Amicis Care Limited

Dalkeith

Inspection report

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Ratings

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

Overall summary

The inspection took place on 21, 22 and 23 July 2015 and was unannounced.

The last inspection of the service was in July 2013 when it was found compliant in protecting people from abuse and safe management of medicines.

The service predominantly cared for older people who lived with dementia, had physical disabilities and mental health needs. It could accommodate up to 22 people and at the time of the inspection 16 people in total were living there.

The registered manager had left in June 2015. A new manager was in position and had started four weeks prior to our inspection. 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.

Summary of findings

Some information of concern was received by us prior to the inspection. We had asked the provider to investigate the issues raised, which they did. They reported that none of the concerns reported were correct. The issues raised were also explored during this inspection.

We found people's needs and risks were not always met because of poor staffing numbers, a lack of staff knowledge and in places inadequate care planning. The manager was aware staff required more resources and support to ensure people's needs were met. The manager was also aware that personalised care needed to be promoted and implemented. Appropriate checks were carried out before staff started work in order to protect people against those who may be unsuitable to care for them. People had access to activities but these were limited and not always provided in a way that met people's needs or preferences. The arrangements in place to ensure people were properly protected under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were being reviewed.

People's privacy and dignity was maintained most of the time, but compromised when, for example, eye drops, were administered in front of other people at the dining room table. People's medicines were managed safely, although some situations discussed with the staff, demonstrated they needed further training to ensure they understood and followed best practice guidelines at all times.

People's care plans were not always maintained accurately and were read infrequently by some staff. This put people at risk of inappropriate and unsafe care because, care plans were not always kept relevant and some staff did not update themselves with the contents. People had access to health and social care professionals and to specialists when required. People were supported to have a balanced diet and to receive enough drinks. People who mattered to those who lived at Dalkeith were able to visit when they chose and were made welcome.

People lived in an environment which was being cleaned but where improvements to the cleaning arrangements were needed. Arrangements were in place to avoid the spread of infection. Other regulators' recommendations were followed and requirements were met, for example, the Fire Officer's recommendations. Improvements to the kitchen were planned for the latter part of 2015. Accidents and incidents were monitored and appropriate actions were taken to avoid reoccurrences.

Representatives of the provider were actively involved in the running of the service, A quality monitoring system was in place but had not effectively measured the service's performance and levels of compliance against their regulatory responsibilities. The manager was aware of the challenges the service faced in moving forward and in becoming compliant with the required regulations. People were responding well to the manager's open approach and they and their relatives felt listened to. People felt confident that they could find a member of staff to speak to if they had a concern or wanted to raise a complaint. They told us the manager was very approachable.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in the following areas: the management of some risks which have an impact on people's health, the planning of people's care, training and support for staff and systems for quality monitoring and governance purposes. You can see what action we told the provider to take at the back of the full version of the report.

We also made four recommendations; that the service ensure that all appropriate deprivation of liberty safeguards have been correctly applied for, that staff receive further training and guidance in relation to medicine administration, that action be taken to improve people's and their representatives' awareness of safeguarding people from abuse and that advice be sought with regard to the provision of varied and meaningful activities.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe. People were not fully protected against risks that may affect them because steps had not always been taken to fully identify and manage people's risks.

People were generally protected against possible medicines errors. A lack of knowledge and understanding of relevant guidance meant, in some situations, staff had not practiced safe administration. Medicines were not always administered in a way that maintained people's dignity.

Staff knew how to report concerns they had in relation to keeping people safe from abuse. Further improvements were needed however to better protect people from harm.

Robust staff recruitment protected people from those who may be unsuitable to care for them.

There had not been enough staff on duty to meet people's needs and to keep them safe. The immediate shortfall was addressed straight after the inspection.

Is the service effective?

Requires improvement

The service was not always able to be effective. Staff required better training to equip them with the skills and knowledge they required to meet people's needs.

The arrangements in place with regard to processes under the Mental Capacity Act (2005) needed improvement to ensure people were fully assessed and protected under this legislation.

People received appropriate support with their eating and drinking. Nutritional risks had been properly identified and managed.

People's health care needs were met because of the involvement and guidance provided by appropriate health care professionals.

Is the service caring?

Requires improvement

The service was caring although at times support was needed to ensure staff remained empathetic and compassionate at all times.

Personalised care had not been fully promoted or supported. Staff required support, training and resources to change from a task driven approach to delivering person centred care.

People's dignity and privacy was maintained when staff delivered people's personal care.

Summary of findings

Staff helped people maintain relationships with those they loved or who mattered to them.

Is the service responsive?

Requires improvement

The service was not always able to be responsive. Care plans did not always give staff the guidance they required to properly meet people's needs.Care was not always in line with people's care plans.

Opportunities for people to take part in social activities were being improved but the arrangements and opportunities remained limited and did not always meet people's individual needs.

There were arrangements for people to raise their complaints and to have these listened to, taken seriously and be addressed.

Is the service well-led?

Requires improvement

The service had not been well-led. The service lacked strong and effective leadership in order for it to develop for the benefit of those who used it.

Systems used to monitor performance, compliance and drive improvement had not been effective in doing this.

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Detailed findings

Background to this inspection

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

This inspection took place on 21, 22 and 23 July 2015 and was unannounced. It was carried out by one inspector who was joined by an expert by experience for one of the inspection days. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case, someone who specialised in the care of people who live with dementia.

Before the inspection we reviewed the information we held about the service. This included the information of concern which had been received by us. It also included notifications of significant events reported to us by the provider. We also gathered information from the local County Council who commission with the service.

During the inspection we spoke with 12 people who used the service and we visited one person who was not able to talk to us about their experience of living at Dalkeith. We also spoke with five visitors who were relatives or friends. We spoke with five members of staff, the manager and a representative of the provider. We obtained the views of one health care professional. We reviewed the care records of five people. These records included their care plans, risk assessments and medicines administration records. We looked at additional care records such as weight monitoring and food intake charts.

We also looked at the recruitment files of two members of staff and the staff training record. We reviewed a selection of records relating to the management of the service. These included a selection of audits, maintenance records, policies and procedures and accident and incident records.

Requires improvement

Is the service safe?

Our findings

People did not always feel safe. They told us this was because they sometimes felt too isolated and alone. They said they sometimes felt "distant" from the staff and this made them feel unsafe. One person told us when staff were helping other people "it can be a long period of time before you see them (the staff) again". One person said, "I can be here for hours and no-one pops in" another said, "I have to walk to the call bell, if I was feeling unwell I don't think they would know". This person was unsure if they would get help when they needed it. Another person told us they had realised, when they were in the lounge, they sometimes needed to provide support to those less able in order to help them remain comfortable. This was because staff were not always available.

Information had been received by us prior to the inspection which said the home was understaffed. We had asked the provider to investigate this, which they did and they responded that arrangements were made to ensure this was not the case.

We observed one person ready to get up but because they needed help to wash and dress they needed to wait a further 45 minutes in bed until a member of staff was free to help them. We were told the home was fully staffed. During one late afternoon one call bell had rung for nine minutes when we decided to respond to it to make sure the person was safe. This person was safe but needed attention. Staff told us it was a "struggle" to get everything done at times. In particular, they felt the staffing levels were "unsafe" when there were just two of them on duty between 4pm and 8pm. They told us this was the usual staffing level at this time of the day, with a cook on duty until 6pm. When the cook was not on duty they said it was "impossible". This was because they needed to co-ordinate tea time, help people with their food and clear up afterwards. We fed back our concerns about the staffing numbers to the manager. The Sunday before the Inspection the manager had come in to help the two care staff on duty as the cook was not on duty at tea-time. The manager told us they considered this level of staffing unsafe. The manager told us they already had a meeting booked with the provider to discuss staffing numbers at this time of the day and to get it resolved.

We asked the manager to review the lengths of time it was taking staff to answer call bells during the late afternoon/ early evening period. On two days, with two care staff and the cook on duty (until 6pm) five call bells took between 5 and 31 minutes to respond to. Straight after our inspection the manager confirmed the provider had agreed to increase the care staff numbers to three (plus the cook until 6pm) between 4pm and 8pm. The hours designated for cleaning were also clarified during this meeting. The manager told us they also wanted to discuss further staff recruitment with the provider in order to be able to provide better activity opportunities and make covering staff annual leave easier.

Risks to people had not been sufficiently considered and appropriately managed to avoid a potential impact on a person's health and well-being. One person had been provided with a specific piece of equipment which helped them alter their position and alleviate pressure from their skin. They had been helped to the lounge and left without the piece of equipment. This had not been realised until a visiting health care professional pointed this out to the staff. The person was therefore unable to alter their position independently which potentially put them at risk of developing pressure ulcers. During the inspection staff reported that damage to a person's skin had developed. When discussing this with the staff they had not fully considered the risks to the area affected once the person was off their pressure relief mattress. Another person's inability to remain continent and the subsequent risk to their skin, when they did not respond to prompts to use the toilet, had not been sufficiently considered to prevent potential skin damage. Although relevant risk assessments were sometimes in place, this did not always lead on to robust care planning giving staff clear guidance on how to manage people's risks.

All actions that were reasonably practicable to help mitigate risks had not always been carried out. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information had been received by us prior to the inspection that people were not appropriately protected against abuse because concerns were not always reported. We had asked the provider to investigate this, which they did and they told us arrangements were in place to ensure people were safeguarded and any concerns were appropriately reported. Staff knew how to report concerns relating to protecting people from abuse. Staff were able to give examples of what would constitute abuse. They told us

Is the service safe?

they would report any incidents or allegations of abuse to senior staff in the home. Most of these staff were also aware of how to contact the local council council's safeguarding helpdesk if they needed to share concerns outside of their organisation. There was however no obvious information for people and visitors on safeguarding people in order to help raise their awareness and knowledge on keeping people safe from abuse.

Information had been received by us prior to the inspection that secondary dispensing took place. We had asked the provider to investigate this, which they did and they responded that no such practice took place. We did not observe this to be the case during the inspection. A member of staff however admitted to having secondary dispensed medicines, on one occasion, without realising that this is what they had done. They had removed medicines from their original dispensed packaging and put them in an alternative container in order for one person to take their medicines at a later time when they were away from the home. The staff member had not realised that this was secondary dispensing and had not understood why this was unsafe practice. Secondary dispensing removes the safety precautions put in place by law; one of those being, medicines should only be dispensed by people who are trained and licenced to do so, for example, a pharmacist or doctor. The Royal Pharmaceutical Society's document Safe Handling of Medicines in social care states this must be avoided as "the risk of mistakes is too great". Staff told us they understood the reasons for not doing this once we had explained these to them and told us this would not happen again.

We observed, on one occasion, tablets which had already been put into two pots before the member of staff had started the medicine round. This is unsafe practice and can potentially lead to errors in administration. The manager told us they would organise further relevant training. People's medicines were stored securely. Whilst administering medicines staff took appropriate actions to ensure the relevant records were completed accurately. The provider had followed National Institute of Care Excellence (NICE) guidance and had chosen a medicine system which they considered to be safe and which would help prevent medicine errors. Arrangements were in place to, as far as was practicable, to avoid staff being interrupted whilst administering medicines so to reduce the possibility of mistakes being made.

People were protected from staff who may be unsuitable to care for them. Staff recruitment records demonstrated that correct and appropriate checks were carried out on staff before they started work.

Accidents and incidents were recorded and were being monitored by the manager. This was to identify why the accident had occurred and to look for reoccurring themes and patterns. For example, in cases where people had more than three falls. This monitoring helped senior staff put appropriate actions into place or to adjust actions which were not working in order to avoid reoccurrences. A representative of the provider subsequently informed us that these were also audited by the provider's representatives.

Information had been received by us prior to the inspection that the home was dirty and smelt. We had asked the provider to investigate this, which they did and they responded that this was not the case. People lived in an environment which was being cleaned but where improvements to the cleaning arrangements were needed. People told us their bedrooms were cleaned on a regular basis. However, we found dust and debris under the bed and behind the furniture in one bedroom. Dirty skirting boards and piping alongside a toilet and unclean looking carpets indicated that deeper cleaning was not taking place frequently enough. Some carpets looked generally unclean but others had heavier markings on them. We were told this was due to a manufacturing flaw which the provider was trying to get resolved. The provider hoped that these carpets would be replaced by the manufacturer. We were not aware of any offensive odours apart from in one bedroom where the person refused the room to be ventilated.

At the start of the inspection there were no recorded cleaning plans or records of what cleaning had been completed. The relevant guidance, the code of practice on the prevention and control of infection and related guidance does not stipulate the need for cleaning schedules for smaller care homes. However, a cleaning plan and records for signing to show what cleaning had been completed was introduced during the inspection by the manager. The member of staff responsible for the cleaning commented that a cleaning plan and being able

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to record what cleaning had taken place was a better idea. There was no periodic carpet cleaning taking place although we were informed that if there was an accidental spillage of body fluid this was addressed.

People were protected from the spread of infection. Arrangements were in place to segregate soiled laundry. Any laundry soiled with body fluids was not handled by staff and cleaned on appropriate settings in the washing machine. Cleaning equipment was colour coded, for example, red mops for the toilets and green mops for the kitchen to prevent cross contamination. Mop heads were used for a week and then disposed of. Staff were seen to be wearing personal protective equipment (PPE) such as plastic aprons and gloves when delivering care. Uniforms were also protected and covered when delivering people's food.

Arrangements were in place to manage risks relating to the environment. The last visit to the property by the fire officer was January and March 2014. It was unclear from records kept in the home whether all the fire officer's requirements had been met. We checked with the fire safety office as to what these had been and visually checked these. We found they had been completed. The last fire drill had been in June 2014 with a recorded poor response. Records said another was needed to re-evaluate staffs' understanding of what needed to be done in such an event but we could not see that this had taken place. A representative of the provider subsequently confirmed that this training had taken place. A current fire risk assessment completed in 2014 was in place. We understood there had been no changes that would affect this since it had been written.

Some of the information in the emergency contingency plan was not up to date and relevant. A representative of the provider told us they would review this and make alternative arrangements. This related to the arrangements for people if they had to evacuate the building and could not return.

We recommend that advice be taken from an appropriate source about what information should be provided and made available for people and visitors to help raise their awareness and knowledge on safeguarding people from abuse.

We recommend that staff receive further appropriate training so they are aware of the guidance given by NICE and the Royal Pharmaceutical Society with regard to administering medicines within a care home.

Requires improvement

Is the service effective?

Our findings

Staff lacked appropriate training and support to be able to always meet people's needs effectively and in a personalised way. Their practice, at times, demonstrated a lack of knowledge and broader understanding of some key areas of care, legislation and guidance. As previously reported this was evident in relation to pressure ulcer development, medicine administration and care planning. Some staff also showed a lack of understanding in how the Mental Capacity Act (MCA) 2005 influenced their practice, how people's dignity could be compromised, an awareness of the needs of those who lived with dementia and an awareness of the content of relevant safeguarding policies.

The service's training record showed six staff had not completed training on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards. One situation discussed with two members of staff, demonstrated their lack of people's rights under the MCA. Records stated that people lacked mental capacity without evidence that a correctly completed mental capacity assessment had taken place. The training record stated that five out of 14 staff had not received "safeguarding" training. Two of the nine staff who had received training had completed this over four years ago with no evidence of a check on their knowledge since. One member of staff was not aware of what agencies could be contacted in relation to safeguarding people and this was despite having received relevant training. This member of staff also told us they had read the provider's policy "ages ago". Training, in this case, was not keeping this member staff sufficiently updated with what they needed to be aware of. Staff spoken with who had not had not received safeguarding training were also unaware of the provider's policy on safeguarding people. They were also unaware of the county council's wider safeguarding policy to which the provider's policy referred to.

The training record stated that most staff had completed training which the provider considered a basic requirement to carry out their work. This included subjects such safe moving and handling of people, infection control and fire safety. However, training in other subjects, very relevant to the needs of people at Dalkeith, such as care planning and continence care had been completed by very few staff. There was no evidence that staff competencies had been checked on an on-going basis.

Staff had therefore not always received appropriate training, support and development to enable them to meet people's needs or to understand their responsibilities fully. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One member of staff told us staff needed more support in being able to communicate more effectively, in particular, with those living with dementia. The training record showed that six out of 14 care staff had completed training in dementia care. The member of staff said training in communication methods with people who live with dementia had been organised. This was to improve staffs' awareness and understanding of the illness. Two members of staff were also due to imminently complete training in safeguarding people and one other still had complete this as part of their induction training. Five staff in total had completed recognised qualifications in care, for example, the National Vocational Qualification (NVQ).

Staff had received supervision sessions from the previous manager and these were being continued by the present manager. These one to one sessions with staff were used to discuss their achievements, aspirations and training needs. The training needs for one member of staff, identified in their supervision session in January 2015 had still been unmet. Two staff who had been promoted in to more senior and supervisory roles had received a specific support session from the manager. This had outlined their new responsibilities. The manager explained these staff would require further training in for example, care planning and supervisory skills before they could delegate certain responsibilities to them.

Past supervision sessions made reference to staff completing the Skills for Care Common Induction Standards but we could not find evidence relating of this. The manager was aware of the new care certificate which replaced the above in April 2015. This sets out and provides a structure for new care staff to acquire the competencies and standards of behaviour that should be expected of a health care worker. The aim that staff will be able to deliver care to a high standard and in a caring and compassionate

Is the service effective?

way. The manager was not aware of the care certificate having been implement at Dalkeith. A representative of the provider subsequently confirmed that the new care certificate had been implemented.

In practice we did not observe anyone refusing the care staff provided. People either verbally agreed or implied, through their behaviour and actions that they were happy to receive the care or treatment staff were providing. Some people's records however stated they lacked mental capacity. The format used to record this did not demonstrate what this was in relation to and that a full mental capacity assessment had taken place.
The documentation used did not include the second step of a mental capacity assessment. This step shows that people were given the opportunity to receive information in a format they can understand. This for example, could be the content of their care plans or in relation to a specific aspect of their care and treatment. It also shows the person had been given the opportunity to retain, discuss and weigh up the information. Where this had not been possible the assessment would determine that the person lacked mental capacity; in relation to whatever the information was. Records however went on to list areas which people may require support with but without determining if they had capacity to do this or not. Care was delivered to people who could not consent, for example, to the content of their care plans but without reference to a best interest process.

The Mental Capacity Act (MCA) 2005 code of practice is in place to ensure people's mental capacity it assessed if there is doubt that they may lack capacity to consent to or make decisions about their care and treatment, that they are protected and cared for in a way that ensures their best interests and which is done in the least restrictive way. During the inspection the manager obtained mental capacity assessment documentation which included the second step. He told us that people's mental capacity would be assessed correctly.

Since arriving in post the manager had not been aware of the need to complete any referrals under Deprivation of Liberty Safeguards (DoLS). However, they had also not yet fully reviewed everyone in relation to the level of control and supervision people received. They were aware of the clarification in legislation issued last March (2014) with regard to this and told us they would prioritise this task following the inspection. During the inspection an appropriate person from the county council (the supervisory body who authorises DoLS) came to review one person's mental capacity.

We asked people what they thought about the food and meal time arrangements. Comments back included, "The meals are nicer now we have a cook", "The food is much better now" and "The cook is lovely." A representative of the provider explained that there had always been a cook but explained prior to the provider purchasing the service in 2013 the arrangements had been that pre-cooked meals were delivered and re-heated. People had possibly remembered this when making their comments to us. Meals were prepared freshly on site and the cook was aware of people's individual likes and dislikes and accommodated these. The cook told us they had tried all sorts of different food combinations for one person to try and encourage them to eat. They also told us that they fortified foods with extra butter, cream and powdered milk when people required additional calories.

Staff informed us that the dining room only comfortably seated 12 people and because of this they actively encouraged some people to eat in their bedrooms or in the lounge. They also said "Mealtimes are a little hectic". We found the lunch time to be relaxed, but we found the evening meal time to be more busy as the staff available needed to cope with several people's needs at once and ensure medicines were also safely administered.

People were supported to eat and drink. Some people required more support than others. When people needed to be fed staff did this quietly and in a way that maintained the person's dignity. People's dignity was however compromised when medicines, in particular, eye drops were administered during a person's meal and in front of others on the same table.

Arrangements at mealtimes to help people who lived with dementia or poor memory abilities remain engaged were lacking. For example, there were no visual clues, such as pictorial menus, to help people remember what they had chosen and then what was on offer generally at the mealtime. One such person said, "We get what we are given I suppose" not being able to remember they had been given a choice and what they had chosen.

People's weights were monitored and a member of staff informed us people were re-weighed at the beginning of

Requires improvement

Is the service effective?

each month. July's weights had not yet been recorded and during the inspection we were given a reason for this. However, a representative of the provider subsequently informed us that people were re-weighed at the end of each month and therefore July's weights had not yet been due. One member of staff told us the care staff recorded people's weights and fed these back to a representative of the provider. The representative then maintained a central electronic weight chart which we were shown by the manager. This record mapped out people's gains and losses over a period of months. The record we saw did this from January 2015 until June 2015. Over a three month period most people had maintained stable weights. One person's recorded weight however showed a significant loss since January 2015. The member of staff we spoke with explained they were unaware of this person's weight loss and generally any changes in people's weight. When we told them the amount the person had lost they said, "She looks as if she has lost weight." This member of staff explained that although they weighed people each month, they (the staff) were not informed of people's over all patterns of weight. Another member of staff explained they were told if someone was losing weight.

We were told by the manager that the Malnutrition Universal Screening Tool (MUST) had been implemented at some point before they started work at the home but was not now in use. The MUST helps staff assess what action they need to take at what point. For example, continue monitoring or refer to relevant health professionals. MUST assessments could not be found during the inspection although a representative of the provider explained they thought these were still in use. The manager told us they planned to reintroduce these. It was subsequently confirmed by another representative of the provider that these had always been in use and were present amongst the files in the office at the time of the inspection.

It had therefore been difficult to properly determine if processes were in place to manage people's nutritional risks. We therefore checked with local health care professionals, who had been in and reviewed these arrangements following the inspection. This included the nutritional risks relating to the person who had lost a significant amount of weight. Health care professionals were able to confirm that nutritional risks had been continuously monitored over the last twelve months through the use of the MUST. This also included the person who had lost weight. People's nutritional risks had therefore been properly identified and managed to ensure their wellbeing.

People's records showed they had access to appropriate health care professionals such as their GP, Community Nurses and a chiropodist. During the inspection a health care professional visited to ensure a person's health needs were addressed.

We recommend that advice and guidance be taken, from an appropriate source, to ensure all appropriate referrals under DoLS have been submitted and that mental capacity assessments are completed correctly.

Requires improvement

Is the service caring?

Our findings

Information had been received by us prior to the inspection which said staff were rude to people and shouted at them. We had asked the provider to investigate this, which they did and they told us there was no evidence of this.

Relatives were mainly positive about the staff. Comments included, “They are a nice lot”, “Great bunch, who seem to care”, “Majority of staff are lovely but some are better than others”. A health care professional told us the staff were very caring and had a lot of enthusiasm. A couple of people referred to some staff as being “snappy” or “brusque” in the way they spoke to them. We found staff were caring and compassionate towards people and demonstrated this through their actions and in the way they spoke with people. When we asked people what they meant by staff being “snappy” or “brusque” they told us some staff could be “irritable” with them when they were busy.

Staff knew the people they were looking after well, in as much as they knew their likes, dislikes and preferences. They knew what made people happy and what might distress them. People were able to make choices but people’s daily outcomes could be improved if personalised care and meaningful activities were fully implemented.

People who mattered to those who lived at Dalkeith, such as family and friends were able to visit without restriction and were welcomed. One relative explained they were able to leave their relative after visiting feeling that the staff cared for them and looked after them.

Requires improvement

Is the service responsive?

Our findings

Information had been received by us prior to the inspection which said the care plans were not fit for purpose. We had asked the provider to investigate this, which they did and they told us arrangements were in place to ensure the care plans were fit for purpose.

Care plans were in place and there was evidence to show they had been reviewed on a regular basis. Sometimes these reflected people's current care needs and the issues that had an impact on them and sometimes they did not. People's care plans did not always identify issues in enough detail for clear guidance to be given to staff in how to manage people's needs. For example, one person had experienced a health event which had left them with specific care needs. The person's care plans did not reflect this at all. The care plans did not sufficiently outline the care the person required for staff to then follow. Another person had problems maintaining their continence. The relevant care plan did not reflect the actual issues staff were having in managing this person's needs and therefore lacked guidance for staff. This person did not have a care plan for personal hygiene even though they required staff to support them with this. The same scenario was found for a person who had lost weight. Care plan reviews during the months the weight loss had been evident did not reflect this at all. Another person who had been diagnosed as living with dementia had no mention of the impact this had on this person and their needs around this. The care plans were therefore not always outlining what people's needs were, the impact of these and the subsequent required guidance for staff to follow. Sometimes, this resulted in people receiving care which was not planned for in their care plans.

This potentially put people at risk of inappropriate and unsafe care through a lack of appropriate care planning. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In one case it was difficult to evidence if a referral to a speech and language therapist (SALT) had taken place because there was no recorded follow up about this. The manager was unaware of this referral having been made and said they would look into it. He also told us he planned to review all care plans to ensure they contained the personalised detail required.

The care files which contained people's care plans were stored behind two locked doors, so they were secure but not easily and readily accessible to busy staff. The manager suspected staff were not reading the care plans fully or regularly and they wanted these to be an integral part of people's care so people received care which was in line with their care plans. The manager planned to make people's care files more accessible to the staff. When we asked three care staff about people's care plans they admitted they did not read them regularly. One member of staff, "Honestly, I have not read the care plans since probably last October" (2014). Another said, "I try to read them but not regularly, I don't have time" and a third member of staff said "There is no time to read care plans". This confirmed to us that the manager's suspicions had been correct.

One person could not remember being provided with the opportunity to review their care or to see their care plans and one relative could not remember having this opportunity offered to them on behalf of their relative. When we spoke with people about this one person said, "What a good idea" to being able to review their care and the written care plans. A representative of the provider has subsequently told us this opportunity is provided to people routinely.

Information had been received by us prior to the inspection which said no activities were done in the home. We asked the provider to investigate this, which they did and they told us that activities were provided. Since the inspection a representative of the provider informed us that varied and meaningful activities were implemented in the home prior to the inspection. During the inspection several people told us they were "bored" and "lonely". Comments about this included, "It's very lonely sometimes", "The staff are very busy and I know they don't have time to talk" and "I have too much time on my own". The manager had tried to initially improve the provision of activities by introducing an activities schedule to ensure designated time was allocated by the care staff each day for an activity. The manager told us they eventually wanted to see an activities co-ordinator employed. The manager had held a meeting and discussed different activities with people. People had requested bingo, watching DVDs and art and craft sessions. One person said, "The new manager has asked us what we would like to do, I am excited about the choices". The manager had also requested ideas for trips out.

Requires improvement

Is the service responsive?

We found people and their visitors were not necessarily aware of what activity was on offer or when it was due to take place apart from the regular hairdressing activity. One person said, “I don’t know if and what activities we are having until it happens”. People and staff told us activities took place when staff were able to do this. One person said, “Some days something happens, sometimes it doesn’t” and another said, “Activities happen if the right staff are on duty”. On one day of the inspection a quiz was planned for a certain time. People and one visitor waited 45 minutes for staff to be available to start this. Staff were continuously called away by people who required help. The people present understood that this had to take priority although some left because they felt they had waited long enough. One visitor told us when the activities took place their relative really enjoyed them as was the case when the quiz eventually took place.

The manager had asked staff to keep an activities diary so he could see what activity had taken place and who took part in it. The manager was monitoring the activities because he told us he felt what was being provided was repetitive and limited. We looked at the activities which had been provided for the month of July up until 22 July 2015. Nine days had been recorded as some activity taking place. These had consisted of a knit and chat session with two people, one quiz with five people and the quiz we observed, four games of hangman, a game of eye spy, a game of cards and two sing a longs. The manager wanted to be able to evaluate people’s enjoyment of these activities and find out if they were meaningful to them.

Staff also completed one to one sessions with people and these had also been recorded. The manager told us some staff were more motivated in providing these than others. One to one sessions were with people who did not enjoy or could not engage in group activities. For example, one person had the newspaper read to them and another discussed a radio programme. Between the same period of time as the activities above one to one sessions had been recorded as taking place on four days. Seven people had received a one to one session on one day, two people on two separate days and two people on another day.

People told us they felt able to speak to certain staff if they had concerns or a complaint. There were mixed comments about who they felt able to speak to. Comments included; “(name of staff member) can be a bit off, I wouldn’t ask her”, “(name of staff member) is lovely, I would wait for her to come on duty” and “I definitely wouldn’t tell (name of staff member), I’d wait until (name of staff member) was here”. The manager told us they operated an open door policy and people were able to talk to them about any concern or complaint they had. People generally spoke highly of the manager and one person said, “I would be able to speak to him about anything that worried me”.

The provider had a complaints policy and procedures which said all verbal and written complaints should be recorded. It also said that staff should manage complaints where possible or refer them to a manager. It stated that staff would receive relevant training in how to manage complaints. We asked staff if they had received this training and they said they had not. The concerns and complaints recorded were from January 2015 and had been managed by one of the provider's representatives. One relative told us about a complaint a family member had raised. We understood this to have been satisfactorily addressed. This had been recorded in the home’s complaint log, including statements from staff and subsequent actions taken to address the issues raised. The actual response to the complainant was not present in the log. Two other complaints had been recorded as acknowledged, one had a recorded response and the other did not.

We recommend that advice be sought from reputable source on how to improve the provision of meaningful activities for people.

Requires improvement

Is the service well-led?

Our findings

The current provider applied to the Care Quality Commission and became the registered provider for Dalkeith in July 2013. Since then the home has had three registered managers. One managed the home for seven months and two for four months. The manager present at the time of the inspection had been in post for four weeks. Although we were told that representatives of the provider based themselves in the home on a regular basis, the evidence gathered showed that the service had not been well-led and staff lacked consistent and effective leadership.

Some staff, demonstrated a dislike to the inspection process which at times was expressed through unprofessional responses and behaviours. Although the manager had been in post for a short period of time he had already identified that the culture needed to alter. He had started to communicate to the staff his expectations and the behaviours he wished to see in place. He had clear views on what areas needed to change and improve. He discussed the short and longer term plans of action with us and what he felt were the main challenges in implementing these. The manager and Directors needed to still work out an effective way of achieving the improvements required. A representative of the provider told us they and one other representative were very involved with the day to day running of the service and wanted to provide support to the manager.

The manager told us one of the main challenges was a lack of staff and structure to the staff team. Prior to the manager's appointment two care staff had been promoted to senior care positions. The manager was very keen for these staff to be well supported in their new role. He told us that until they were fully competent he was unable to confidently delegate responsibilities and tasks to them.

The manager was slowly introducing his way of doing things. He had clear visions and values which he told us he had started to communicate to staff, the people who lived at Dalkeith and their relatives. People made positive comments about him which included “Very approachable” and “A lovely man”. They also commented that there had been a few managers who had "come with their ideas" and they hoped this one would stay. This indicated that people wanted to some longevity and consistency when it came to the home manager. The manager told us he was keen to involve everyone and listen to their views, opinions and ideas on various things. Relatives were confident that their voice was heard by the manager and felt he was open and responsive. They were full of praise for him. A representative of the provider told us that people's views, opinions and ideas had always been sought at Dalkeith. A health care professional told us they had heard good things about the new manager.

Although the provider's representatives were present in the home on a regular basis and, as they told us, they were up dated with events and checked the running of the service, the arrangements for quality monitoring the service had not been sufficiently effective. We saw some audits, which a representative of the provider subsequently explained were part of a "comprehensive schedule of audits". This system had not identified the shortfalls identified in this report and therefore needed improvements. It had not identified areas of required compliance necessary to keep people safe from inappropriate care and treatment and to enable their needs to be met at all times.

The provider had not ensured that systems were able to sufficiently assess, monitor and continually improve the quality and safety of the services provided. **This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People's risk were not fully managed because not all reasonably practicable steps had been taken to mitigate these. Regulation 12 (1), 12 (2)(a) and 12 (2)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff had not received appropriate, support, development and training as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People's care plans did not always provide a clear and relevant plan of care, which then ensured people's needs were met. Regulation 9 (3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems had not been developed sufficiently assess, monitor and improve the quality and safety of services provided. Regulation 17 (2) (a).