Platinum Care Homes Limited

Church View Care Home

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?	**Inadequate**

Summary of findings

Overall summary

Church View Care Home is a care home which provides accommodation and nursing care for up to 78 older people, some of whom are living dementia. At the time of our inspection there were 75 people who lived there. The home is purpose built and set over three floors, with a lift to all floors. The home is divided in to six units with a variety of communal areas including lounges, dining rooms, and quiet areas.

The inspection of Church View took place on 17 and 18 October 2016 and was unannounced. This inspection was to follow up on actions we had asked the provider to take following the last inspection to improve the service people received.

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

At our previous inspection on 30 September 2015 we found breaches of two of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action in relation to risk assessment and poor moving and handling techniques and assessing and monitoring the quality of the service provided. The provider sent us an action plan and provided timescales by which time the regulations would be met. They stated that the actions would be completed by 30 November 2015.

During this inspection we found that some improvements had been made. However, they were not sufficient enough to meet the requirements of the regulations. A further five breaches were also identified.

Risk assessments for some risks were in place; however we noted that there were inconsistencies in the recording of risks associated with people. Not all risks had been identified, assessed and managed to minimise the risk of harm to people. This meant that people were placed at risk of harm as appropriate guidance and best practice was not always followed. Since the inspection the registered manager has informed us that risk assessments are now in place and equipment has been purchased that should mitigate the risks for two people.

Staff did not have a clear understanding of Deprivation of Liberty Safeguards (DoLS) or the Mental Capacity Act (MCA) 2005 or their responsibilities in respect of this. Mental capacity assessments and DoLS applications had not been fully completed in accordance with current legislation.

Staff were not always competent to meet people's needs and the support they received had not always been appropriate to ensure they worked to the expected standards. Since the inspection the registered manager has informed us that additional training has been organised. We will assess the information and how staff are using this in practice to care for people at the next inspection.

People had enough to eat and drink throughout the day and night, however there were concerns that not everyone received the support they needed or that those at risk of dehydration were supported.

People were supported to have access to healthcare services and healthcare professionals to support their wellbeing. The service worked effectively with health care professionals and referred people for treatment when necessary. However, where people had specific health care needs these had not been taken into account when planning the care or identifying what support they needed. There were inconsistencies in the monitoring of people's health and support needs.

There were inconsistencies in the way staff involved and treated people with compassion, kindness, dignity and respect. People's preferences, likes and dislikes were not always being taken into consideration and support was not being provided in accordance with people's wishes.

People's preferences, likes and wishes were not always taken into consideration as staff did not always treat people with compassion or respond to their care and support needs. Care records were not always up to date. Since the inspection the registered manager has told us that all care plans will be reviewed with support from a nurse at the clinical commissioning group. We will assess how people's care has improved as a result of this action at the next inspection.

Although the home was generally comfortable one unit for men living with dementia was sparse and not homely. Since the inspection the registered manager has assured us that this has now improved for people.

There were quality assurance systems in place to review and monitor the quality of service provided, however they were not robust or effective enough to identify missing information or poor practices or to have made the improvements required at the last inspection. Not all safeguarding incidents had been reported to the local authority or the commission. Since the inspection the registered manager has confirmed that appropriate incidents have been notified to safeguarding and the commission. However the failure to do so prior to the inspection remains a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People told us they felt were safe at the home, one person told us, "I feel safe here and the girls look after me and I do not have to worry about anything." Staff had a good understanding about the signs of abuse and were aware of what to do if they suspected abuse was taking place.

Recruitment practices were safe and relevant checks had been completed before staff commenced work and we found that there were enough staff to safely support people and help keep them safe.

People received their medicines when they needed them and the administration and storage of them were managed safely. Any changes to people's medicines were prescribed by the person's GP.

People's relatives and friends were able to visit. People's privacy were respected and promoted. Staff told us they always made sure they respected people's privacy and dignity when providing personal care.

People told us if they had any issues they would speak to the staff or the registered manager. People were encouraged to voice their concerns or complaints about the service and there were different ways for their voice to be heard. Suggestions, concerns and complaints were used as an opportunity to learn and improve the service provision.

People had access to activities that were important and relevant to them. People were protected from social

isolation with the activities, interests and hobbies they were involved with. Staff supported people with their interests and religious beliefs in their local community. Religious services were conducted weekly at the home.

There was a contingency plan in place should an emergency have an impact on the delivery of care. Staff had a clear understanding of what to do in the event of an emergency such as fire, adverse weather conditions, power cuts or flooding.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found one breach of the Care Quality Commission (Registration) Regulations 2009.
You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People had risk assessments in place however they were not always related to the person's care and support needs.

People were not always protected against the potential risks.

Recruitment practices were safe and relevant checks had been completed before staff commenced work. There was a sufficient number of staff deployed to keep people safe.

There were effective safeguarding procedures in place to protect people from potential abuse. Staff were aware of their roles and responsibilities.

Medicines were managed and stored safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had limited working knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards.

There were inconsistencies in the support that staff received such as supervision and appraisals that promoted their professional development or reviewed their performance.

People had enough to eat and drink. However there were concerns around how people were supported during mealtimes and how to protect people at risk of dehydration.

Staff provided care and support which promoted well-being. Healthcare professionals were involved when assessing health risks.

People were supported to have access to healthcare services.

Is the service caring?

Requires Improvement

The service was not always caring.

There were inconsistencies in the care that people received which included how staff respected people's privacy and dignity.

People's likes and dislikes had been taken into consideration.

People's relatives and friends were able to visit.

Is the service responsive?

Requires Improvement

The service was not responsive.

People's needs were assessed when they entered the service and reviewed regularly. Care records were not always up to date to reflect people's needs.

There was inconsistencies in the response to people's care needs. Where people required their health needs to be monitored, this was not always put into practice.

People were supported to participate in a range of activities.

People and their relatives were not always involved in developing care plans, changes to people's needs were not always reflected and acted on by staff.

People were able to express their views and were given information how to raise their concerns or make a complaint.

Is the service well-led?

Inadequate

The service was not well- led.

Although the provider had systems in place to regularly assess and monitor the quality of the service these were not robust or effective enough to identify, correct poor practice or improve the service.

The provider had sought, encouraged and supported people's involvement in the improvement of the service. People's opinions had been recorded but no information regarding action taken had been captured.

People told us the staff were friendly, supportive and management were visible and approachable.

Church View Care Home

Detailed findings

Background to this inspection

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

We carried out an unannounced inspection to the home on 17 and 18 October 2016. The inspection was conducted by four inspectors and a specialist adviser. The specialist advisor reviewed the clinical management of the home including the management of medicines.

Before the inspection we reviewed the provider's action plan which they had supplied to tell us how they were meeting or intended to meet their legal requirements in relation to the breaches of regulations we found at our last inspection.

Prior to the inspection we reviewed the previous inspection report. We gathered information about the home by contacting the local authority safeguarding and quality assurance teams. We also reviewed records held by the Care Quality Commission which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

The provider had already completed a Provider Information Return (PIR) for our inspection in September 2015. This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. We did not ask for another PIR but we gathered this information during inspection.

During the inspection we spoke with 14 people, six relatives, seven care staff, one kitchen staff, the general manager and the registered manager. We observed care and support in communal areas; looked at six bedrooms with the agreement from the relevant people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at seven care records and other records in relation to the running of the service. This included recruitment records, complaints policies and procedures and external and internal audits.

We last inspected this home on 30 September 2015 when we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe and secure at the home and with the staff who provided care and support. A person told us, "Staff look after me well. I feel safe living here, no one has ever shouted at me." A relative told us, "My mother is safe living here. Staff always seem to be nice to her." Despite the positive comments from people about how safe they felt we found that improvements were needed to ensure people were always protected from risk of harm.

At our last inspection on 30 September 2015, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities). There were inconsistencies in the way risk was identified, recorded and mitigated. Some risk assessments did not contain adequate information to guide the staff in taking action to protect people from the risk of harm. There was insufficient information in regard to people using bed rails. Pressure mattresses were not always kept at optimum level to give comfort and relieve pressure on susceptible areas prone to pressure ulcers. During this inspection, we found that although the provider had addressed the bed rails and mattress pressures they had not improved the way risk was identified and mitigated. We also identified new concerns which meant there was still a breach of the regulation.

Risk assessments did not identify the level of risk, who was at risk and did not provide staff with appropriate guidance to minimise the risk. Where people required their behaviour to be managed when providing personal care, or where people were at risk of or developed pressure sores, management strategies were not clear or specific enough for staff to know what to do. One person was at risk of trips or falls because of the footwear they chose to wear. The risk had not been assessed. One person did not want to have drinks with the thickened fluids they needed to prevent the risk of choking. They had full capacity to choose to have unthickened fluid as they were able to understand the risk this posed. No risk assessment had been carried out to assess the risk and determine that the person was able to take this risks even when this went against their best interests. The staff refused to give unthickened drinks and as a result the person often refused drinks which posed a risk in itself of dehydration.

Although staff knew people well and they did take action to try to prevent harm occurring this was down to individual knowledge rather than a system to identify, assess and mitigate risks for people. Therefore people were still at risk as new staff or temporary staff did not have access to guidance on how to protect people.

Risks and any healthcare issues that arose were discussed with the involvement of social or health care professionals such as the GP, speech and language therapist or tissue viability nurses (a nurse who specialises in wound care and prevention). Although this information was recorded in the person's care plan, it was not included in their assessment to guide staff in how best to prevent risks occurring.

There were no arrangements in place to reduce fire risks for people who smoked. People were not offered a protective garment whilst smoking; there was no safe smoking area and no fire safety equipment in the smoking area. The provider told us they had not considered a smoking risk assessment was needed for people. During the second day of the inspection, the provider had informed us that they had ordered fire

protection equipment and had organised a risk assessment to be conducted. Since the inspection the registered manager has assured us that the equipment and risk assessments are now in place. We will assess the impact for people of this action during our next inspection.

Each person had a personalised emergency evacuation plan however it did not mentioned when people used oxygen. This is important because the risk posed when oxygen is in use would be increased during a fire or evacuation. Additional guidance should be in place for staff in safely managing oxygen. Since the inspection the registered manager has informed us that risk management plans are now in place and they have contacted the fire and safety authority for advice on storing oxygen safely. We will assess the safety and impact these measures have had for people at the next inspection.

Failure to identify, assess and mitigate risk and provide safe and appropriate care is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 30 September 2015, people were at risk of harm because safe moving and handling practices were not used by staff. Since the last inspection staff had been re trained in how to help people to move safely using the equipment available. Staff confirmed that they now received training every six months in moving and handling people safely and integrated this knowledge into their practice. During this inspection staff were observed carrying out safe moving and handling practices. Staff kindly explained to people what they needed to do and allowed people to move at their own pace. The risk of harm had been reduced as people were supported by staff who were competent.

Peoples' medicines were managed, stored and administered safely. People told us, "My medicine is for my Parkinson's and I always get it the same time every day. Staff give it to me on spoon which is how I like to take it." A medicines profile had been completed for each person so that staff knew which medicines people received and any allergies to medicines were recorded. The medicines administration records (MAR) were accurate and contained no gaps or errors. A photograph of each person was on their MAR to ensure that staff were giving the medicine to the correct person. There was guidance for staff about reporting and recording if a person refused to take their medicine. All medicines coming into and out of the home were recorded and medicines were checked and recorded at each handover. Any changes to people's medicines were prescribed by the person's GP.

People received their medicines from competent and trained staff. Only staff who had attended training in the safe management of medicines were authorised to administer medicines to people. When staff administered medicines to people, they explained the medicine to them and why they needed to take it. Staff waited patiently until the person had taken their medicines. Staff knew the importance of giving medicines on time and the reasons why this was important to reduce the risk of side effects.

There were written individual PRN [medicines to be taken as required] protocols for each medicine that people took such as painkillers. These provided information to staff about the person taking the medicine, the type of medicine, maximum dose, the reason for taking the medicine and any possible side effects to be aware of. We observed staff asking a person if they were in any pain and would they like something for it.

Fire safety arrangements were in place to keep people safe, except when they were smoking. During the inspection the registered manager started to take action to address this shortfall. There was a contingency plan in place should an emergency have an impact on the delivery of care. Staff had a clear understanding of what to do in the event of an emergency such as adverse weather conditions, power cuts or flooding.

People lived in a well maintained environment. Communal areas, stairs and hall ways were free from

obstacles which enabled people to move freely around the home. Regular monitoring and safety checks of equipment were carried out to help keep people safe. People had access to specialist equipment such as wheelchairs, stair lift, walking frames, hoists, specialist beds or bathing aids to use whilst having a bath or shower.

There was a staff recruitment and selection policy in place and this had been followed, to ensure that people were supported by staff who were suitable. Staff confirmed that they were asked to complete an application form which recorded their employment and training history, provide proof of identification and contact details for references. Staff confirmed they were not allowed to commence employment until satisfactory criminal records checks and references had been obtained.

People told us they felt there was enough staff. A relative told us that sometimes there could be a shortage of staff but most of the time there were three staff on the unit where their family member lived. We clarified with the registered manager that the normal staffing is 3 carers on each unit with 1 nurse covering each floor of 3 units and an additional nurse on duty to help where needed. We found that this staffing level was consistently available unless staff called in sick without notice. Another relative told us, "There are enough staff here, all the family are very happy with it."

There was a sufficient number of staff to keep people safe and the consistent staff team were able to build up a rapport with people who lived at the home. This also enabled staff to obtain an understanding of people's care and support needs. The staffing rotas were based on the individual needs of people, if changes in people's needs occurred then staffing levels would be reviewed. This included supporting people to attend appointments and activities in the community. On the day of our visit people's needs were met promptly and they were given support throughout the day. The service had a call bell system in place that enabled people who chose to stay in their rooms to call for assistance when needed. When this was activated we observed that staff responded promptly.

Staff knew what to look for and what to do if they suspected any abuse. The service had a copy of the most recent local authority safeguarding policy and company policy on safeguarding adults at risk. This provided staff with up to date guidance about what to do in the event of suspected or actual abuse. Staff told us that they had received safeguarding adults training within the last year. We confirmed this when we looked at the staff training programme.

Requires Improvement

Is the service effective?

Our findings

People spoke positively of the staff working at the home. One person told us, "They give you service – they listen and are kind to me." Another person told us, "Staff will wash my back and legs for me, they are very helpful." Despite people's positive comments we found that improvements were still needed to ensure people received effective care.

At our last inspection on 30 September 2016, we made a recommendation that the management reviews its Mental Capacity Act (2005) (MCA) assessments and Deprivation of Liberty Safeguards (DoLS) applications to ensure people were protected from having their freedom restricted in accordance with current legislation. During this inspection we found that MCA assessments and DoLS applications had not always been completed and submitted. People's rights were not upheld in line with current guidelines.

People's rights were not protected because staff did not act in accordance with the MCA. Where important decisions needed to be made and staff had reason to believe someone may lack capacity due to their dementia, ill health or other reasons no assessment had been completed. The 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. Best interests were not always considered in relation to specific decisions that affected people. For example, a DoLS authorisation was requested for covert medication for one person. Covert medicine is a practice of deliberately disguising medicines usually in food or drink, in order that the person does not realise that they are taking it. However, there was no completed MCA assessment or best interest meeting held in relation to this decision. Where decisions had been made for people by their relatives, no documentation was in people's care plans which evidenced that relatives had the legal authority to do this.

The Care Quality Commission monitors the operation of DoLS which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The provider and staff did not have a clear understanding of their responsibilities under the MCA and DoLS. Although records viewed confirmed staff had received training, they were unable to put their knowledge into practice. We found that not everyone had a DoLS application completed and submitted to the local authority in accordance with legislation. Some people required three care staff to provide personal care, which meant that two members of staff were used to 'restrain 'or 'control' the person which deprived them of their liberty. DoLS application had not be completed and submitted in regard to this matter to ensure people were only restrained in their best interests and as least restrictively as possible. Since the inspection the registered manager has informed us that two urgent DoLS applications have now been submitted for the people being restrained during care.

Failure to meet the requirements of the Mental Capacity Act 2005 is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Consent was sought before simple personal care was provided. Staff checked with people that they were happy with the support being provided on a regular basis and attempted to gain people's consent. Staff waited for a response before acting on people's wishes. Staff maximised people's decision making capacity by seeking reassurance that people had understood questions asked of them. Where people declined assistance or choices offered, staff respected these decisions. This excludes the person who was restrained during personal care.

People told us about the food at the home. One person said, "I like the food here, if I don't like something I can have something else." Another person said, "The food is reasonable, I don't eat much." A relative told us, "The food is good, always plenty of vegetables." There was a choice of nutritious food, snacks and drinks and alternative options were available if people did not like what was on offer.

People had their dietary needs assessed and specific care records had been developed in relation to this. Kitchen staff were able to explain to us the individual preferences of people and that people had access to fortified puddings or drinks to reduce the risk of malnutrition. Where people needed assistance with eating or had special dietary requirements, information and guidelines were recorded to ensure their needs were met. Some people required products to be added to their food and drink to enable them to swallow without harm and instructions were given to staff regarding the dosage and consistency required. People were provided with well-presented pureed meals, in accordance with their care plan, to reduce the risks of choking. People had their food and fluid intake monitored and documentation was correctly completed so staff could monitor they were having enough to eat and drink.

There were inconsistencies in the support that staff received such as supervision and appraisals. Staff told us they had regular supervisions where they discussed their role, the people they cared for and their training needs. We reviewed the provider's records which reflected what staff had told us. Whilst the majority of staff had also received an appraisal, two staff had not received supervision since 2014 and 2013 respectively. The general manager stated that they would ensure these were carried out. An appraisal is an opportunity for staff to have an overview of their performance over a year. Since the inspection the registered manager informed us that all staff supervisions are now appropriate and up to date. We will assess how effectively staff are supported to carry out their role at the next inspection.

One person commented about the staff , "I think they must have been trained. They know how to help me." Many people were living with dementia and were unable to describe their experience of being cared for effectively so we observed the staff interacting with them. The staff were competent to carry out most of the basic care that people required. However although they had been trained and supervised some staff did not always use their training in practice. There were times when staff did not help people to eat appropriately or support people in a way that showed they knew how to do so competently, compassionately and effectively. Although staff had received regular training and supervision their competency had not been monitored effectively to enable them to carry out the duties they are employed to perform.

The provider's records confirmed that all staff had received mandatory training including: administration of medicines, safeguarding, moving and handling, fire awareness, food hygiene, health and safety, and infection control. Although a training programme was in place it did not always take into account the full needs of people living at Church View. For instance staff were unable to described correctly the different types of seizures people were having when documenting in their care plans. This meant that people's health conditions would not be able to accurately monitored or reported to health care professionals. Since the inspection the registered manager has assured us that further staff training has been arranged, including Mental Capacity & DOLS, epilepsy awareness and dementia awareness. We will assess how people's care has improved as a result of increased staff knowledge and competence at the next inspection.

The provider is failing to deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons to effectively meet service user's needs. They are also failing to appropriately supervise and appraise staff to enable them to carry out the roles they are employed to perform. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to healthcare professionals such as the GP, district nurse, optician, dentist, physiotherapist, and speech and language therapist. People told us they could see a doctor when they needed to. One relative told us that she was confident that health concerns were addressed and she was kept informed. They told us how staff called out the GP to deal with their relative's health condition, "They got the GP out and it was all sorted out." If people's health needs changed, staff had obtained guidance or advice from the person's doctor or other healthcare professionals. Outcomes of people's visits to healthcare professionals were recorded in their care records.

Requires Improvement

Is the service caring?

Our findings

People's views of the care and the staff that provided the care were positive. One person said, "Staff were friendly and always talk to them." Another person told us, "Staff here are nice and they are always polite to me." A third person told us, "Staff are kind and very friendly." A relative told us, "The staff are all good, very patient and kind. They always welcome me, offer me a drink and have a chat."

Despite these comments we found there were inconsistencies in the care that people received. During our observations, we saw examples of good and poor care; staff were very busy which had an impact on the support provided.

People's experience of mealtimes varied, whilst some people's experience was positive, others were not. We saw staff assisting people to get ready for lunch at a slow and steady pace. However there were inconsistencies in the way staff supported people, who required it, to eat. We saw some staff sit beside people encouraging people. However, other staff stood next to people. On occasions staff used a large spoon when a small spoon would have been more appropriate and we saw staff did not allow people time to properly swallow their food between spoonful's which would have been an unpleasant experience as well as increasing the risk of choking.

People were not always spoken to or treated in a respectful way by staff. Where one person was confused at times and spoke to staff in an accusatory manner staff did not respond to them. However when we spoke to this person about their past life, their mood changed to be positive and engaged quickly. When a person told a member of staff, "I am sad", the member of staff responded by saying, "You can go to bed after lunch". This same person told another staff member she was tired to which the staff member responded by offering them cold milk. A member of staff was observed walking over to a person, wiping their chin with a tissue without any verbal interaction or explanation about what was happening. Later the same staff member was observed walking in and out of a person's room four times without knocking or any verbal interaction. There was an incident between two people at one point and because staff did not intervene appropriately the situation escalated.

People were not always supported to make their own choices. People could choose when to get up in the morning, what to eat for breakfast, what to wear and activities they would like to participate in. However not everyone was able to personalise their room with their own furniture and personal items so that they were not surrounded by things that were familiar to them. One person's room did not have anything in there except a bed and furniture, there was nothing in their room to ascertain what they liked or to give you a sense of the person. When we discussed this with the registered manager, he replied that the person had, "zero cognitive response". They had not taken action to determine from the person or their family what the person might like to have in their room. However, it was clear to us that this person had some degree of awareness as they were able to respond to us when we spoke to them. On the second day of our visit we found the provider had listened to our concerns and had placed a television and radio in this person's room.

The majority of areas in the home were decorated to a satisfactory standard. However, there was a stark

difference in one of the units compared to the rest of the home. This area was for male residents who were living with dementia. There were no pictures on the walls and no home comforts such as cushions. Floors were laminate throughout the corridors and communal areas and there were no 'easy' chairs of a style normally found in a lounge. Name plates were missing from some people's doors with pieces of paper stuck to the door with other people's names crossed out. In general the environment was undignified for the people living there and there was no attention paid to designing an area suitable for people living with dementia. On the second day of our visit, some improvements had been made. Since the inspection the registered manager has assured us that the environment in the men's dementia unit has been improved for people. We will assess the effect this has had for people at the next inspection.

Failure to provide care and treatment to ensure people's dignity and respect was recognised was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of our inspection interaction between staff and people was better. However, although staff knew people's care and support needs their care was not centred on ensuring that people were at the heart of what they did.

The remainder of the home was comfortable and homely; there was a room full of objects and pictures that people could use to reminisce. Each unit except the one mentioned had comfy chairs, plants and pictures throughout. Some people had objects in their rooms that could assist relaxation or stimulate people's senses. There were quiets areas throughout the home where people could sit and chat with visitors.

There were some positive examples of staff interacting with people. For example when providing support to assist with people's mobility. Staff checked throughout the task that the person was happy with what was being done. Staff spoke to people in a kind and gentle manner. Where people were in wheelchairs staff bent down to maintain eye level with them. When people asked for help it was provided straight away and staff waited for people to respond before progressing with a conversation.

Staff did ensure that people's privacy was maintained and respected. People told us that their personal care needs were attended to in the privacy of their bedrooms with the door closed. Staff interacted with people throughout the day to provide personal care and activities but some people felt they would appreciate more one to one interaction at times.

Staff knew the people they supported. Staff were able to talk about people, their likes, dislikes and interests and the care and support they needed. They provided us with guidance and information about how to approach people. One person became distressed and confused regarding a recent bereavement they had experienced. A member of staff provided a careful explanation about what had happened and used the funeral order of service as an object of reference to reassure the person. There was information in care records that highlighted people's personal preferences, so that staff would know what people needed from them.

When staff asked people questions, they were given time to respond. For example, when offering people drinks. Staff did not rush people for a response, nor did they make the choice for the person. Relatives, health and social care professionals were involved in individual's care planning

We observed positive examples of staff responding to people needs. Where a person had a hearing impairment, staff communicated with them by writing things down. Through this communication, they were able get this person interested in reading and the person confirmed they loved the book as it was their favourite book as a child.

People were able to maintain relationships with family and friends and visitors were welcome. People confirmed that they were able to practice their religious beliefs, because the provider had religious services held in the home and these were open to those who wished to attend.

There were inconsistencies in how staff approached to end of life care. The managers informed us that no-one was on end of life care, although there were a few people receiving funding for this. Care plans did not contain information about how people wanted care and support during this time. Information about how to support people's wishes after their death was not fully recorded. Where necessary, people and staff were supported by palliative care specialists. Services and equipment were provided as and when needed.

We recommend that end of life care planning is improved to enable staff to provide for people's individual wishes and needs at this time.

Requires Improvement

Is the service responsive?

Our findings

People told us they were happy with the support they received. One person told us, "I chose to have a female; I can choose to have who I want to look after me." Another person told us, "They are good, he (pointing to a member of staff) is good. I am teaching him things. " Despite people's comments, people were not receiving responsive personalised care that met all of their needs or preferences.

People's care was not always based on individual's needs. Where people had specific needs such as a learning disability these had not been taken into account when planning their care or identifying what support they needed. Where people had behaviour that was challenging to the service or others, there was no assessment about the person's risks, needs or support. There was no care planning in place such as mental health or behavioural support guidelines to guide the staff in knowing what care this person should receive to meet their specific needs.
Where people had epileptic seizures, there was no information about the type of seizures they had as the only information recorded was the date and a description such as, 'twitching or shaking all body'. The purpose of a seizure chart is to record the type of seizure people experience so these could be monitored and appropriately responded to.

People's daily records were not written in a person-centred way. Although daily records were completed these did not record information about a person's well-being, interactions, activities or mood. This meant that although information was up to date it did not provide a full picture of the person to enable staff to monitor the person's wellbeing.

Care plans were hand written and were inconsistent in their approach, care plans on one unit were very difficult to read and therefore it was difficult to ascertain what care people required. Although existing staff were knowledgeable about people's day to day needs, new or agency staff would not have that knowledge or have access to accurate information to enable them to respond to people's personalised needs and wishes. Since the inspection the registered manager informed us that that the care plans would be improved to give staff additional guidance on how to meet people's needs. We will assess how this change helps staff respond to people's needs at the next inspection.

Failure to provide care and treatment in a person centred way taking account of people's preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People confirmed that they took part in the activities in and outside the home. One person said, "Oh yes, I make my own choices. I join in the activities I want to do, they don't force me." Activities included arts and crafts, board games, pet for therapy, sing a-longs, chair exercises, jigsaw puzzles and ball games. We saw photographs of outings or events people had attended. We observed a timetable of activities on a board. People were seen enjoying the activities on offer as well as sitting in the communal areas watching television, listening to music and talking to people. Staff encouraged people to engage in activities and offered a variety that catered to people's needs and interests. During the inspection we saw a few one to one activities taking place, which provided social interaction and reduced isolation for people who remained in

their rooms or who did not wish to participate in group activities.

People knew how to make a complaint. One person said, "If I was unhappy about anything I would speak to the manager or staff." We looked at the provider's complaints policy and procedure to review their processes. We reviewed the manager's complaints log and noted that 20 complaints since the last inspection had been processed in a timely manner. We saw information about the complaint procedure displayed in the home, which provided people with the information about the process, contact details for the registered provider, CQC, the local adult social care team and the Local Government Ombudsman. Staff had a clear understanding of what to do if someone approached them with a concern or complaint and had confidence that the registered provider would take any complaint seriously.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 30 September 2015, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Effective systems were not in place to assess, monitor and improve the quality of service people received and to identify poor practices. During this inspection the quality monitoring systems had not improved sufficiently to identify continued breaches of regulation and therefore action had not been taken in a timely way to ensure regulations were met or that people received a safe, effective, caring, responsive and well led service.

People remained at risk of harm because the system for assessing and mitigating risk remained unsafe and this had not been identified through the quality monitoring system adequately.

At the last inspection we recommended that the provider review their mental capacity arrangements to ensure people were protected. The quality monitoring system had not identified that this recommendation had not led to improvements. Staff and management still did not have clear working knowledge Mental Capacity Act 2005 and DoLS to protect people's right and ensure people were not restricted unlawfully.

Staff had received training but the quality monitoring systems had failed to identify that staff were not always supervised and were not delivering care competently or with compassion.

The quality monitoring system had not identified that people were not receiving personalised care that met their needs and preferences. Care plans did not contain the detail that staff would need to deliver care that each person preferred. Although individual staff did know people they cared for they were not always delivering care that was centred on the individual.

People's records were not always accurate and up to date. People had been weighed but some staff had recorded the details on a blood pressure chart instead. This created the potential for confusion and inaccurate recording of important statistics about the person.

People's care plans were handwritten and some were difficult to interpret. Therefore the provider, registered manager, staff and others involved in people's care would not always be able to determine that people received appropriate care or that what was written about people was accurate.

Where people had developed pressure sores accurate records were not being maintained which made the monitoring of progress difficult or inaccurate. The quality of the pictures of wounds were inconsistent as some pictures were dark so it was difficult to see the wound properly. Pictures did not have a scale to give an indication of the size of the wound. This information is important as it provides evidence of whether or not the wound is healing. Where the grade (severity) of a wound had been recorded this was inaccurate according to one of the nurses and the tissue viability nurse who attended people with sores in the home.

Failure to assess, monitor and improve the quality and safety of the service, not identifying and mitigating risks and failing to maintain accurate, contemporaneous records was a continued breach of Regulation 17

of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the inspection the registered manager informed us that many of these actions had been taken or were planned to be taken to improve people's experience and care. We will assess the effectiveness of these changes at the next inspection.

Other audits were carried out. For example, health and safety audits were carried out to help ensure people were not at risk of harm from the environment or equipment.

The registered manager was not fully aware of their statutory requirements to notify us of particular incidents. The manager had notified the Care Quality Commission (CQC) about a number of important events which the service is required to send us by law. However we noted that not all notifiable incidents or events had been submitted. This meant that we were unable to effectively monitor the service or identify concerns.

Failure to notify the Commission without delay of the incidents specified which occur whilst services are being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity is a breach of breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Since the inspection the registered manager has informed us that action has been taken to inform the appropriate local authority of the safeguarding matters which had not been notified previously.

People and those important to them had the opportunities to feedback their views about the home and quality of the service they received. The latest surveys were sent to people during May 2016. Feedback from the survey ranged from people wished for more activities, others complained about the food. Action taken was to arrange a meeting with the external caterer to discuss the issues around food.

We saw records of accidents and incidents that occurred every month and an analysis of the falls was carried out by the registered manager. The analysis identified a number of issues and as a result recommendations and learning outcomes were made. We noted that action taken was recorded.

People and staff told us that the management team were approachable and would discuss issues with them. A staff member told us that the manager was approachable and that they were, "Firm but fair." A relative told us, "Both X [registered manager] and Y [general manager] are very easy to speak to." The management team engaged with people, they were polite, caring towards them and encouraging to people.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the Commission without delay of the incidents specified which occur whilst services are being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider did not ensure people's care and treatment was always appropriate or met their needs and reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider failed to ensure that people were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider failed to gain appropriate consent in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider failed to ensure staff provided safe care to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to deploy enough skilled, competent staff who were adequately supervised and appraised to carry out their roles.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not ensured good governance in the home.

The enforcement action we took:

We served a Warning Notice.