Caring Homes (Salisbury) Limited

Laverstock Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 21, 23, 27 and 28 March 2018. The first day of the inspection was unannounced. This was the first inspection of the service, as there was a change in the provider's legal entity in August 2017. Before the change, the service had a history of non-compliance with regulation. As a result of this, we issued a condition on the provider's registration. This meant the provider was required to send us monthly reports regarding a range of audits such as staffing and the management of risk. The provider adhered to the condition although the information within the reports provided to us, was not fully accurate.

Laverstock Care Centre is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Laverstock Care Centre accommodates 80 people in one purpose built building. On the first day of the inspection, there were 69 people living at the home. People's bedrooms were located over three floors. Each floor had two separated units. One unit supported people with nursing needs whilst the other supported those living with dementia. Each unit had a separate lounge and an adjacent dining room and kitchenette. Bedrooms had en-suite facilities and there were communal bathrooms and toilets. All units were supported by a central kitchen and laundry.

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. The registered manager was available during the inspection on all but the second day.

At this inspection, serious concerns were identified regarding people's care. There were not enough staff to support people effectively and in a dignified way. There were periods during the early morning between 06.00 and 08.00 when units were not staffed. This was because the allocated member of staff was helping another member of the team, in a different unit. Insufficient staffing at this time meant two people did not receive assistance with their personal care. One person asked staff to help them to the toilet. Staff told the person to use their incontinence aid, as staff did not have time to assist them.

Potential risks to people's safety had not been identified or properly addressed. In one person's bedroom, there was a crash mat against the wall. This should have been on the floor to minimise injury, if the person fell from their bed. Re-positioning regimes to minimise people's risk of pressure ulceration were not being accurately followed. People's medicines were not safely managed and staff did not always follow safe moving and handling procedures.

People were not treated with dignity and respect and care was not person centred. The majority of interactions were task orientated and did not take into account people's preferences. In one unit, people

were assisted to bed without consultation. All except two people were in bed by 19.45. In the morning, there was an expectation a number of people would be "up and dressed" before the day staff came on duty at 08.00. Some people were "top dressed". This was a practice where people were assisted to wash and dress the top half of their body. They were then able to return to sleep. One member of staff told us they started assisting people to get washed and dressed from 05.00 onwards. This showed routines were task orientated and for the benefit of staff, rather than people's preferences.

We were not assured that people had enough to drink. Staff had identified those people at risk of dehydration. However, records showed some people had consistently not reached their recommended daily fluid intake. Whilst this had been identified, there was limited evidence to show additional fluids had been promoted.

Not all staff had an understanding of people's needs. One person became clearly distressed whilst receiving assistance with their personal care. Staff did not use any de-escalation techniques to minimise the person's agitation or distress. At 06.45, another person was in bed, fully dressed in the clothing they had worn the previous day. At 11.25, they still had the same clothing on but their trousers were wet, with a strong odour of urine. Some people had repeatedly declined support with their oral care. Strategies to address this had not been appropriately considered or monitored.

People's calls for help were not always responded to appropriately. This included one person sitting at a dining room table, calling for help. The person sounded distressed and repeated their request for assistance. A member of staff sat next to the person but did not speak to them for ten minutes, before offering assistance.

Staff were not properly supervised and there was no direct leadership within the areas. Not all staff had received sufficient training in dementia or positive behaviour management. A range of training which was deemed mandatory by the provider had been arranged but some staff had not completed all topics. Training in subjects associated with older age and people's nursing needs had not been recorded.

Agency staff were used to cover staff sickness, annual leave and vacancies. However, not all agency staff were given clear information about people before supporting them. This did not ensure they had an understanding of people's needs, to maintain safety.

The home was not clean. There was food debris down the side of armchairs, on over-bed tables and on dining room chairs. The kitchenettes were dirty with spillages and food debris down the side of the cupboards. Flooring in the lounges was stained and surfaces such as window sills were dusty. Other items were difficult to keep clean due to their state of repair.

There was a defensive culture from management, which did not encourage shortfalls to be properly raised and addressed. Staff were worried about the consequences of sharing their views. Others felt they had raised their concerns but no action had been taken.

A range of quality audits were in place to assess the quality of the service but these were not effective in identifying shortfalls. Information, such as the number of infections, was not always properly analysed, to minimise further occurrences. There was not a clear, accurate management overview of the service. Monthly management reports and information sent to us to comply with the condition of registration were not accurate and did not identify shortfalls.

The registered manager had a clear vision for the service. This was to ensure each person had something

positive in their day to remember or experience. There were some positive interactions. This included staff offering reassurance by smiling and stroking a person's arm. Staff were caring and attentive when giving people their medicines. Some staff knelt down to the person's level to communicate. They smiled and used the person's preferred name.

People were supported to access a range of services to meet their health care needs. This included the tissue viability specialist nurse, care liaison and the speech and language team. Detailed wound treatment plans were in place for those people who had a skin tear or pressure ulcer.

Staff were aware of their responsibilities to report a suspicion or allegation of abuse. A record of incidents reported to safeguarding was maintained. There was a copy of the complaint procedure in the passenger lift and main entrance of the home. The record of complaints showed all had been addressed, usually by speaking to staff and reminding them of their responsibilities.

While some records were in place we were unsure if all care, accidents and incidents were recorded. This did not allow robust quality assurance systems to be in place.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not enough staff to support people safely or effectively.

Risks were not properly identified or addressed.

The home was not clean.

People's medicines were not safely managed.

Is the service effective?

Inadequate

The service was not effective.

Staff did not have the right skills and knowledge to enable them to meet people's needs.

Staff were not always appropriately supervised.

People did not always have enough to drink.

The service did not always follow the principles of the Mental Capacity Act 2005.

People were able to access a range of services to meet their healthcare needs.

Is the service caring?

Inadequate

The service was not caring.

Dignity was not promoted.

People were not always treated with dignity and respect.

Care was task orientated and not person centred.

Is the service responsive?

Inadequate

The service was not responsive.

Not all staff had a clear understanding of people's health conditions.

Staff were not responsive to people's needs.

Spoken and written terminology was not always person centred.

Is the service well-led?

Inadequate

The service was not well led.

There was not a management overview of the care people received.

Audits did not identify shortfalls in the service.

There was a defensive culture, which did not encourage shortfalls to be identified or addressed.

Laverstock Care Centre

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.

The inspection was prompted by concerns raised about staffing levels and the impact this had on people's care. The concerns included people being assisted to get up, washed and dressed very early in the morning, poor moving and handling techniques and some people not receiving the care they needed. In addition, the information indicated that staff assisted some people to wash and dress their "top half", from 01.30 onwards. People were then assisted back to bed. Some of these concerns were confirmed during our inspection.

Before we visited we looked at notifications we had received. Services tell us about important events relating to the care they provide using a notification. We had also received another concern about inadequate staffing levels. This was sent to the provider to investigate. As we brought the inspection forward due to concerns, we did not ask the provider to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

The inspection took place on 21, 23, 27 and 28 March 2018. The first day of the inspection was unannounced and started at 5.50 in the morning. The third day of the inspection started at 16.00 to observe people's care during the evening.

On the first day of the inspection, there were four inspectors. There were three inspectors on the second day of the inspection and two inspectors on the third and fourth day.

In order to gain feedback about the service, we spoke to people and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with four relatives, 21 members of staff and one health care professional. After the inspection we wrote to four health and social care professionals to gain their

feedback about the service. Three responded regarding the format of the information required but no further detail was sent.

Inadequate

Is the service safe?

Our findings

There were not enough staff to ensure that people were safe particularly at night.

The building was spread over three floors. Each floor was split into two resulting in six distinct areas of accommodation. At night, the provider's staffing levels were six care staff and two registered nurses on duty. One care staff member worked on each area and the registered nurses covered all three floors. The registered nurses were not always available to support people as they were completing activities such as medicine rounds. An additional member of staff known as a 'floater', who assisted where required, was deployed at times. There was not a 'floater' on duty during the night of our inspection. The duty rota's were unclear so we were unable to determine how often the 'floater' was on duty. Staff told us that the lack of the floating staff member was a frequent occurrence.

The provider's staffing levels at night meant one care staff supported up to 16 people. We were told and care records confirmed that many people required the support of two staff in areas such as safe moving and handling and to meet personal care. One person needed the assistance of three staff.

At night, when the registered nurses were busy and a person needed two staff to assist them, staff called upon support from another area. During our inspection, between the hours of 06.00 and 08.00, this repeatedly occurred and at times meant areas were unstaffed. For example, at 06.10 the member of staff left the area that supported 14 people with a cognitive impairment (three of whom were at risk of falling and displaying challenging behaviour.) They had not returned to the area by 06.50. Another area was unstaffed for 20 minutes. This left people in the areas that were unstaffed at significant risk. Two people on one area did not receive personal care, as the staff member from another area was busy and unable to come and help. Both of these people were due to have their continence aid changed. As this was not done, there was a risk that both people were uncomfortable and soiled. This impacted on their dignity, the condition of their skin and their overall wellbeing.

We heard one person was calling out, as they said they were uncomfortable. No staff were in the vicinity to hear the person. We used the person's call bell, which they did not have access to. A member of staff answered the call bell and offered assistance. The person's need for help was identified, as we brought it to staff's attention. Without us doing this, there was a risk the person would not have received appropriate support, resulting in being uncomfortable for a longer period.

Another person was distressed, as they thought their mother had died in the night. We used the person's call bell to gain staff assistance. Staff responded to the call bell and told the person they were alright. The member of staff rearranged the person's bedding and said this would make them more comfortable. They offered the person a cup of tea and then left. The person continued to cry. The member of staff told us they were supporting people with their personal care, so could not spend longer with the person. They were not happy with this but said "This is what it's like." The member of staff did not have time to reassure the person effectively.

At 06.45, one person was in bed fully dressed. Staff told us this was because they were unable to support the person to change their clothes from the previous day due to "resistance." At 07.12 the person walked along the corridor and their trousers were wet. At 07.34 a night check record showed the person had been incontinent of urine. The documentation did not show what assistance the person had received. At 07.35, the person remained in wet clothing. A member of staff told us they had not been able to provide any personal care due to the person's "resistance." At 11.25, the person was still wearing the same clothing, which had a strong odour of urine.

Staff did not use safe moving and handling techniques. One person required the support of two members of care staff for safe moving and handling but was supported by one registered nurse. The registered nurse was aware that the intervention should be with the support of two members of staff but did not seek help from a colleague. The person was supported to use a bedpan without the registered nurse following correct moving and handling techniques, in accordance with their level of need. The person's care plan stated and staff confirmed, the person needed two staff to assist them with their personal care and moving safely. Another member of staff told us staff supported people on their own when two staff were required. They said "Sometimes you just got to do the repositioning on your own. Even when you know there should be two of you." Another member of staff said, "there are a few doubles here that I won't even try by myself. But most doubles you do on your own. There's no support."

There was a high level of feedback about inadequate staffing levels. One person told us "We're in a very bad way with staffing. They're very short staffed." Another person said "they answer the bell quite quickly but there's a long wait before they get another member of staff to help so it's difficult if you need the toilet."

Three relatives told us inadequate staffing was a real problem. One relative said "the care staff do a great job but they are run ragged. Due to their needs, people need a lot of time but staff can't give it. They just don't have time". Another relative told us "I do worry that staff do not have enough time to help my [family member] to eat. Like a lot of people here, they take a long time and I'm not sure staff have that time." Another relative said "There are never enough staff. There always seems like they need just one more [staff on the area]."

One relative told us they often assisted people to eat and drink, to help staff when they were particularly busy. During the inspection, another relative assisted a person, who was not their own family member. Whilst this was a kind gesture and intended to help, relatives were not aware of people's individual needs or the risks involved. This included if people required a special diet or had been assessed as being at risk of choking. Not having this information increased the risk of people sustaining harm.

Staff consistently told us there were not enough staff to support people. Specific comments were "I won't work nights as it's not safe. I would if there were more staff", "We're staff. Not miracle workers", "It's impossible. We can't split ourselves in two", "staffing levels are a concern" and "We can't give the care we want to. There's just not enough of us. We are always short staffed".

One member of staff gave us an example of inadequate staffing levels. They told us at 20.00 in one area, there were often a number of people becoming anxious, agitated and challenging in their behaviour. The staff member was concerned as there was only one member of care staff to support people, as the registered nurse was administering medicines. The member of staff was tearful and said "It's just not enough. People don't get the care." Another staff member who worked nights confirmed this. They told us "I might not be able to get to everyone." Another member of staff said "Sometimes if someone's pad is wet, you've just got to leave them for the day staff as you can't change their bedding and clothes by yourself." Staff told us the lack of staffing was often stressful. One member of staff told us "I'm here for the residents

but there are times when I could walk out. It's hard." Another staff member said "I would change the staffing levels if I could."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's safety were not always appropriately identified and addressed. Not all people had access to their call bell. We asked one person what they would do if they needed assistance, as their call bell was not accessible to them. They answered by saying "well, it's tough really." When assisting people to transfer with the hoist, we saw staff did not always apply the brakes on the wheelchairs. This meant the wheelchair moved when staff positioned the person in it. On one occasion, after assisting a person to their armchair, staff kicked the wheelchair out of the way. This was not safe practice. One person had a 'crash mat' in place to support them if they fell from their bed. On the third day of the inspection, the person was in bed but their crash mat was upright against the wall. This left the person at risk of injury if they fell out of bed.

Agency staff were being used to cover staff sickness, annual leave and vacancies. However, not all agency staff were given a thorough handover to ensure they were aware of people's needs. Staff asked one agency staff to assist a person to their room. The agency member of staff was not informed of the person's needs. They asked us if we knew the person's room number or if they used a wheelchair to help with their mobility. Another agency staff was told to put their bag down and help another member of staff with a person's personal care. There was no introduction or information sharing about the person's needs. The member of staff said they did not have time to do this. One member of agency staff was not given fire instruction before they started work. They were working on their own in one area, with the support of a registered nurse at times. This did not ensure they would be aware of what to do in the event of a fire. There were times when agency staff were aimlessly walking around. One agency staff member spent time looking out of the window, then walked backwards and forwards in the kitchenette.

Some people had stair gates in the doorways of their room. We asked staff about this and were told they were to prevent other people from entering people's rooms. The risks associated with the gates such as people falling over them or in the event of a fire, had not been considered. The use of the stair gates had not always been identified in people's emergency evacuation plans (PEEPS) or on the home's fire evacuation plan. One person had their bedroom door propped open at night with a footstool. This meant their door would not close in the event of a fire. The person's wish to have their door propped open was not recorded on their PEEP. There was a key in another person's door. Staff told us the person liked staff to lock the door whilst they were in their room, to ensure privacy. However, the room could not be unlocked from the inside. The risks of this, particularly how the person would get out of the room in the event of an emergency or fire, had not been identified. On the second day of the inspection, a spare key had been placed by the person's door and the lock had been changed. This enabled the door to be unlocked from the inside. An assessment to assess the risks of this practice or to ensure all possible safety measures had been taken was not in place.

People had been assessed as being at risk of developing pressure ulcers. During handover, on the first day of our inspection, a staff member told others that a number of people had sore areas of skin. However, measures to minimise these risks were not effective. For example, one member of staff told us "people need turning every 2-3 hours but it depends on the resources." There was a note on the dining room wall in one area reminding staff of the need to re-position a person strictly every two hours. This was because they had a pressure ulcer. The person's records and staff gave conflicting information regarding the frequency of this person's repositioning regime. Their re-positioning chart had not been fully completed. On 19 March 2018, the person's chart only had three entries, which were at 01.00, 03.00 and 05.00. There were no further entries until 08.00 on the following day. A period of 27 hours.

We saw that whilst one person's pressure relieving mattress was on the correct setting, a label on the mattress and the record showing daily monitoring gave inaccurate, conflicting information. We saw that two other mattress settings were on the wrong setting for the person's weight. This left people at increased risk of developing pressure ulcers.

Some people displayed behaviour that challenged. Whilst information was in place to guide staff on the ways to support this, one record showed a person had hit, head butted and threatened to kill staff. These incidents were identified on an Antecedent-Behaviour-Consequent (ABC) chart but the information recorded, had not been evaluated. This did not make sure potential causes could be analysed to minimise risks of re-occurrence. Another ABC chart showed a person had been shouting and banging the table in order to get staff's attention. The chart stated the person was asked not to do this and it was explained that the member of staff was talking to another person. This response showed a lack of understanding and increased the risk of the person feeling unvalued, which in turn could affect their well-being. Another member of staff had a scratch on their arm. They told us a person had scratched them. Incident forms had not been completed regarding this injury or the incidents of the person assaulting the member of staff. This lack of recording did not ensure all incidents were captured, appropriately investigated and lessons learnt.

People's medicines were not safely managed. Three people were prescribed the same type of medicine but with different dosages. These were all stored on one shelf in the medicine trolley, which increased the risk of error. The prescriptions for these three people did not correlate with the Medicine Administration Record (MAR). The MAR recorded different stock levels compared to what was present for each of the three people. These were checked with a registered nurse who could not account for the discrepancies. This meant there was a risk that people had been administered medicines prescribed for other people. Records showed one person was given their medicine at 21.00 instead of 22.00, as prescribed.

Information was available to staff regarding the administration of "as required" medicines. However, in some cases there was insufficient detail to ensure the medicines were given as prescribed and to ensure maximum effectiveness. For example, one person was prescribed Lorazepam. The record stated this was for "anxiety/agitation" but there was no further detail to inform staff at what stage the medicine should be administered. Information about soluble medicines did not inform staff how the person liked to take these. Staff had generally dated topical creams when opened and in the majority of cases, an expiry date was stated. Whilst this was good practice, some creams were still in use after their expiry date. Staff had not dated open medicine bottles and fluid thickener containers. This meant there was a risk of these items being used, when not appropriate to do so.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff administered medicines with kindness and dignity. A registered nurse knelt down with a person, smiled and stroked their arm. They explained to the person that their medicines were for pain, so would make them feel better. The person asked "Are you sure?" The registered nurse nodded and smiled whilst saying "I'm sure." Another person declined their medicines. A registered nurse explained they would return when the person was "feeling more awake."

The home was not clean. There was food debris down the side of armchairs, on over-bed tables and on dining room chairs. Some armchairs had brown stains and others were sticky to touch. The kitchenettes had food and liquid spills on the cupboard doors. The sealant around one sink was black and had debris around it. The microwave contained food debris on the inside surfaces and there was a meal still inside, from the day before. The floors in the lounges were not clean and sticky in places. The windowsills were dusty and in

one lounge, there were cobwebs around the room. Records showed one lounge had been cleaned but this was not accurate. After a member of staff had cleaned the room, there remained food and liquid spills on the furniture and there was debris under the cupboard. The furniture had not been moved to ensure effective cleaning. Two relatives told us they had concerns about the cleanliness of their family member's room and the kitchenettes. One relative told us the bed rails and underneath their family member's bed were often dirty. Another relative said whilst they were offered a drink during their visit, they always declined because of poor hygiene.

Other items were difficult to keep clean due to their state of repair. This included broken tiles in a toilet and the flooring coming away from the wall in another. The grouting and wooden toilet seats were stained. One toilet seat had a number of holes exposed, which did not promote good infection control. One person had a commode chair in their bathroom, which had a rubber seal hanging off the wheel. There were items such as wheelchairs and fans stored in a sluice room and in bathrooms. People's shoes and a vanity case were stored under the sink area in the sluice. The clinical waste bin in the sluice and another bin in a toilet had broken, as the foot operated mechanisms did not work. This meant staff were not able to use the foot pedal to lift the lid of the bin, so had to use their hands. This increases the risks of cross contamination.

Three care staff had very long finger nails and brightly coloured nail varnish. This increased the risk of staff damaging people's skin and compromised infection prevention and control. A senior member of staff told us there was a policy which stated staff had to have short nails. This was not being adhered to.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were aware of what constituted abuse and their responsibility to report any suspicion or allegation. The registered manager told us they notified the local safeguarding team of any incidents or falls people sustained. This included discussing actions taken or any further precautionary measures required. Records showed the safeguarding alerts that had been made.

Records showed a formal recruitment procedure was consistently followed. This included checking the applicant's identity, previous work performance and their suitability to work with vulnerable people. However, one application form showed concerns and the applicant was scored very low at their interview. They were unable to answer key questions such as safeguarding and professional responsibilities. Despite these concerns, they were appointed, with no rationale for doing so.

Inadequate

Is the service effective?

Our findings

There were varying comments about the competency of staff. One person told us they did not like agency staff. They told us "There's a lot of agency and they don't know you. You have to tell them each time what you need." The person said they saw many different faces and it was an on-going problem. Another person told us "It depends who's on as to what you get. Some are good and efficient. Others aren't." Relatives confirmed this. One relative said "the staff, particularly [name of staff] and [name of staff] are excellent but there's some I don't really know even though I regularly visit."

Not all staff had received a range of training that was deemed mandatory by the provider. The up to date overall training matrix showed a high number of courses were awaiting completion or the renewal date was overdue. This included 23 members of staff who were in need of 'people moving' training. 14 staff had not completed manual handling training. A member of staff had completed 'Train the Trainer' training in moving and handling, to enable them to train other staff in moving people safely. Whilst this was positive, there was no evidence that they had received updated training and their qualification had expired. This meant that this staff member may not have trained others effectively.

There were certificates in staff personnel files, which conflicted with the staff training records. This meant there were not accurate records of the training completed by staff. Some staff had completed training in health care conditions such as diabetes and Parkinson's disease. An overview of this training had not been captured. Not all staff had completed positive behaviour management training or dementia training that supported them in their role. Whilst some staff had received a foundation level of dementia training this was not effective to meet the complex needs of some people living at the service. The registered manager told us a certain percentage of staff needed to complete the first stage of the provider's dementia training before the next stage could be completed. They explained this was difficult with staff changes and the lack of permanent staff.

This meant people were being supported by staff who did not always have the knowledge or skills to recognise the right strategies to use to de-escalate anxieties or episodes of distress. Staff we spoke with told us they were waiting to do "specialist dementia training".

A health care professional whilst giving some positive comments about the care and support people received confirmed the team would benefit from additional dementia care training. Records showed some staff had requested more training in certain areas such as end of life care and dementia. There was no evidence these requests had been addressed.

Staff gave varying comments when asked if they felt supported in their work. Some staff said they felt supported, particularly from other members of the team. Others felt less supported. Records showed staff met with their supervisor on a one to one basis but this was generally ad-hoc and to inform staff of an instruction. The sessions were not used to enhance the on-going development of the individual staff member or their practice. The registered manager told us they were in the process of revamping the formal staff supervision system, as they were aware it was not effective or working well.

During the inspection, the registered nurses did not always lead their shift. There were practices which showed staff did not have a clear understanding of areas such as person centred care, behavioural management techniques and dignity in care. The staff were not properly supervised, guided or supported to use good practice in a range of areas. Records demonstrated there were gaps in training for these areas.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were not assured that people were supported to have enough to drink. Internal auditing systems identified the number of infections people experienced each month. These figures at times were high. For example, in December 2017, 12 people had urinary tract infections (UTI's). In November 2017 there were seven people and in August eight people had an UTI. To prevent and treat UTI's, people should be encouraged to drink sufficient amounts. Records did not show this consistently occurred.

Charts were in place, for those people considered at risk, to monitor the amount of fluids each person had. However, some people had consistently not reached their recommended target amount. There was no evidence staff had encouraged additional fluids or this had been identified, to enable a review of the support needed. Records showed on one day, a person had only consumed 370mls of fluid. They had spent periods of the day asleep but staff had not taken the opportunity to encourage fluids when the person was alert. Another person had a target intake of 1750mls. Throughout the week before our inspection, records showed the person's daily intake varied between 400 and 800mls. There was no evidence to show that this had been analysed and remedial action taken. One member of staff was not able to tell us who had a fluid monitoring chart in place. This did not ensure those people at risk of dehydration received regular encouragement to drink.

One person was unable to open a bottle so they could have a drink. We called for staff assistance, as the person did not have access to their call bell. Without alerting staff, there was a risk the person would be thirsty, without a drink being accessible to them.

Two relatives told us on their arrival, their family members were always thirsty. One relative told us their family member often drank a whole glass or two of water or squash. They said they did not feel their family member had enough to drink and staff did not encourage fluids, as much as they should.

The serving of drinks varied across the home. Some people asked for drinks and were offered them regularly. Other people were offered cups of tea, as a means of distraction or to sit down. Hot drinks were served at key times such as mid-morning, mid-afternoon and at mealtimes. We observed that some people did not receive drinks between these times. One person asked for a cup of tea and was given this at 07.12. It was placed on the person's over-bed table and they were told it was hot, so they would be assisted with it "shortly". At 08.10, the staff member informed another member of staff that the person would need help with their drink. This was an hour later, which meant the tea would have been cold. In another area, people were not asked if they wanted a drink or a snack before they were assisted to bed. In one area, each person was given a black currant drink. They were not asked if this was what they wanted or if they would prefer an alternative. This increased the risk of people not drinking due to it not being a drink of their preference.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed people had been assessed to determine if they were at risk of malnutrition. If a risk was identified, the person's food intake should be monitored. Records described the food and the amount the

person had eaten. However, in one area, snacks between meals given to ensure additional calories, were not documented. Staff monitored people's weight and discussed any concerns with the GP or dietician.

The views about the food were generally positive although one person was observed not to have eaten their breakfast. We asked them why this was so, to which they replied, "Would you eat it? Look at it." The toast was buttered and had marmalade on it but it was black in colour, where it had been burnt. We brought this to the attention of a member of staff who asked the person if they wanted some more. The person refused as it was too late and they did not feel like eating.

A relative told us they were generally happy with the food, as their family member was not losing weight. However, they suggested the taste of pureed food could be more varied. Another relative suggested rather than having yoghurt or mousse as a repeated dessert, fresh fruit could be pureed. After lunch, one person told staff "Tell the chef that was good rice pudding." Another person had not wanted rice pudding so had chosen yoghurt. One person told us "The food is good. If I'm not feeling hungry at tea, they ask if I want a hot chocolate and some biscuits to help keep me going."

People were able to access a range of services to meet their health care needs. This included an older people's specialist, a tissue viability specialist and the speech and language team. Records showed other support was received from the mental health team, care home liaison and the hearing and vision team. One person received weekly foot care appointments. A health care specialist told us staff were very good at identifying possible symptoms such as a urinary tract infection. They said staff knew the people they supported well and were always able to answer any questions asked of them. The said the registered nurses had built good links with the diabetes team, as there was one person who had very unstable diabetes. In addition, they said people had annual health checks and regular reviews of their medicines. One relative told us "They are very good at telling me if a GP has been in. They keep me updated."

The registered manager had a good understanding of the Mental Capacity Act 2005. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Decision specific mental capacity assessments and best interest meetings had been completed in line with the MCA. In addition, family members or medical professionals had been appropriately involved in the processes. For example, one assessment determined if the person had capacity to consent to receiving care and treatment at the service. Another assessment related to the person's consent to the use of bed rails. A best interest decision concluded the least restrictive option would be the use of a crash mat due to the potential risks of bed rails. Another person had their medicines administered covertly. This is where the medicines are placed in food or drink without the awareness or consent of the person. There was an assessment of the person's capacity and information about a best interest meeting. The GP had been involved and because the medicines were being crushed, the service had consulted a pharmacist.

Whilst appropriate procedures had been followed with regard to the MCA, there was some inconsistency. Other options such as sensor mats had not been considered for those people who had stair gates in the opening of their bedrooms. Another person had signed a record to show their consent for bed rails in October 2016. There had been a monthly entry thereafter which stated the bed rails and bumpers were to remain in place. The information did not highlight if the person still wanted or needed the rails or if a least restrictive option had been considered. Another record showed a best interest decision but there was no evidence the person's preferred form of communication had been explored. Another record did not show how the decision to live at the home had been made. Not all aspects of the form had been completed.

Care plans were not always sufficiently detailed to enable staff to support a person in their best interests. For example, one plan stated if a person declined support with their personal care, staff should return after thirty minutes. On the third attempt, the information stated "care input must be performed by three staff members." The information did not explain what each member of staff should do to support the person. This increased the risk of the person receiving inconsistent unsafe care. Within another person's daily record, staff had documented the person was shouting and insisted they did not need their continence aid changed. A further entry stated "In best interest it was changed + 3 carer." The entry did not show the measures taken to encourage the person to receive support with their personal care or how the intervention was undertaken.

The home was purpose built and therefore people's bedrooms and communal areas were light and spacious. All bedrooms had en-suite facilities which included a toilet, washbasin and shower. The corridors were wide and there were handrails, which enabled easy manoeuvrability. There were assisted baths in the communal bathrooms. People's bedrooms were personalised with pictures and photographs. However, some of the rooms were in need of decoration, as there were marks on the walls and the paint was chipped in places. The lounges were of a similar condition.

Inadequate

Is the service caring?

Our findings

People were not always treated with dignity. On the first day of our inspection, one person wanted to use the bathroom and was calling for staff help to do this. At 06.00 a registered nurse told the person "Wait two minutes and we'll be back." The person continued to call for help and at 06.40 they were told "[Person's name], you have a pad. You can go in your pad." The person expressed their frustrations and distress by saying, "You need to help me quick." The registered nurse responded by saying "When I've finished my rounds I will help you, until then you can make in your pad. You can go in your pad and we will clean you up later." The person did not receive support until 07.00. The member of staff had not considered the person's dignity or the impact on their wellbeing throughout this interaction.

Another person was stood in the dining room with their incontinence pad around their ankles. A member of staff supported the person to walk towards their bedroom but did not consider the trip hazards and indignity of the situation. Another member of staff saw this and intervened. Another member of staff was allocated a person to take to bed. They stood in front of the person in the lounge and took their disposable gloves out of their pocket. They then put the gloves on and assisted the person to their room. There was no consideration to how this might have made the person feel. We observed an agency member of staff approach a person and feel their lower leg, presumably to check for fullness of a catheter bag. The member of staff did not ask or inform the person, what they were doing.

There were other practices which did not promote people's dignity. For example, whilst accompanied by a member of staff, the top of the person's continence aid was visible over their jumper. The staff member did not support the person to adjust their clothing. Another person was in bed with their door open. They had screwed up their bedding, which had exposed them. The person had 'net' knickers on, which showed their continence aid. We used the person's call bell to request staff to assist the person to become more comfortable and covered. Another person had their clothing pulled up over their knees, showing their bare legs, whilst staff supported them with their mobility in a wheelchair. Staff did not support the person to adjust their clothing. Within the corridor of one area, there were photographs of people, one of whom appeared asleep and had a clothes protector on. The photograph did not promote the person's dignity.

In one area, staff were allocated to people who needed assistance with their personal care or to go to bed. A whiteboard in the dining room was used to display the allocation. This was very public. The information was headed "bed" and "P/C" and there was a list of people's room numbers under each heading. A member of staff told us "bed" showed a list of people who needed to be assisted to bed. "P/C" were people already in bed, who would need a "pad change". The member of staff told us they had used room numbers to promote people's privacy. Other negative aspects of this practice had not been considered. The people in the lounge were taken to bed one after another, without choice or consultation. At 19.45, all but two people had been assisted to bed. This was poor practice, which totally disregarded the person and their wishes.

On the first day of our inspection, 13 people had been assisted to dress before 08.00. An additional seven people had been assisted to have their "top half" dressed. We had been informed of concerns regarding this practice, before our inspection. One member of staff told us they had assisted three people to get washed

and dressed at 05.00 when doing the "pad round". Staff told us there was an expectation, although not an instruction, that four or five people were assisted with their personal care before the day staff came on duty at 08.00. One member of staff said "some staff expect more than others." To achieve this, one member of staff told us they would start getting people up who were awake, from 05.30 to 06.00 onwards. One member of staff told us "Some staff want to make the day staff happy. They don't listen to the resident."

Staff told us some people who were nursed in bed, were assisted with their "top half" at a similar time, or before if they were soiled. Entries such as "Top dressed him" were documented within staff handover records. The records and staff feedback showed this practice took place routinely. This showed care and support was not centred on the needs of individuals but rather task based for the convenience of the staff. During a handover, people were spoken about in terms of the tasks that needed to be completed. One member of staff said "If you've got the majority of them in bed it's alright."

There were other care routines, which did not promote people's dignity or individuality. Staff spoke of "pad rounds", which were specific times of the day and night, when they supported people with their continence care. The routines did not take into account people's individual needs or wishes. One member of staff told us "we do all the people that are single, then do the people that need two [staff] but it depends on the staff working." This showed staff availability and preference were dictating care routines, rather than the emphasis being given to people's individual wishes and wellbeing.

The terminology staff used when talking to each other was not always person centred. Staff were regularly heard to say to each other "who do you want to do next?" Other discussions were "Have you any more pad changes to do?" and "Have you breakfasted anyone this morning?" This showed people were supported according to tasks, staff preference and availability, rather than what each individual wanted. We asked one agency member of staff about their role. They told us they had been called to the area to "do pad changes and put people's pyjamas on." Terminology within care records was similar. For example, within an assessment undertaken by the registered manager, the person was described as "pleasantly confused". A daily record stated "Toileted throughout the day when needed."

Concerns were raised about some people's dignity. For example, two relatives told us their family member's clothing was not always changed when food or drink had been split. They said this was degrading as their family members had been smart and presented well in their earlier life. Another relative told us "I think the staff and care are exemplary. I have no complaints but seeing my [family member] with a scrappy piece of material or a bib around their neck is degrading humiliating and does not promote their dignity at all."

Generic decisions had been made, which did not reflect person centred care. For example, people were unable to enter communal bathrooms. This was because the doors were locked from the outside, with a bolt type lock. The fitting of the locks had been a corporate decision, as a precautionary measure, as someone (not within the organisation) had drowned in a bath. The generic approach to this did not take into account people's individual needs and wishes. The risks of locking the bathrooms had not been assessed and formally documented within a risk assessment. Similarly, some people's bedrooms could not be locked from the inside. Staff told us this was because people with dementia might lock themselves in their rooms, which would also be a fire risk. People's individual needs and their right to privacy had not been considered.

People's records were not always stored securely. Daily records and care charts in some areas were left on a table in the dining room. This meant they could be accessed by anyone, without the authority to do so. There were records belonging to people in an unlocked linen store. Some of the records were loose piles of paper, which were scattered across the floor. The linen store was unlocked throughout the second day of

our inspection. This did not ensure the records were stored securely or show respect to people and their property.

On the first day of our inspection, within two areas, the morning handover of information from one shift to another was undertaken in the dining room with people present. The discussions included personal information about people's care needs, what care they had received and what was still needed. Discussing such personal information within a public place, did not promote confidentiality or people's dignity.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other interactions showed staff were caring. They held people's hands and gently touched their arm to offer reassurance and warmth. Some staff knelt down to the person's level to communicate. They smiled and used people's preferred names. One member of staff leaned in to a person and quietly explained it was time to take their tablets, if they were happy to do this. They showed concern and asked the person if they were feeling alright. A registered nurse talked to another person about where they used to live. They were discussing the local area and the registered nurse asked "Do you know Durrington?" The person replied "Oh yes." The registered nurse used a friendly tone and said "Ah, we're practically neighbours."

There were positive comments about the staff team. These included "Girls here are good as gold. They always tell me what is happening", "The staff know [family member] well. Some of them can make [family member] smile, which is lovely and reassuring" and "I can't complain about the staff. They work hard."

Staff told us they enjoyed their role and liked working with people. They spoke of wanting to provide a good standard of care and to "do a good job." One member of staff told us "I like working with people with dementia. I love the personalities of the people here." Another staff member said "This is the best job ever. I love caring for people." Other comments were "This is the person's home and we respect this. I like to go home knowing I've done a good job" and "I love it here."

Staff gave us examples of how they promoted people's privacy and dignity. This included drawing curtains and making sure doors were closed, when supporting people with their personal care. Staff said during care interventions, if a person did not have any clothing on, they would cover them with a towel. One member of staff told us people could choose the gender of staff supporting them with intimate personal care. They said their choices were fully respected. The gender of staff was taken into account when staff were allocated those people who needed assistance to go to bed.

Relatives told us they were able to visit at any time and staff made them feel welcome. They said they were able to have a meal with their family member if they wanted to. There was a room on the ground floor that was used for private dining. This room was comfortable, nicely furnished and light. Relatives could also eat with their family member in their room if they chose to.

The registered manager told us a "Dignity" Group had recently been started. The aim of the group was to "promote dignity" and consisted of senior staff, care staff representatives, a relative and two people who used the service. A notice board in the entrance area had been allocated to the topic. This showed the discussions that had taken place within the group and key action points.

Inadequate

Is the service responsive?

Our findings

Not all staff had a good understanding of people's needs and their health conditions. For example, staff were assisting one person with their personal care. Their bedroom door was shut but within the corridor, we heard the person shouting and calling for help. Their voice was becoming louder and louder and they were becoming clearly distressed. The person was saying they were "frightened" and wanted staff to "get out". Whilst staff repeatedly used the person's name, they did not use any de-escalation techniques to minimise the agitation or distress. Later in the day, the person told a staff member they had eaten enough of their meal and did not want any more. The member of staff on this occasion respected the person's decision. This showed that earlier in the day, staff had focussed on the task of personal care, rather than respecting the person's wishes and appropriately managing their distress. A senior member of staff told us they would review the person's care.

In another area, an agency member of staff supported a person to have a drink. The interaction was undertaken in negative manner. The staff member put the straw to the person's mouth, whilst sitting next to them. They then looked away from the person and continued to look around the room. The staff member did not communicate with the person during the intervention. They then removed the cup and walked away.

Another member of staff explained a person's reluctance to receive support with their personal care. They said the person sometimes agreed to have a bath, as it helped them relax. However, the staff member said by the time they got the towels, the person had forgotten and declined the support. The member of staff had not ensured they were prepared with what they needed before offering the person a bath. This did not take into account the person's short term memory loss.

Staff assisted another person to move using a hoist. They pulled the person towards them to position the hoist sling without giving the person an opportunity to participate. Staff told the person they were "going up" as the hoist lifted them. The person was then suspended in the air, whilst staff manoeuvred the hoist and wheelchair. Staff did not give the person any reassurance, other than saying "going down" when being positioned towards the wheelchair. The person was positioned in the wheelchair and taken to their room without discussion. There was no reflection or consideration to how this person might have felt during the interventions. This lack of awareness did not show staff had a clear understanding of the person's dementia care needs.

People's calls for help were not always responded to appropriately. One person was sat at a dining room table, calling for help. The person sounded distressed and repeated their request for assistance. A member of staff sat next to the person but did not speak to them. The person had been calling for help with the staff sat next to them, for ten minutes before they introduced themselves and said "I'm here to help." Two members of ancillary staff were in the dining area of the same area although at a different time. A person tried to speak with them on two occasions. They looked in the person's direction but ignored their requests and walked out of the room.

Staff did not offer visual choices of the meals. People had pre-chosen their "chicken or fish" option the evening before and were asked while seated at the dining table if they would like "mash or chips." Some people were able to make this decision without visual prompts but others found the choice difficult. Staff discussed between themselves how they would offer one person the choice but did not show the person the option. Chips were given but staff then noticed the person was finding these difficult to eat. They determined this was because the person only had their bottom set of teeth, as the top set could not be found.

In one area, staff used the person's name when serving their meal and explained the contents to them. However, this was not consistent practice in other dining rooms. A relative told us that sometimes they were not able to decipher what the pureed food consisted of. They said they asked staff but they did not always know. This made it difficult for the relative to inform their family member of what they were eating, whilst being assisted.

One person used a book that contained 'flash cards' of questions and words, to assist them with their communication. This enabled the person to communicate decisions such as whether they wanted a bath or a shower. When asked for the book, staff were not sure where it was. Staff spoke louder to the person in an attempt to enable them to understand. In all interactions observed, staff did not use the person's communication book. This did not ensure the support tools in place were fully utilised, which impacted on the person's wellbeing.

Records showed people did not always receive oral care. For example, during the month of the inspection, one person had declined support in this area 22 times. Two people had declined 13 times and one person had declined 10 times. One person had not had not received mouth care throughout all of March, and only had their teeth cleaned four times in February. Whilst it is recognised people have the right to decline, there was no evidence that discussions had been held to find out what the person disliked and what measures may help to promote successful mouth care. In addition, records did not show that staff had worked with people to enable them to feel more positive about this aspect of their care. One member of staff told us "If she won't let us in the morning then we probably don't have time to go back and try again later." The person's care plan stated they needed their teeth cleaned twice a day and staff were to try to get the person to do as much as they could for themselves. The information stated "[Person's name] needs prompting to clean her own teeth and only given support if she needs it or her oral hygiene assessment flags it as a concern." No oral hygiene assessment had been completed and concerns about the person's oral care had not been identified. The person had lost 7kg since September 2017 but the potential connection between oral care and weight loss had not been considered.

Care staff told us they always reported any care that was declined such as oral care, to the registered nurses. However, a senior member of the care and management team was unaware of the number of people who had declined support in this area.

During handover, on the first day of our inspection, a staff member told others that a number of people had sore areas of skin. Details of the sore areas were not documented in the person's daily records and there was no information about the action taken. A registered nurse confirmed staff should record such details in the person's daily records. They said more significant wounds such as skin tears or pressure ulcers would be recorded separately. The lack of recording increased the risk of aspects, such as soreness, being missed and not appropriately treated.

Many of the entries in people's daily records were task focused and did not reflect wellbeing. One entry stated "Only said she was in pain once or twice, assisted with personal care and creams applied." There was

no further detail about the person's pain or how this was managed. Another record stated "[Person] was in bed on my arrival. She was asleep and had her pad changed when required." In addition to being task focused, the information was not specific and did not include the times the person was supported. This did not inform staff when the person would need further assistance. One daily record was not accurate, as it stated the person had received support with their personal care. This person was one of two, who did not get assistance in a timely manner, on the first day of our inspection. The next shift was informed of this but the person did not receive assistance with their personal care until after staff had taken their morning break. One member of staff told us "people do get left in bed, it is not person centred here."

Records were not always written at the time support was given, or by the staff member who provided the assistance. This did not ensure the account was accurate and increased the risk of information being missed. One member of staff completed people's fluid charts later in the day, which did not ensure accuracy. There were occasions when a member of staff asked others for information such as "how much did [person] drink at lunch time?"

The registered manager told us a new care planning system was in the process of being implemented. This meant there were two systems running alongside each other. Those people new to the service had care plans using the new system, whilst other people who had been at the service for longer, were using the old system. It was expected that this information would be transferred, after each person's formal care review.

Some of the information was conflicting. For example, on a handover record, a person was identified as having a 'fork mashable' diet. This was also stated in the person's care plan but other sections described the person's diet as 'fork mashable' meat only, soft diet and a normal diet. The lack of clarity increased the risk of the person being given the wrong textured food, which increased their risk of choking.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a poor culture and care routines were not reflective of people's individual needs and preferences. For example, the morning medicine administration round took place between 06.00 and 07.00. In one area, the registered nurse woke people by knocking on their door, switching on the main bedroom lights and offering the medicines. The lights were then switched off and people could return to sleep. After the handover, a member of the day staff then opened each bedroom door, called out "morning" and switched on the bedroom lights again. The member of staff told people "It's morning now. We will get you up and washed soon." Two staff talked about a person between themselves in the corridor. One of the staff asked "Are we getting [person's name] up first or giving him his breakfast?" People were not involved in decisions about their preferred routines.

Staff used institutional terminology. For example, one member of staff said "I hate bath days". They were referring to the days people were supported to shower in their en-suite bathrooms. When asked to explain what 'bath day' meant, the member of staff said "Half have 'bath days' one day and we offer the other half a 'bath day' on the next day." The member of staff explained people could decline or if a person wanted to be assisted to have a bath every day, this would be arranged. However, the overall opportunity of having a bath or shower was not person centred.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some aspects of record keeping were managed well. For example, those people with a skin tear or pressure

ulcer had a wound assessment in place. Each contained up to date photographs of the wound with measurements and a clear treatment plan. The service had involved the tissue viability specialist nurse as required and their guidance was being followed. One person displayed behaviour that challenged. Their distress care plan was positively written. The information showed identified triggers and clear strategies for staff to follow.

People were not consistently offered choice but when choice was offered, it was done so with kindness. Some people were not woken and staff used the person's name, whilst asking them if they wanted to get up. They gave verbal reassurance when a person expressed discomfort. This included "You're doing really well, you're nearly there." The person was then offered clothing choices such as "What clothes do you want to wear today? Would you like to wear a vest?"

In one area, staff were friendly and welcoming when supporting people to the dining room. People were asked where they wanted to sit and were supported to their chair. Staff talked through the process and provided reassurance, to help the person to become seated safely. One member of staff said "You alright [person's name]? The chair is just behind you. That's it, well done." Another person was being supported to the table and had linked arms with a member of staff. The staff member commented "Oh I love that shirt on you" and the person responded "me too." People were asked if they wanted a clothes protector. For some people, this was rephrased and the description of a "tabard" was used. One person became unsettled and staff quickly brought them a 'twiddle muff'. This was well received by the person and diverted their attention, whilst they were waiting for their meal.

There were positive comments about the care provided. One health care professional told us "I visit Laverstock care centre on a professional level, and felt I should comment on the amazing care that the staff are giving to sometimes very challenging dementia patients. They have encompassed individualised care, and go above and beyond to meet the patients individual needs. One fantastic example, is by providing a pool table for a resident who has a love of the game. The staff engage with this gentleman in a really positive way and you can truly see such a positive difference. I felt it was important to highlight this superb care, and I was personally touched by this outstanding recognition of the person as an individual." The healthcare professional told us staff had an application on their phone, which converted words into other languages, to communicate with those people whose first language was not English. During the inspection, we observed that staff did not consistently use this.

There were a range of social activities arranged for people to join in with if they wanted to. The activities included bingo, quizzes and a reading and poetry group. A poster displayed on the notice board showed the activities for the week. During the weekends, "Chats and Conversations with your Carers" were the stated activities. One member of staff told us they felt social activity was an area that could be improved. They told us "The activities are a waste of time. There's a suitcase for 'time goes by' but it's been the same thing for years. The residents know every item. It's boring." People who were nursed in bed or chose to stay in their room received little stimulation. This increased the risk of social isolation.

Records showed one person's social activity was "Lava Java". This was a trolley with a selection of drinks, such as different varieties of tea and coffee. The person was in bed and talked out loud for much of the time. Whilst walking past the person's room, staff did not enter and engage with them. A senior member of staff explained this was because the person talked to themselves. They said it was "something they often did." People's social needs were not recorded in their care plans. This did not ensure staff were aware of people's interests and what they liked to do.

There was a copy of the complaint procedure in the passenger lift and entrance area of the service. Whilst

there was a copy in the Service user's guide in people's rooms, it was not clearly visible and accessible to people.

There were varying views about the management of complaints. One relative told us a response was dependent on who they had raised their concerns with. They told us some concerns were dealt with quickly but others, such as inadequate staffing levels, were never addressed. Another relative told us "we often raise things, as this is my [family member] and they are very special to us but nothing really gets done. Sometimes things change for a while but it soon reverts back."

The registered maintained a copy of complaints. All showed they had been addressed, usually by speaking to staff and reminding them of their responsibilities.

Inadequate

Is the service well-led?

Our findings

This location has had a history of non-compliance with regulation and as a result, a condition was issued on the provider's registration. This meant the provider was required to send the Care Quality Commission monthly reports regarding staffing levels and the management of risk. In August 2017, a change was made to the legal entity of the service. This meant a new registration was established and this was the location's first inspection. Within the registration process, there was a voluntary agreement by the provider to transfer the condition to the new legal entity.

The provider has complied with the condition and sent monthly reports as required. However, the information was not always accurate and showed all aspects, such as staffing levels, were being properly addressed without concern. This was not what we found during our inspection. Whilst there were a range of audits to assess the safety and quality of the service and monthly senior management reports, these had also not identified the shortfalls we found. This showed the auditing systems were not effective. Other than raising the difficulties of recruiting staff and the impact of agency staff, the registered manager or senior managers were not aware of the concerns we identified.

There was a culture within the home, which did not encourage shortfalls to be properly raised and addressed. Some of the staff were worried there would be reprisals, if management knew they had shared any negativity with us. One member of staff told us "I am going to get into so much trouble. [Manager's name] is going to come and ask me what I've said. I'm honest though, morale is low and I do dread coming in because you don't know what you're going to get."

Other staff were concerned they would be identified. Some were frustrated, as they had already raised their views with management but had "got nowhere." One member of staff told us "we have repeatedly told them, we do not have enough staff but they think there's enough. We know what we face. They don't know. It's hard." Another staff member told us "I have reported some poor practice to the manager but I don't feel confident it has been dealt with." Another staff member said "I'm fed up of the lack of support here. They have been telling us for two years that things will change, but they don't. You are expected to just get on with it by yourself, even if you know there isn't enough staff for it to be safe." A senior manager disagreed with our view that there was a poor culture within the home. They said staff were very open, honest and readily shared their views when they spoke to them.

After the first day of our inspection, we wrote to the provider requesting an urgent action plan in response to the serious concerns we identified. The provider responded as required. However we observed one of the key actions the provider was going to take, was to take statements from staff to ensure accuracy of our evidence. This did not show a responsibility of providing safe and appropriate care or a commitment to people's overall wellbeing. Within one person's care plan, there was a scrap piece of paper. On this, it was written "Please complete the End of Life care plan. CQC like to see these." This gave focus to the task and what we wanted, rather than ensuring the person received good quality care, which reflected their wishes.

After the inspection, we met with the provider to discuss the seriousness of our concerns. Our discussions

included inadequate governance, insufficient staffing, poor care practices and lack of dignity and respect for people. We informed the provider we would be taking enforcement action. The provider gave us assurances that there would be a strong senior manager presence and improvements would be made.

There were shortfalls in the environment which had not been addressed. Some toilet seats were broken and the boarding behind the toilet in one bathroom was coming away from the wall. There were containers in the kitchenettes, which contained items such as cereals and biscuits. Some of the containers were dirty and not all had lids. The opening dates of these items and jars of food in the refrigerators had not been documented. This did not inform staff when the foods had passed their expiry date. There was a carton of soup in one refrigerator. It had been opened on 06 March 2018 and should have been used in 48 hours. Another fridge had an open tin of soup, with the tin lid left open and no opened date recorded.

There was not a management overview of the standard of care people received. This included the staff culture, task orientated routines and the lack of dignity and respect some people experienced. Staff were not appropriately supported, trained or supervised. One member of staff, who had been recruited without a clear rationale for doing so, was not formally monitored. Errors were made but not satisfactorily addressed.

Records showed there had been three night visit audits since April 2017. This was despite staff raising concerns about inadequate staffing levels at night. Records showed concerns about mouth care were highlighted during a health and safety meeting in January 2018. The action recorded was that torches had been provided to staff and there was a supply of toothbrushes, which had been made available. The information did not expand on why torches were needed and there was no discussion about other methods that could support people with their mouth care. This area had not been further monitored, as there remained shortfalls in this aspect of people's care.

Information collected as part of auditing systems was not always sufficiently analysed. For example, the number of infections people experienced were identified each month. These figures at times were high. For example, in December 2017, 12 people had urinary tract infections (UTI's). In November 2017 there were seven people and in August eight people had an UTI. The information did not show what action had been taken to minimise the risk of people experiencing such infections.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the shortfalls in the overall management of the service, there were positive comments about the registered manager. This included personal qualities such as "caring" and "very nice in their manner". However, staff and relatives told us they rarely saw the registered manager "on the floor." They said this was because the registered manager was generally office based and on the whole, worked office hours, Monday to Friday. Staff and relatives told us they could meet with the registered manager if they went to their office but the majority of interactions took place with other senior staff. One member of staff told us they would ring the registered manager if they needed to. Another staff member said "I cannot complain about management"

The registered manager had a clear vision for the service. This was to ensure each person had something positive in their day to remember or experience. The registered manager said they wanted each person to have a purpose and a good quality of life. To assist with this vision, the registered manager said they had employed additional activity staff. This meant there were now three activity organisers in post who worked at different times and on different days. The registered manager told us this enabled more opportunities to be offered to people.