clyde unit staff had access to a board which outlined people's main needs including whether they had an infection, any wounds, their food and fluid requirements, mobility, weekly weights if needed, and falls which included the date of the last fall to better judge the risk for that person. This provided key information in a clear and succinct format which was essential due to the use of agency staff being used in the home. This was mirrored in each unit although the quality of the information varied.

When we arrived on the Shannon unit on the first day of the inspection, the television in the lounge was playing very loudly. The person in the lounge put their hands over their ears and left the room. We mentioned this to the deputy manager who said they could not find the remote control and turned the television off. Later in the morning, a care assistant told us they had found the remote and had sorted out the television. We saw the television screen said 'DVD' but no programmes were playing.

Many of the people, who spent most of the day in their rooms, did not have anything to provide entertainment or stimulation. People sat in chairs facing the corridor. During the afternoon we heard music being played in the lounge. However, when the CD finished no attempt was made to play another one. There was a complete absence of any interaction with people and no activities were arranged for people to engage with.

On the Clyde unit people were encouraged to sit when they were walking up and down the corridor. We heard one care assistant say, "Just sit here for five minutes. It'll be lunchtime soon." No attempt was made to sit with the person or engage then in an activity in any way. Later in the afternoon we observed one person trying to get out and becoming very distressed. Again, a different care assistant said, "You need a sit down." This person tried a further time to leave but was escorted back to their room without any explanation by the care assistant who just said, "I don't have the code to get out." Loud music was playing constantly on both days which was difficult to avoid. This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as care was not person-centred.

The only activity for people on the first day was the hairdresser and the activity co-ordinator encouraged people to attend the café where drinks and cakes were provided. People were engaged in this but the cafe could only accommodate a small number of people at a time. We saw no evidence of any attempt at one-to-one interactions with people in their rooms; if care staff did go into the room it was to complete records and little attempt to engage with people was made. We did not see anyone supported to go outside with staff even though there was an enclosed area for people to access. One person did tell us, "They have arts and crafts sometimes, I do my crosswords," and a relative said, "I'm perfectly happy, I can come anytime. They call me if they want me." Daily records confirmed few people engaged with any activity provision.

There was a small print complaints policy on the wall in the home which was not in line with the Accessible Information Standard and one relative told us they had complained about poor medication practice by agency staff. Other people told us they had raised issues but not all felt they were resolved satisfactorily. The home had only one complaint recorded in 2018 and this had been acknowledged and dealt with appropriately. We saw a nice display book in the reception of area of compliments received by the home which included, "Thank you for all the caring", "We appreciate all you have done" and "[Name] and [name] for the new lease of life on activities."

Inadequate

Is the service well-led?

Our findings

The home did not have a registered manager in post. Since the last inspection two managers had been in post and the home had just recruited a third who was on their induction. They were in the process of registering with the CQC.

There was a clear lack of leadership evident in the home on both days of the inspection. The deputy manager was part of the staffing figures on the first day and the manager was on their induction. This meant, despite the presence of other senior managers in the home, staff generally had little direction or guidance. We found little evidence of improvement within the home following the previous inspection. This is a continuing breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the assessment and monitoring regarding the quality and safety of the services provided was ineffective.

We did observe one nurse provide clear direction during meal time to a care assistant who was supporting one person with a drink. This nurse was both knowledgeable about the people in their unit, sharing specific information about people we had expressed concerns about, and was empathetic in their manner.

There was a notice on the wall staying the manager was available every weekday night between 4 and 5.30pm every weekday if anyone wanted to raise any concerns.

One relative told us, "There are relatives' meetings. I didn't come to the last one. Time before only me there. Can't complain if you don't come, can you? I'd tell them anyway if there was a complaint." We were given copies of meetings from August 2017 only and a meeting scheduled for February 2018 showed no one had attended.

During the first day of the inspection, there was a staff meeting to introduce them to the new manager. One care assistant told us, "We have staff meetings when we need them, perhaps two or three times a year." Another care assistant said, "I do not always get support as I do not see my mentor." We had copies of a staff meeting from July 2017 and February 2018 only. Although providing specific information, the regularity and evidence contained was limited and did not show where staff had contributed to any discussion or where learning had been considered.

One person told us, "It'd be nice to know who's on duty when you come in, I suggested a board with photographs and names like you see in hospitals etc. I was told they can't do that because someone may get a vendetta against one of the staff and track them through social media or something."

Quality assurance processes were in the middle of change and not comprehensive. The audits we looked at were ad hoc and did not identify many of the concerns we found. We were advised a new 'walkaround' governance framework was being implemented which was hoping to provide more consistency. There was a plan for daily walkarounds to identify key issues for the home each day and then for action to be taken promptly. We saw evidence of some of these but found an inconsistent level of action taken. Not all actions were recorded as completed.

The home had daily flash meetings where concerns could be immediately addressed but these tended to focus on small, specific issues rather than the wider cultural issues we noted. A live clinical risk register was updated daily which considered specific concerns such as weight loss or skin integrity concerns. However, this only reflected what was reported which we discovered was not every issue.

Notifications were submitted to the relevant authorities in line with statutory requirements but actions taken were not always reflective of what was required and limited in their scope. Not all analysis showed incidents had been reflected on fully or lessons learned. Our observations during our two days at the home also meant we were concerned not all incidents were being considered in sufficient depth to demonstrate improved outcomes for people.