Chippenham Limited

Goldenley Care Home

Inspection report

Forest Lane
Chippenham
Wiltshire
SN15 3QU

Tel: 01249443501

Date of inspection visit:
26 June 2017
27 June 2017
29 June 2017
03 July 2017

Date of publication:
19 September 2017

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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

We carried out this inspection over four days on 26, 27, 29 June and 3 July 2017. The first day of the inspection was unannounced.

Goldenley Care Home provides accommodation to people who require personal care. The home is registered to accommodate up to 19 people. People supported were living with dementia, a mental health condition, a learning disability or physical disability. On the first three days of the inspection, there were 16 people living at the home. On the last day, there were 17 people.

Our last comprehensive inspection to the service was in November 2016. We issued two warning notices as the provider had repeatedly failed to meet a number of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We completed a focused inspection in February 2017 to check the provider had taken appropriate action to meet the warning notices. We saw that improvements had been made. However, further shortfalls were identified at this inspection.

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 is responsible for the day to day management of the home.

Prior to this inspection, there had been a number of serious allegations, from a range of different sources, regarding potential abuse at the home. The allegations included verbal, physical abuse and poor care practice. The allegations are currently being investigated by the local safeguarding team and the police. In response to the allegations, the Quality and Monitoring Manager and Operations Manager were deployed to the home. Their remit was to assess, monitor and develop practice, as well as providing support to the registered manager. Both managers told us they would remain at the home, until all actions had been taken and improvements had been made. A clear action plan was in place and being regularly updated. Updated copies were being sent to the Care Quality Commission and the local authority for assurances and monitoring purposes.

At this inspection, potential risks to people's safety continued not to be properly identified and addressed. This was identified at previous inspections in 2015 and 2016. An audit undertaken by the service had shown risk assessments did not sufficiently identify triggers or specific measures to mitigate the risks. In response to this, all risk assessments were being reviewed. Accidents and incidents were not analysed to minimise further occurrences. Specific risks such as a pressure relieving mattress bleeping and showing a fault, had not been identified.

People's care was not always planned in such a way to meet their individual needs. This was identified at previous inspections in 2015 and 2016. Each support plan was similar in content and much of the

information lacked clarity and detail. The Quality and Monitoring Manager had identified this and was in the process of reviewing all information, starting with those areas of greatest priority.

Not all people looked well supported with their personal care. Information did not inform staff of the most effective ways to manage any resistance a person displayed. Some people were subject to restrictions, which had not been formally agreed within the appropriate processes. This included the restriction of cigarettes to minimise the risk of fire and injury but also to minimise the amount smoked.

Staff did not always promote people's privacy and dignity. Some staff spoke over people and regular terms of endearment were used. Terminology within some records was judgemental and did not show an understanding of the person's needs. People's beds did not always look comfortable, which did not show time and care had been taken when they were being made. Staff promoted other areas of people's privacy such as knocking on doors before entering.

Not all aspects of the environment were well maintained. There was a large amount of rubbish to the side of the property and offensive graffiti on the front wall. Various items such as an old commode and a flower pot containing rubbish were located outside. Some people's rooms had staining on the walls by the bed and the hand wash basin. The Operations Manager explained a full audit of the environment had been undertaken and measures were in place to address all shortfalls. A skip had been arranged to remove all rubbish.

People received good support from health care professionals. They had regular contact from the GP and specialised services were requested as required. People's risk of malnutrition and hydration had been assessed and people were supported to have regular hot and cold drinks. People liked the food and had enough to eat. A new catering system was in the process of being implemented. This meant all meals would be purchased frozen and then reheated in a specialised oven. The system was intended to ensure each meal was nutritionally balanced and met the person's individual dietary needs.

People and their relatives knew how to make a complaint. Meetings were in the process of being arranged to enable people to discuss any concerns they might have. In addition to discussing concerns, the meetings were also intended to find out more about people, in order to develop their support further.

During our inspection we found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Two of these breaches were repeated from the last inspection as sufficient action had not been taken to address the shortfalls. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded. The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take

action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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.

A number of serious allegations of potential abuse had been made. These were being investigated by the police and the local safeguarding team.

Potential risks to people's safety had not been sufficiently identified and addressed.

Improvements had been made to the cleanliness of the environment but there were some areas, which did not promote good infection control practice.

Staff administered people's medicines safely yet guidance for "as required" medicines and some topical creams was not clear.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not supported to make decisions in line with the Mental Capacity Act 2015.

Staff felt well supported and were happy with the training they received. However, not all had completed the training deemed mandatory by the provider.

People were supported to have regular hot and cold drinks. A new system to ensure people received nutritious, well balanced meals was being introduced.

People received good support from a range of health care professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not always promoted.

Terminology used in written records did not always value people

and promote their wellbeing.

People liked the staff but not all practices demonstrated a caring approach.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's support plans had been rewritten but were being further reviewed. Not all information was sufficiently detailed to inform staff of the support required.

Staff were not always responsive to people's needs.

People and their relatives knew how to raise a concern.

Is the service well-led?

Inadequate

The service was not well-led.

The service has a poor history of compliance. Sufficient action had not been taken to address previous breaches in regulation and improvement had not been sustained.

Audits were not comprehensive and not effectively identifying shortfalls.

A senior management team had been deployed to the home to improve the safety and quality of the service.

Clear action plans were in place and being sent to key stakeholders for assurance and monitoring processes.

Goldenley 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was unannounced on the 26 June 2017 and continued on 26, 28 June and 3 July 2017. The inspection was carried out by one inspector, a specialist advisor in dementia and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with seven people living at Goldenley Care Home and three relatives about their views on the quality of the care and support being provided. We spoke with the registered manager, a Quality and Monitoring Manager, an Operations Manager, five staff and one health/social care professional. We looked at six people's care records and documentation in relation to the management of the home. This included staff supervision, training and recruitment records and quality auditing processes. We looked around the premises and observed interactions between staff and people who use the service.

Before our inspection, we looked at previous inspection reports, safeguarding minutes and notifications we had received. Services tell us about important events relating to the care they provide using a notification.

Inadequate

Is the service safe?

Our findings

Prior to this inspection, there had been a number of serious allegations, from a range of different sources, regarding potential abuse at the home. The allegations include verbal, physical abuse and poor care practice. The allegations are currently being investigated by the local safeguarding team and the police. Management had taken appropriate action including the suspension of staff whilst the investigations were taking place. Some disciplinary action had followed.

During the inspection staff told us the allegations had impacted on morale, however they had not seen any practice which concerned them. Staff confirmed they were aware of safeguarding and whistleblowing procedures and told us they would always report any concerns to the registered manager or senior management. Staff told us they had undertaken training in safeguarding people from abuse. Training records showed four members of staff had not completed this training. In addition four staff had not received any updated training. This was because two staff members had completed the training in 2014 and two had completed it in 2015. One member of staff had undertaken safeguarding training but not until a month after starting their employment.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last comprehensive inspection in November 2016, we identified the service was not meeting Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because potential risks to people were not always identified and properly addressed. We issued a warning notice to ensure the provider made improvements. A focussed inspection in February 2017 identified action had been taken to address the shortfalls. However, at this inspection, further shortfalls were found. The breach in this regulation was initially identified during an inspection in 2015.

A recent audit undertaken by senior management had identified assessments lacked detail about the triggers and specific measures to reduce the risk. As a result of this, the Quality and Monitoring Manager told us all risk assessments were being reviewed to ensure they were "fit for purpose". This lack of detail within assessments was evidenced at the inspection. For example, one person had an assessment regarding dementia care. The assessment showed the identified risk was low but it did not detail what the risk was or what action was required. There was another assessment, which identified a potential risk to the safety of others. The record was located at the back of the person's support plan, so was not easily seen. A senior member of staff told us they were aware of the risk but said the staff team had not been informed. They were not aware of the action that was required to ensure the safety of the person and others. Other assessments were in place which identified risks associated with areas such as falls, malnutrition and tissue viability. Staff were aware of the measures in place to minimise such risks. Health care professionals had been contacted for advice as required.

Records were maintained of any accidents or incidents. However, the information was not detailed and some parts of the record were not fully completed. One record showed a person had fallen down the last

few steps of the stairs. There was no detail to show how this had happened, if any injuries had been sustained or the measures taken to minimise further occurrences. The format of the accident form asked "consider the danger removed and the home safe again?" The member of staff had recorded "yes". There was no information to show how staff had come to this decision. There was not an overview of accidents and incidents. This did not enable potential trends to be analysed.

A person's pressure relieving mattress, used to reduce the risk of pressure ulceration, (sometimes called bedsores) was bleeping and showing a fault. Staff had not identified this. We brought it to the attention of the registered manager but at the end of the day, the fault was still showing. The registered manager apologised and explained they had misheard the room number we had given. They said the person often disconnected the mattress and sometimes, when staff cleaned the room, the plug could be knocked. The Quality and Monitoring Manager told us staff would always check pressure relieving mattresses were in good working order, when assisting a person to bed. This was acknowledged although this check would be too late to enable any problems to be easily rectified. One member of staff told us pressure relieving mattresses were checked weekly but the checks were not documented. This system was not sufficient to ensure the equipment was in good working order and reduce the risk of people developing pressure ulceration .

Prior to the inspection, the service informed the Care Quality Commission that one person had left the home unsupported on four separate occasions. Staff had followed protocol and the police had located the person and supported them back to the home. Records gave limited information about the detail of what happened or the timescale of events. The action taken in response to the person leaving the home had been insufficient to ensure the person's safety. During the inspection, another person was walking around the garden. They were rattling the gate and trying to look over the fence. They had previously said they wanted to go home. Once brought to their attention, the Quality and Monitoring Manager supported the person to move away from the fence area. After lunch, another person did the same. They were walking on a slight slope and on areas which were uneven. A member of staff was in the dining room, which overlooked the garden, writing in people's care records. They glanced at the person walking across the garden but did not intervene. The member of staff continued writing and did not "keep an eye" on the person's whereabouts. There were outdoor garden chairs but these were very light and unstable, which increased the risk of people falling.

At the last comprehensive inspection, it was identified the laundry door was unsecured. This meant people could access harmful substances such as disinfectant. Whilst the laundry door had a keypad to restrict access, on two occasions during the inspection, the door was not shut properly. As some people had a cognitive impairment, there was an increased risk of the substances being misused, causing harm. The registered manager told us they did not know why the laundry door was not shut, as staff were conscious of the need to secure the room. All other hazards, as identified at the last comprehensive inspection had been addressed.

Cleanliness within the home had improved and the majority of areas were clean. However, one commode pot was empty but had a strong, unpleasant odour and brown debris on the lid. There were two toilets that had debris, brown drip marks and pieces of dried toilet paper, around the bowl and seat. The commode and toilets were cleaned later in the day. Within the laundry, there was soiled linen in a basket, which was overflowing against the wall. One person had their dentures, soaking in their hand wash basin, in their en-suite. Later in the day, the teeth were on the window sill. This did not comply with good infection control guidance.

Not all medicine profiles, which identified a list of people's medicines, matched the medicine administration records. This meant the profiles were not always kept up to date. The Quality and Monitoring Manager told

us they would address this with staff and ensure each staff member was clear regarding whose responsibility it was, to update the records. Clear guidance for staff was not always in place regarding medicines to be taken "as required". After the inspection, the Quality and Monitoring Manager stated this had been identified and was being addressed. One person had a range of prescribed topical creams, all to be applied at the same time. The records did not clearly show where the creams were to be applied. The MAR stated the creams should be "applied as directed". The Quality and Monitoring Manager told us they would clarify this and amend the records accordingly.

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

People's medicines were orderly and securely stored. Staff administered medicines safely. They waited and observed each person taking their medicines. Staff signed the medicine administration record, before moving on to the next person. In the event of hesitation, staff explained what the medicines were for and gave encouragement. Staff asked people if they wanted any pain relief. There were clear records showing the receipt of people's medicines. Staff had documented when they had opened short shelf life medicines such as eye drops. The Quality and Monitoring Manager told us they were in the process of changing the medicine administration system currently used. They believed the new system would be more effective and would be implemented once staff had received the appropriate training.

A health care professional told us staff were good at not relying on sedative type medicines, to manage a person's agitation or potential aggression. Staff told us they received training and had their competency assessed before administering medicines to people.

At the last comprehensive inspection in November 2016, we identified the service was not meeting Regulation 19, Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because records did not show a robust recruitment process was consistently being followed. We issued a requirement notice to ensure the provider made improvements. At this inspection, improvements had been made to the process. Each applicant had completed an application form and supplied contact details of two people, who could provide details of their work performance and character. All applicants had a formal interview and undertook a Disclosure and Barring check (DBS). This enabled providers to make decisions about the applicant's suitability to work with vulnerable people. However, whilst the systems in place were clear and ordered, some were not robust. For example, one interview record identified the applicant had a stable and logical work history but this was not accurate. Some people, who provided information about the applicant's performance, were different from those identified on the application form. The reasons for this were not stated. The information was sometimes addressed "to whom it may concern". Records did not show these had been verified. A recent audit of personnel files showed gaps in some candidate's employment history. This had been addressed.

People told us they felt safe at the service although one person said they wanted to go home. Another person said "I like it here so long as it's not too crowded. People are friendly". One person put their thumb up and smiled, to show they felt safe. A relative told us they did not worry about their family member and had no concerns about their safety. Another relative was not as positive. They explained their concerns and said these had been raised with the registered manager and the local safeguarding team.

Improvements had been made to moving people safely. One person was assisted to move using the hoist. This was done safely and the person was given reassurance during the intervention. People's support plans had been updated to reflect moving and handling procedures. The registered manager told us a new hoist had been purchased and people had their own slings. Records showed other equipment such as slide

sheets were in place and being used.

People and their relatives told us there were enough staff to provide the support required. This view was confirmed by all but one member of staff. The member of staff told us they felt more staff would enable improved care to be given, rather than solely meeting people's basic care needs. They said "staffing is definitely an issue". Records showed there was one senior carer, two junior care staff, a cook, housekeeper and activities co-ordinator on duty during the morning and early afternoon. This reduced to two care staff with an apprentice during the late afternoon and evening. At night there was one waking care staff and a member of staff undertook a "sleeping in" role. This meant they were available for advice or assistance as required.

During the inspection, there were enough staff to support people. Staff responded to any call bells and requests for assistance in a timely manner. There was a staff presence within communal areas, where most people spent their time. One member of staff spent approximately 30 minutes, assisting a person to eat their lunch. There was no pressure for them to undertake other tasks during this time. However, in the afternoon, one member of staff was responsible for preparing and serving the evening meal. This meant they were in the kitchen and taken away from their caring responsibilities. The Quality and Monitoring Manager told us there were plans to introduce a new catering system. They said this enabled staff to spend less time in the kitchen, as all meals would need to be re-heated, rather than prepared from scratch. The Quality and Monitoring Manager and the registered manager told us staffing numbers were sufficient to meet people's needs. The registered manager told us they now lived on the premises and were regularly available to assist when required. They said a dependency tool was used to determine the number of staff needed on each shift.

Requires Improvement

Is the service effective?

Our findings

The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The Deprivation of Liberty Safeguards are part of the Act. The DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

The principles of the MCA were not always appropriately followed and applied. Staff had control of some people's cigarettes to minimise the risk of fire and injury but also to minimise the amount smoked. During the inspection, people asked staff for a cigarette but received varying answers. This included "in a minute", "wait five minutes" and "you've just had one". A best interest meeting had not been held to discuss the management of people's cigarettes. Staff told us another person's wishes often conflicted with those of a family member. They said this was at times difficult. Best interest meetings had not been held to agree decision making. One relative told us they had been asked for their views about whether their family member would like to be resuscitated. They were concerned with this request, as they believed their family had capacity to make this decision themselves. There was no information in the person's support plan about their wishes regarding resuscitation. The Quality Monitoring Manager told us they would investigate this and ensure the appropriate processes would be followed and documented. At the front of people's care records, the administrator had been identified as the "consent giver". This was not appropriate.

Staff told us they had undertaken training in the MCA. However, records showed only eight out of seventeen staff had completed this. Two staff had completed their training in 2014. Staff said they encouraged people to make decisions. This included what each person wanted to wear and what time they got up and went to bed. However, at lunch time, staff placed a clothes protector on some people, without asking if they wanted one. Other interactions were better and involved staff asking people "would you like me to?" and "is this how you wanted it?"

An audit, which had recently been undertaken by senior management, had identified shortfalls in this area. The records stated "the majority of assessments were not carried out in line with the principles of the MCA and the outcome of the assessment was concluded wrong". The Quality and Monitoring Manager told us all mental capacity assessments would be reviewed once other areas of greater priority had been undertaken. They said they understood all DoLS applications had been appropriately submitted.

This was a repeated breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the start of their employment, not all staff were well informed and clear of their responsibilities. Records showed staff had a brief introduction to the home and there was a health and safety induction booklet. There was no evidence within personnel files of recognised induction programmes, such as the Care

Certificate. The Quality and Performance Monitoring Manager told us such programmes were in place. They said there was an expectation the Care Certificate would be completed after the staff member's first 12 weeks of employment.

Two members of staff were employed as apprentices. They were responsible for tasks such as clearing tables, tidying and washing up. One apprentice told us they helped serve meals and drinks and assisted with some people's personal care. Records showed an apprentice had completed some training such as safeguarding, nutrition and hydration, health and safety and moving people safely, but other topics had not been covered. A training and development plan for the apprentice was not in place. The apprentice told us they had no formal programme or a mentor but would be starting their Health and Social Care Diploma after a year into their apprenticeship. Without a clear plan of learning, there was a risk the apprentices would not reach their full potential. In addition, there was no information about the associated organisation which ran the apprenticeship. The Quality and Monitoring Manager told us they were in the process of reviewing the title of the apprentices, as they did not feel it was not fully accurate.

Not all staff had completed training courses, deemed mandatory by the provider. For example, one member of staff who regularly supported people on their own had only completed training in safeguarding and duty of care. They had not undertaken training in moving people safely, first aid, infection control or the management of challenging behaviour. Another member of staff had not completed any training other than a session on Parkinson's disease. Records showed topics such as first aid, personal safety and communication were not applicable to this staff member. This was despite them working with people, often on their own. Records showed ten out of the twelve care staff had completed training in dementia care. However, their practice during the inspection did not demonstrate their learning. For example, staff did not acknowledge people by name and regularly used terms of endearment such as "come on little one", "alright darling" and "you're welcome sweetheart". In addition to not recognising people's dementia care needs, this attitude and terminology did not show a person centred approach. Records showed training related to people's needs such as dementia and mental health, was "not applicable" to ancillary staff. This was despite staff such as housekeepers, having contact with people.

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

The Quality and Monitoring Manager told us they were reviewing the training staff had received. They said in addition, a programme of specific training was being introduced. This included scenarios such as the trainer not listening to the staff member and talking over them. The Quality and Monitoring Manager told us the training was centred on how it made staff feel, which was deemed a good way to learn. They said it was an innovative method for staff training, which had proved to be very effective in other services within the organisation.

The majority of staff told us they felt well supported. They said they gained support from each other as well as from the registered manager and senior managers. Staff told us they received regular formal meetings with their supervisor. They said they discussed topics such as performance and any concerns they had. One member of staff told us they could ask for additional sessions if needed. There were records of the meetings and the areas discussed. Such topics included relationships and communication. Whilst the meetings occurred regularly, areas for development, including specific actions, were not documented. This did not promote the on-going improvement of practice and staff's individual skills.

Staff told us there was a mixture of "on line" and "face to face" training, which helped different learning styles. One member of staff told us they had difficulties accessing a computer so the registered manager

allowed them to use the home's computer. Staff told us training was usually completed in their own time. They said they were told what courses they needed to complete and had reminders, if they did not do so. Not all staff could remember what training they had completed. Others told us they had completed training in areas such as Parkinson's disease, moving people safely and fire safety.

People had regular hot and cold drinks. They said they liked the food and had enough to eat. One person told us "it's grand. Spot on". Other comments were "there's always enough to eat here" and "I like my squash and I chose vegetable pie today, as I like that". A person put their thumb up to show their views about the food. One relative told us "X has better food here than when they were at home". Another relative told they believed the meals could be more nutritionally based. One member of staff told us consideration was being given to this. They said the menus were being reviewed so foods were not regularly repeated. The member of staff told us at present, many foods such as pies and soups were purchased, rather than being homemade. They said they wanted to develop more "home cooking" as this would be more nutritious for people.

Staff told us the menus were devised according to people's personal preferences. There were two roast lunches a week and always fish on a Friday and gammon on a Tuesday. Other lunch meals included sausages or pies. Whilst based on people's preferences, the menus were somewhat repetitive and did not ensure a nutritionally, well balanced variety. On the first day of the inspection, lunch consisted of toad in the hole with mashed potato, sweetcorn and carrots. There were three flavours of angel delight with sprayed cream for dessert. One person had rice pudding, as this is what they wanted. The lunch time period was calm, relaxed and unhurried.

The registered manager told us staff monitored and documented each person's food and fluid intake. The majority of records were completed and totalled appropriately to show each person's daily intake. Assessments identified people's risk of hydration and malnutrition. Records showed people's weight was monitored at varying frequencies, depending on their need and risk. Staff told us any concerns would be discussed with the person's GP. A referral to the dietician would be made if necessary. Staff told us of the importance of good hydration and how they promoted this.

The Quality and Monitoring Manager told us all meal arrangements were being totally revamped. They said all meals were to be purchased "ready-made" but frozen. Staff would then reheat the meals using specialised ovens. The Quality and Monitoring Manager told us the new system would enable better choice and ensure each meal was nutritionally balanced. They said "taster" sessions were in the process of being arranged for people and their relatives, before the system was fully implemented.

People were supported to see a range of health care professionals when required. The GP visited on a regular basis and knew people well. This ensured consistency and enabled any health issues to be identified quickly. Some people were supported to go to the local GP surgery for their consultations. Staff told us the support received from health care professionals was excellent. This included six monthly health checks. Staff told us other health care professionals would be contacted, when needed. This included district nurses, speech and language therapists, dentists and dieticians. One member of staff told us an occupational therapist and physiotherapist had recently been involved with a person and their changing mobility needs. Records were maintained of all health care interventions including any changes to a person's medicines.

Requires Improvement

Is the service caring?

Our findings

At the last comprehensive inspection in November 2016, interactions between staff and people who used the service were generally related to tasks, which were being undertaken. This included the serving of drinks or meals and accompanying people to and from the dining room. At this inspection, interactions were similar. Conversations or pleasantries were limited. Staff regularly walked through the dining room and acknowledged one person but not others. They sometimes talked over people and did not show a person centred approach. This included one member of staff saying "I'll feed you in a minute". Another member of staff said "when everyone's done I'll feed X". There were comments about people's health conditions, including personal details, which were discussed in front of people.

A keypad had recently been installed on the kitchen door. This was in response to an incident and was intended to ensure people's safety. However, as people approached the door, they were told "come away from the kitchen door X. You're not allowed in here" and "you can't come in here". The brusque response from staff emphasised the restriction and caused one person in particular, heightened frustration.

Some people's beds had not been made properly so looked untidy and uncomfortable. The sheets and blankets had not been straightened, tidied or folded under the mattress properly. The bottom sheets were thin and wrinkled and there was some stains on the sheets and one pillow. The way in which the beds had been made did not ensure the person's comfort or promote their dignity. The wrinkles in the sheets did not promote the effective prevention of pressure ulceration. One relative told us "when we visit I would like to have a chair to sit on in X's room, as I am not too sure how clean the bedding is". The Quality and Monitoring Manager told us they had identified people's bedding and towels were in need of replacement. They told us more had been purchased and were in the process of circulation. One person confirmed this. They told us they had received new sheets, which looked "very smart".

Within an audit undertaken by senior management, it had been identified that some information within daily records was undignified. This was further evidenced within a note to relatives, placed in the corridor on the first floor. The note explained "protected" mealtimes had been introduced but if family members wanted to assist people with "feeding", this was promoted. Other records stated "spoke to safeguarding about X's escape" and "X is wandering". This was not appropriate terminology. Another record stated "will urinate on his bed, chair or anywhere that suits him". This statement was judgemental and did not show an understanding of the person's needs.

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

In other areas, staff promoted people's privacy and dignity. They ensured a person was appropriately covered whilst being assisted to move, using a hoist. The registered manager told us discussions had recently been held about the person wearing trousers rather than a skirt. This would enable the person to be better covered, whilst transferring. Staff knocked on people's bedroom doors and called out, before entering. They ensured any personal care was undertaken in private, with doors closed. One member of staff

knelt down in front of a person whilst speaking to them. This enabled the person to hear better but also enabled a more positive interaction.

People told us they liked the staff. One person told us "they're lovely people here". Another person said staff were "very high class and competent". Other comments were "they look after me well", "they're alright" and "they're sweet and nice". One person put their thumb up and smiled when they were asked about the staff. Relatives confirmed staff were friendly with people. One relative said the majority of the staff had worked at the home for many years and knew their family member well. They told us "on the whole we feel very happy with X living here". They explained one of the positives about the home was that their family member could "do what they wanted". Relatives told us they were able to visit at any time. One relative said "we can come here any time and spend as much time with X as we want. Staff always come in, to ask whether we are alright".

Requires Improvement

Is the service responsive?

Our findings

At the last comprehensive inspection in November 2016, the service was not meeting Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's care was not always planned in such a way to meet their individual needs. The shortfall was also identified in 2015.

At this inspection, whilst it was noted all support plans had been rewritten using a new format, shortfalls in their content remained. The Quality and Monitoring Manager told us they had identified this and were in the process of reviewing all care documentation. They said key areas linked to safety such as nutrition and hydration, were being targeted first, with other areas to follow. After further discussion, the Quality and Manager told us they would also add tissue viability to their review. They said to ensure safety, they would prioritise those people with greater need and review their support plans first.

Each support plan was similar in content and much of the information lacked clarity and detail. For example, one person was at risk of developing pressure ulceration. Their support plan stated they should be encouraged to move seats to minimise them being in the same position. There was no detail to inform staff how often this should be. Information identified equipment used and informed staff to be careful whilst giving assistance and report any signs of pressure damage to the registered manager. The information did not detail further preventative measures or the management of any resistance. Other people were also identified as being at risk of pressure ulceration. Each support plan was very similar and not person centred. On the first day of the inspection, one person had been assisted to go to bed early. They were asleep on their back at 17.45. There was no guidance in the person's support plan about the assistance they needed to change their position at night.

Another person sometimes wanted to leave the home. Their support plan stated they should be reassured and asked if they wanted tea or coffee. There was a suggestion that the activities organiser may be able to take the person out, if not busy with others. The information stated the person liked to use a chalk board but there were no details as to why this was so and in what way. The information was insufficient to enable staff to safely support the person and minimise the risk of them becoming further agitated and unsettled. Staff checked this person on a 15 minute basis and recorded their whereabouts on a chart. The record showed entries such as "asleep" or "in the lounge". It did not give any details of the person's mental state including their mood. This did not enable staff to identify any trends or if the person was becoming unsettled and therefore likely to leave the building.

Support plans stated some people required staff to "make frequent conversation" to keep them "cognitively stimulated". This instruction was not followed. Two people spent the majority of time in their room. Despite their support plans stating they liked music, both people sat in their chair or led on their bed, without stimulation. Other people spent large amounts of time, outside smoking. Other than supplying people with their cigarettes, staff interaction was limited. One person told us "I get up, go to the dining room then lay on my bed". They told us "that's it really. It's just healing really, no treatment". Some people had a mental health condition. Support plans did not show how this impacted on their daily lives or what support they required to aid recovery and promote independence. Records showed one person regularly led on their bed.

They did this on one day, throughout the afternoon and early evening. The record stated the person was assisted back to bed at 20.15 and then was in the lounge at 22.45. Information did show how the person was to be supported to achieve a more appropriate day and night routine. Records showed the person was involved in very little activity and stimulation.

Not all people looked well supported with their personal care. Two people had stained jumpers and another person's hair was greasy and dishevelled. Whilst some people had manicured and sometimes polished nails, other people had dirt under and around their finger nails. The registered manager and staff explained this was because many people showed resistance to personal care and often refused the support they required. The resistance was identified within people's support plans. However, there was limited information to inform staff how this should be managed. There was no information about what interventions were successful or what the person disliked. One plan stated the person was more accommodating to receive support with their personal care, in the morning when they got up. The information did not detail the approximate time of this. Another plan identified any support should be at a time "convenient to the person". It was not clear how this should be determined.

Staff were not always responsive to people's needs. For example, one person was in the lounge and a member of staff placed their evening meal in front of them, on an over-bed table. The person was not sat upright and could not reach their meal effectively. Another person identified this and offered to move the plate forward and cut the food up. In doing so, they left the person's cutlery upside down. A member of staff was assisting another person on the other side of the lounge. They did not intervene. Another member of staff walked through the lounge and noted the person was not eating. They said "give me a minute X and I'll help you". The person had eaten their previous meal in the dining room. Due to being seated in a wheelchair, the table was quite high and the person needed to lift their arms, to effectively reach their meal. The person dropped some of their food onto their lap and ended up using their fingers. Two other people were given their meal in the lounge. One person did not have any cutlery and needed to wait for this. Another person was told "I'll feed you in a minute X".

At lunchtime on the first day of the inspection, one person was trying to load food onto their spoon. Whilst doing so, much of the food was being pushed from their plate. Some of the food was falling on the floor. The person had difficulty chewing and placed chewed food back on their plate. All but one member of staff did not notice this or intervene. On the next day of the inspection, the person was given a plate guard and their food was cut up into smaller pieces. This enabled the person to eat their meal in a more dignified manner.

Staff assisted one person to the dining room in a wheelchair. On reaching the dining room table, the staff member positioned the person appropriately and applied the brakes on the wheelchair. The member of staff then left the person to assist others, without speaking. Some staff explained the contents of the meal and asked if any assistance was needed. However, this was not consistent. One member of staff assisted a person to eat but they said they did not like the food. The member of staff continued to encourage the person whilst repeating "just one more mouthful". The person repeatedly refused and was offered a banana, cut into slices. The person happily ate this independently. Some people did not eat well. Staff removed the plates but did not always ask the person why they had not eaten their food. Alternatives were offered to some people but not all. One person had a milky drink and a snack later, as they had not eaten their meal.

A member of staff walked by one person and told them to stop scratching. They did not talk to the person to find out what was troubling them or if any assistance was required. Another person was standing in the dining room. They were bent over with their hands on their knees. On asking a member of staff if the person was alright, the staff member replied "yes, they've got a bad chest". They did not interact with the person to see if they needed any assistance. Shortly afterwards, the person was seated but knocking their head on the

table. Again, staff did not intervene or ask what was wrong.

One person (female) had a large amount of facial hair. Staff told us the person was often resistant to receive support to remove this, although would sometimes allow the hairdresser to assist. Strategies to support the person with this aspect of their personal care were not detailed in their support plan.

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

Other interactions were more positive. For example, one person had a cold drink but they said they would rather have a cup of tea. The staff member apologized and said "of course you can have a cup of tea, how would you like it?" The person's wishes were respected and the tea was quickly given. Staff had assisted another person to move to the lounge after their meal. They ensured the person was comfortable and asked if anything else was needed, before they left.

A member of staff was deployed to arrange social activities with people. They had many ideas of activities they wanted to introduce. This included supporting people with accessing the community more regularly. During the inspection, they played draughts with a person, assisted others with flower arranging and a jigsaw puzzle. They encouraged discussions and supported some people to attend a knitting group within the local community. The member of staff told us people had very diverse abilities and interests, which made catering for everyone a challenge. They said they had spent time talking to people in order to find about their histories, previous hobbies and interests. The member of staff told us they were intending to use this information, to develop meaningful activities for people.

People and their relatives told us they knew how to make a complaint. They said they would talk to a member of staff or the registered manager if they were unhappy about the service. The registered manager maintained a brief record of complaints in a bound book. The Quality and Monitoring Manager told us more detailed records showing any investigations were stored more securely.

Inadequate

Is the service well-led?

Our findings

At the last comprehensive inspection in November 2016, we identified the service was not meeting Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because arrangements to monitor the quality and safety of the service were not operated effectively. We issued a warning notice to ensure the provider made improvements. In February 2017, we undertook a focussed inspection and improvements had been made. At this inspection, further shortfalls were identified and improvement had not been sustained. The breach in this regulation was first identified in 2015. This shows the service has a very poor history of complying with regulation.

The organisation's Quality and Monitoring Manager and Group Operations Manager had been deployed to the home. This was to assess, monitor and develop practice, as well as supporting the registered manager. The Quality and Monitoring Manager told us they would remain at the home until they were confident any required actions had been completed and the service was operating as it should. There was a clear action plan, which was being regularly reviewed and updated. Copies of the action plan were being sent to the Care Quality Commission and the local authority for monitoring purposes. The Quality and Monitoring Manager told us they were required to give an update to the provider on a daily basis. Meetings had been held with staff regarding key themes. This included whistle-blowing and maintaining professional boundaries.

The Quality and Monitoring Manager and Group Operations Manager told us whilst they were concentrating on the day to day management of the home and organisational systems, the registered manager was working with staff. This included working various day and night shifts, to monitor and improve practice. The registered manager told us to do this further, they had moved to the home and were living on the premises. They said this enabled increased checks to be easily made. The registered manager's remit was to have a clear understanding of "what was going on, on the floor". This involved supervising staff and addressing any practice, which was deemed unsatisfactory. Whilst acknowledging the deployment of senior management was a positive step, on-going improvement and sustainability was required to ensure people consistently received a good standard of care.

During the inspection, the registered manager had a presence in the home and was regularly seen supporting people. This included assisting people with their personal care, serving meals and drinks and managing some people's agitation. At one point, the registered manager took a person to a local 'do it yourself' shop to buy plants for the garden. People responded to the registered manager well and it was clear good relationships had been built. However, directing staff and identifying practice, which could have been improved upon, was limited. For example, staff had been instructed they should write their daily records in the lounge whilst interacting with people. This was instead of completing the records in the dining room, whilst leaving people unsupervised. During the inspection, some staff continued to use the dining room whilst others sat together in the lounge. One person laughed and said "it's like a mother's meeting". The Quality and Monitoring Manager addressed this and said the registered manager would normally re-direct staff but did not want to interfere with the inspection.

Not all areas of the home were well maintained. Outside, at the side of the property, there was a large amount of rubbish. This included old furniture, equipment, mattresses and fence panels. Whilst people did not have access to this area, the items increased the risk of fire and vermin. The Quality and Monitoring Manager told us they had identified this and a skip had been organised to enable the area to be cleared. A part of the wall to the front of the building had collapsed and there was offensive graffiti drawn on another area. The guttering surrounding the home was dirty. Outside the patio doors from the small lounge, there was a dog's bowl filled with dirty water. On the other side, there was a flower pot which contained cigarette ends, disposable gloves and a substance, which looked like moulded wet bread. At other points in the garden, there was an old commode with a wet, discoloured cushion and a long handled brush on the ground. Whilst looking unsightly, these items were potentially trip hazards.

A health care professional told us they felt the environment was tired and could be made more pleasant for people. There was a hole in the outside panel of a person's double glazed window. Some bedroom walls had staining by the bed and hand washbasin. There were fixings from a radiator cover, on one person's wall. The registered manager told us the person had removed and broken the cover but it was in the process of being replaced. The Operations Manager told us one of their first jobs had been a full audit of the environment. They said arrangements were in place to address all areas identified.

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

A health care professional told us the diverse range of people's needs gave the service certain challenges. They said in a way, they felt it would be easier to have one "client" group such as dementia or mental health. This would enable specialism, to be built more easily. The healthcare professional told us in their opinion, the service managed people's care to the best of their ability. However, they said on some occasions, they felt the registered manager should request further support from other agencies, rather than "rolling up their sleeves and getting on with it". Other comments were that the home could be developed in a more person centred way. The Quality and Monitoring Manager told us they would be looking at ways to achieve this. They said they were planning to review staff roles and issue further guidance about the areas of work, which needed to be completed during each shift. When this was operating effectively and people's safety was assured, person centred practice would be targeted. They said there were plans for the activities co-ordinator to visit other care services. This was expected to enable the member of staff to gain ideas about meaningful activities and their implementation.

The registered manager told us they usually sent annual surveys to people and their relatives, to gain feedback about the service. However, due to current issues, one to one meetings were being arranged. It was expected these meetings would enable any concerns to be discussed as well finding more out about the person. This would be used to further develop support plans and introducing more person centred care.