Quality Care Management Limited

Quality Care Management Limited

Inspection report

2-6 Spencer Road
Southsea
Hampshire
PO4 9RN

Tel: 02392811824

Date of inspection visit:
21 September 2016
22 September 2016
28 September 2016

Date of publication:
13 March 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 21, 22 and 28 September 2016 and was unannounced.

Quality Care Management Ltd is a registered care home and provides accommodation, support and nursing care for up to 38 people, some of whom live with dementia. Support is provided in a large home that is across four floors. Communal areas include two lounges and a dining room. At the time of our inspection there were 23 people living at the home.

The home did not have a registered manager. 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. An acting manager was in post and had applied to the Commission to become registered. Throughout the report we refer to this person as the acting manager.

Following an inspection in May 2015 the Commission served three warning notices for failing to ensure safe care and treatment, good governance and appropriately skilled and trained staff. In addition to these requirement notices were issued for failure to ensure safeguarding of people, safer recruitment process, person centred planning and ensuring appropriate consent was sought.

A second inspection in December 2015 was carried out to follow up the warning notices. This inspection showed improvements had not been made to the assessment and management of risks for people, staffing and governance systems. The Commission took further enforcement action and placed a condition on the registration of the provider which stopped them from admitting any people to the home without CQC's permission. At this inspection we found that sufficient improvements had not been made and there were still multiple breaches of the regulations.

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. This service has a rating of inadequate in the well-led question. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is

still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

At this inspection staff and the acting manager had received training in safeguarding adults at risk. They were able to describe what action they would take if they were concerned. However we found incidents continued not to be reported or investigated. We found a number of unexplained injuries for one person that had not been reported to the Commission and there was no evidence of any investigation into these. We also found records which showed an incident that should have been reported to the Commission and it had not. We referred these concerns to the Local Authority Safeguarding team.

Recruitment checks were not consistently received to the service before staff commenced work and we have made a recommendation about this. Staffing levels enabled staff to respond promptly to people most of the time. However the system used to determine staff levels and skills was not used effectively and we have made a recommendation about these.

The assessment and management of risks associated with people's needs had improved. These were better known by staff and records were clearer however, we did find examples of where this still required improvement. The management of medicines had improved but records required further improvement. The CQC monitors the operation of the Mental Capacity Act 2005 (MCA 2005) and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We continued to have concerns regarding this. Whilst staff could tell us this was to ensure people made their own decision this was not reflected in their practice. Consent was sought from people who did not have the legal authority to provide this and mental capacity assessments were not decision or time specific.

There was a lack of understanding of DoLS. Applications had been made for people who had capacity to make their own decisions and some staff told us they would restrict people who had capacity. Where applications had been approved and conditions set, we saw these conditions had been met.

Staff had been provided with more training and supervisions were taking place. However staff did not always apply the training they had received into practice. We have made a recommendation about this.

People's nutritional status was regularly assessed and monitored to ensure no concerns. Additional support was provided to help people gain weight when this was a concern. However care plans were not clear about how much staff should encourage people to eat and drink. People were supported to access a range of health care services to ensure their needs were met.

People said they felt safe and relatives confirmed this. Observations showed staff had a good understanding of people's right to privacy and dignity but also showed they did not know how to effectively communicate with people. At times their interactions were not respectful and choice was not always provided.

Some care records reflected people's likes, dislikes and preferences. The personalisation of care plans had improved and people's representatives were involved. Activity provision had improved for people.

Feedback was sought from people and action taken to address any complaints.

Staff spoke positively about the acting manager and provider of the service. They expressed how they felt supported and confident that they were now listened to and concerns acted upon. They felt the acting manager was making improvements in the home. However, the nominated individual, acting manager and a director were unable to demonstrate a consistent understanding of how the regulations applied to people using the service.

Systems were in place to monitor the quality of the service. However these systems remained ineffective in identifying all concerns and making improvements. Records relating to the care of people remained inaccurate at times.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Unexplained injuries and other incidents had not always been reported appropriately and investigated.

The provider had failed to consistently operate an effective recruitment process as appropriate recruitment checks were not consistently carried out prior to staff commencing work. We have made a recommendation about this.

Staffing levels enabled staff to respond promptly to people most of the time. However the system used to determine staff levels was not used effectively and we have made a recommendation about this.

The assessment and management of risk had generally improved and the management of medicines had improved but further improvements could be made.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff understanding of the application of the Mental Capacity Act 2005 had not improved and consent was not sought from an appropriate person.

Supervisions had started for some people but these had not been embedded. More training was being delivered but was not always applied in practice. We have made a recommendation about this.

People nutritional status was monitored but at times people and staff would have benefited from clear guidance.

People had access to other professionals as needed.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were not always respectful and were unable to communicate effectively to respond to their distress and needs.

Staff interactions demonstrated a good understanding of people's right to privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Improvements to care plans and activities had been made but needed embedding. People and their relatives were involved in the planning of their care and the staff responded to people's change of needs.

People were aware of the complaints policy and confident that any concerns would be acted upon.

Is the service well-led?

Inadequate

The service was not well led.

The nominated individual, acting manager and a director were unable to demonstrate a consistent understanding of how the regulations applied to people using the service.

Quality assurance systems were not effective in identifying concerns and driving improvements. Records were not accurate.

Incidents which required reporting to the Commission had not always been reported.

Quality Care Management Limited

Detailed findings

Background to this inspection

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

This inspection took place on 21, 22 and 28 September 2016 and was unannounced.

The inspection team consisted of one inspector, a pharmacy inspector 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.

Before the inspection we reviewed information we had about the service, including previous inspection reports and notifications the provider had sent to us. A notification is information about important events which the provider is required to tell us about by law. We also received feedback from the local authority.

We spoke with four people who lived at home and seven visitors. We observed the care and support people received in the shared areas of the home. We spoke with the acting manager, the nominated individual for the registered provider and a director of the company. We also spoke with 12 staff including nurses, care staff and ancillary and activity staff.

We looked in detail at the care records for four people and sampled a further six peoples records. We looked at medicines administration records for 13 people who lived at the home, staff duty rotas, and eight staff recruitment and supervision records. We looked at staff training records, records of complaints, accidents and incidents, policies and procedures, safeguarding and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe in the home and that there were plenty of staff to support their needs. A relative said, "The atmosphere makes [them] feel safe". A second said, "Call bells are responded to within a couple of minutes", and, "they are doing a good job. I think [person] is safe because there are cameras everywhere."

At our inspection in May 2015 we found the registered person had not reported safeguarding concerns appropriately and this was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a requirement notice and received an action plan following this which told us that the provider would ensure vigilance in reporting any safeguarding concerns. They said they would be compliant with the regulation by 6 August 2015.

At this inspection we continued to find safeguarding concerns had not consistently been reported appropriately or investigated by the registered person. For one person we found records which showed six episodes of unexplained bruising. The acting manager confirmed there was no record of any investigation into the cause of these bruises and also confirmed that they had not been reported to the Local Authority Safeguarding team. However, for another person we saw one incident of an unexplained injury had been reported to the Local Authority (LA) the cause had been investigated and action taken to prevent a reoccurrence. The acting manager and nominated individual of the provider told us this was a learning point for them. We referred these concerns to the local authority.

Staff told us they had received training in safeguarding people and were able to talk to us about the types of abuse and how to report this. All said they felt confident any concerns they raised would be dealt with appropriately by the acting manager and if they did not feel their concerns were being acted on appropriately they would report directly to the LA. The acting manager had received training in safeguarding people however, they could not confirm these incidents had been investigated. They told us how they thought these may have occurred which could constitute a safeguarding concern but also confirmed they had not reported these to either the Commission or the LA. Another member of staff told us about this potential safeguarding concern stating they had reported it to the acting manager.

A failure to ensure systems and processes enabled appropriate reporting and investigation of potential safeguarding issues placed people at risk of abuse. This was an ongoing breach of Regulation 13 of the Health and Social Care Act 2014.

At our inspection in May 2015 we found the registered person had failed to ensure appropriate recruitment checks were received prior to staff commencing work. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a requirement notice and received an action plan following this inspection which told us that they had a new system in place which would ensure compliance with this regulation by 6 August 2015.

At this inspection we saw some improvements but these were not consistent and at times the provider had failed to ensure appropriate recruitment checks were received prior to staff commencing work. One member

of staff who had commenced working at the home since our inspection told us they had completed an application form, attended an interview and had not started working in the home until their references and Disclosure and Barring Service check had returned.
The provider's policy for recruitment detailed that new staff would not start work until the provider had received two satisfactory references and a disclosure and barring service check (DBS). These checks help employers make safer recruitment decisions to minimise the risk of unsuitable people working with people who use care and support services.

Three staff file records indicated they commenced working before two references were received by the provider in line with their policy. For two of the staff only one reference had been received prior to them starting work and for the third member of staff, no references had been received at the time of starting work.

These three staff files also recorded start dates before the provider had received the DBS. The nominated individual told us they did not think this was accurate and subsequently sent us duty rotas which showed two of the three staff started working with people after the DBS check result were received. However they confirmed that the third member of staff did start working earlier than the DBS check results were returned. This was the same staff member whose references had also not been received prior to them commencing work.

One member of staff had no records to demonstrate the provider had explored any gaps in their employment and for another member of staff there were no records to suggest the provider had undertaken any health checks.

The provider had not clearly demonstrated they consistently operated an effective recruitment process as appropriate recruitment checks were not always consistently carried out prior to staff commencing work.

We recommend the provider review their recruitment processes to ensure clear adherence to their own policy and in so doing demonstrate unambiguous compliance with the regulation.

People and their relatives did not raise any concerns with us about staffing levels. During the inspection visit we were advised that the provider did not use a dependency tool to assess the number of staff required to meet the needs of people but the director told us they had been given one and would be looking to use this. However, on 28 September 2016 we received an email from the provider which contained the staffing levels policy and guidance they said they used to inform staffing levels. We could not see how this had been implemented into the home. This tool (in the form of guidance from the West Sussex District Health Authority) identified the need for two registered nurses between 08:00 and 14:00 hours without considering the building layout and people's needs. The acting manager told us they currently had a minimum of one registered nurse per shift with five care staff throughout the day and three care staff at night. In addition to this activity and ancillary staff were also employed.

Rotas provided to us did not reflect that the staffing levels identified by the West Sussex District Health Authority guidance were consistently followed as for the period of 1 September 2016 to 25 September 2016, nine days showed only one registered nurse on duty between 08:00 and 14:00 hours. The rotas also did not reflect that the staffing levels the acting manager told us were in place were provided consistently. We identified 14 days between 29 August 2016 and 21 September 2016 where the rota showed a lower number of staff were provided. We asked the acting manager to clarify if these rotas were accurate and provide us with evidence to demonstrate if they were not correct. We received an email on 28 September 2016 which confirmed to us that at times the rota was not accurate however also confirmed that on five occasions only two care staff had been provided for a night time shift. For two of these occasions we were told this was

because the number of people in the home had reduced. We were not assured that there were always sufficient staff available to meet the needs of people.

Our observations reflected that staff responded promptly to call alarms. However, observations over meal times suggested that there were not enough staff to meet people's needs. Staff were often interrupted or distracted when supporting people to eat their meals and some people waited a long period of time before being given their meals. For example, on day one of our inspection we observed a several people had nearly finished their lunches in the lounge and one person had not been given theirs. We observed on the second day of our inspection staff providing support to people to eat their meals but while doing this moving to other people to help them and then returning to the person. We also saw a person waited 30 minutes longer than others in the room before they were given their meal and then supported to eat this.

We recommend the provider seek advice and guidance from a reputable source on the latest best practice in respect of developing a systematic approach to determining the number of staff and skills required to meet the needs of people using the service and keep them safe.

At our inspection in May 2015 we found the registered person had not ensured risks associated with people's care were effectively assessed and managed. Risk assessment and care plans did not always provide sufficient guidance to staff about the actions they should take to minimise risks to people. This was a breach of Regulation 12 of the Health and Social Care Act 2014. We served a warning notice to the provider following this inspection. At our inspection in December 2015 we found insufficient improvements had been made the breach continued. This breach informed the imposed condition to restrict the provider from admitting any new people to the home without CQC's permission.

At this inspection improvements had been made however further improvements were required. Staff told us, and we saw, that one person was provided with a normal consistency of diet. However records demonstrated that this person had been reviewed by a speech and language therapist approximately one month prior to our inspection who recommended this person be given a soft, fork mashable consistency of diet to reduce the risk of aspiration and/or choking. Care records provided inconsistent information about the consistency of food this person should have. For example, their nutrition and dietary care plan stated "is on a normal diet/soft diet". The Acting Manager and Nurse told us this had been an error and the person should be receiving a soft diet. They told us they would rectify this. Failure to follow the professional advice and ensure the person was receiving the appropriate consistency of meals could place the person at risk of health complications, however on the second day of our inspection we saw the person being given a soft diet.

Records showed that risks associated with people's needs had been assessed and plans developed to minimise these risks. This included risks associated with certain medicines, behaviours which may present challenges, specific health conditions and falls. Plans contained information to guide staff about how to identify risks and how to support the person.

For example, for one person who was living with Parkinson's disease, a clear and detailed plan had been developed to inform staff of this condition and how it impacted on the person. It gave staff clear guidance about what they should be aware of and how they should provide support. Staff spoken to were knowledgeable about how this condition impacted on this person and how to offer support. The use of bed rails was assessed and where these were deemed as not safe to use, alternative measures such as crash mat, sensor mats and lowered beds and regular checks were implemented. Where equipment was used such as pressure relieving mattresses these were monitored and checked daily to ensure they were on the appropriate settings. Whilst the setting was not recorded in the care plans, they were recorded on the

monitoring charts and staff knew that this was based on people's weight.

At our inspection in May 2015 we found the management of medicines was not safe. This was a breach of Regulation 12 of the Health and Social Care Act 2014. We served a warning notice to the provider following this inspection. At our inspection in December 2015 we found insufficient improvements had been made the breach continued. This breach informed the imposed condition to restrict the provider from admitting any new people to the home without CQC's permission. At this inspection this had improved although further improvements could be made.

Systems and processes were in place for the ordering of medicines. Medicines were stored safely by staff but not always within their recommended temperatures. Temperature records were kept for most medicines, including those requiring refrigeration. However, when the medicines fridge records indicated the fridge was outside the recommended temperature range appropriate actions were not always taken. When we brought this to the attention of staff appropriate actions were taken, which meant refrigerated medicines would be safe and effective for people.

The acting manager told us two people were administered medicines covertly (without their knowledge, mixed in food or drink) when necessary. Although staff recorded that these people lacked capacity there were no capacity assessments with respect to medicines within the care plans. These records also lacked specialist pharmaceutical advice to ensure the medicines remained active whilst administered covertly, as not all medicines are suitable for mixing with food or drink.

Staff used Medicine Administration Records (MARs) to record when medicines were administered. We reviewed a total of 13 medicine administration records (MAR) and identified that one person had been prescribed a topical medicine to be applied three times a day, however the MAR chart showed this had been applied four times a day. This showed that this person had not received their medicines in the way prescribed for them. A care worker explained how they applied creams to people as part of their personal care. We viewed cream administration records for three people with a care worker. These records indicated the name of the product, and where and when the creams were to be applied. Staff signed when creams had been applied to people.

Each person's MAR or care plan contained information about allergies, "when required", "variable dose" and "how I like to take my" medicines. Risk assessments had been developed for some medicines which could pose a risk. Records for one person whose blood required monitoring as a result of their records showed this was done safely. These records contained test results, subsequent scheduled tests, the exact dose to administer and how to escalate their care if they showed signs of an adverse reaction. This therefore ensured staff responded appropriately if an adverse reaction to the medicine occurred.

Homely remedies (medicines which the public can buy to treat minor illnesses like headaches and colds) were available within the home which meant staff could respond to people's minor symptoms in a timely way.

At our inspection in May 2015 we found the registered person had not ensured effective infection control measures were in place. Areas of the home and equipment were dirty and no infection control audits were taking place. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection this had improved. The environment and equipment was clean. When a spillage occurred this was cleaned promptly using appropriate disinfectants. Staff wore personal protective clothing and were

seen to wash their hands in between providing care. Cleaning records were maintained and infection control audits carried out. The last audit carried out in August 2016 identified no concerns.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

At our inspection in May 2015 we found the registered person did not ensure appropriate consent was sought and that where a person lacked the capacity to make certain decisions, the Mental Capacity Act 2005 was understood and applied. People's records did not contain decision specific mental capacity assessments which meant staff did not have guidance regarding the decisions people had the capacity to make and those which they did not. This was a breach of Regulation 11 of the Health and Social Care Act 2008. A requirement notice was issued and we received an action plan which said that mental capacity assessments were in place and being updated. They said they would be compliant with this regulation by 6 August 2015.

At this inspection this had not improved. The acting manager, and staff told us they had received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff could tell us what this meant however, we found that the principles of this Act were not always applied to practice and consent was sought from people who did not have the legal authority to provide this. Of six records we looked at five people's consent forms relating to care and welfare had been signed by persons who did not have the legal authority to provide such consent. For three people using bed rails, consent had been sought from relatives. The acting manager was unable to show us that these people held lasting power of attorney (LPA) for health and welfare decisions and records did not show they had this either. The acting manager told us these relatives did not have this LPA.

Although staff said they had received training and could tell us that the MCA 2005 was to support people to make their own decisions, they did not know how to apply this in practice. Two people were receiving medicines covertly. A nurse and the acting manager confirmed they did not do a mental capacity assessment and did not have any evidence of best interests decision having been made regarding this. They told us they had sought permission from the doctor to do this. Records seen for one of these people, confirmed this.

We heard a nurse ask the acting manager if they should contact a relative and ask if they wanted their loved one to have the flu jab. The acting manager agreed. When asked, the nurse told us they hadn't asked the person because they were not able to make this decision themselves. The nurse showed us this person's records which did not contain evidence this relative held LPA for health and welfare decisions. We asked the nurse if a mental capacity assessment had been done. They said it had and showed us an undated document which did not record the decision to be made. The attached best interests record dated March 2016 also didn't record a decision and said the person "has not got the ability to make decisions" but did not specify which decisions. The nurse and acting manager's decision to ask the relative and the assessment

and best interests documentation did not follow the principles of the MCA 2005.

A failure to ensure consent is sought from appropriate persons and the Mental Capacity Act 2005 is understood and applied correctly was an ongoing breach of Regulation 11 of the Health Social Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Deprivation of Liberty safeguard (DoLS) applications had been made for most people who lived in the home however no assessment of their capacity to make decisions such as where they wanted to live and the support they received had been completed. A nurse told us in the presence of the acting manager that they felt DoLS applied to everyone because everyone in the home was restricted. They told us they don't let people go out alone as they might not be able to manage on their own especially if they were in a wheelchair. This nurse did not understand that if a person has capacity to make this decision, they cannot stop them from going out alone. We were required to explain this to the nurse in the presence of the acting manager.

Two staff told us if a person with capacity to make the decision, wanted to go out they would open the key coded door for them. However, a third staff member told us they would not allow the person to go out because they were "not capable". A director of the provider company told us they did not disagree with this because they wouldn't want people to get hurt. We were required to explain the law surrounding DoLS to this director.

One person we spoke with, whom staff told us had capacity to make their own decisions, said the only thing they did not like about living in the home was that they couldn't go out alone. The acting manager told us this person had never asked.

A failure to ensure DoLS was understood and to ensure that people could not be deprived of their liberty unlawfully was a breach of Regulation 13 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

At our inspection in May 2015 we found the registered person had failed to ensure staff were appropriately supported through effective supervision and training. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served a warning notice to the provider following this inspection. At our inspection in December 2015 we found insufficient improvements had been made the breach continued. This breach informed the imposed condition to restrict the provider from admitting any new people to the home without CQC's permission.

At the last inspection we were concerned that staff had not received the training that would support them in their role and that the training they had received was not effective.

At this inspection staff told us that training had increased and that they were receiving significantly more face to face training. The Care Certificate had been introduced for staff. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe

and high quality care and support. Some staff had also been enrolled to complete a health and social care vocational qualification. The training matrix provided to us at the time of the inspection was incomplete and the provider was requested to send this to us following the inspection. They sent this to us and it showed that more staff had received training in safeguarding, the Mental Capacity Act and Deprivation of Liberty Safeguards, caring for people with dementia as well as other subjects including moving and handling and health and safety, since our last inspection. Staff told us they had received training in safeguarding people and were able to talk to us about the types of abuse and how to report this. Staff could tell us that the Mental Capacity Act 2005 was in place to ensure people could make their own decisions, and that best interests decisions were needed if they were not able to. Whilst safeguarding and Mental Capacity Act 2005 training had been provided it was not always applied in practice.

The training matrix showed that 29 of 39 direct care staff had completed a workbook regarding dementia. 12 of these and an additional four had also completed face to face training in caring for people living with dementia. However at times staff showed a lack of understanding about how to communicate effectively with people living with dementia. They did not allow time for them to process information and answer questions. For example on one occasion we observed a person in distress whilst a staff member repeatedly ask them why they were crying, the staff member did not wait for an answer between the questions and before leaving the person.

We recommend the provider seek advice and guidance from a reputable source on the latest best practice in respect of developing a systematic approach to ensuring training provided is applied in practice to meet the needs of people using the service.

At this inspection supervision meetings with staff had been taking place but not everyone had received one and this practice had not been embedded. For three of the eight staff files we looked we found no records of supervisions meetings having taken place since our last inspection and since they had commenced employment. One started in June 2016, a second had started in May 2016 and the third had started in August 2016. In addition there were no records that these staff had received an induction into the home. Following the inspection the provider sent us a list of all staff that had received supervisions. This showed that nine staff included on the rota's had not had a supervision meeting since January 2016. The acting manager told us they had planned to write a supervision plan and display this for staff. They said they intended to ensure all staff received supervision at least once every three months. Following the inspection the provider sent us a plan for the supervision meetings for staff, for the month of October 2016 which showed that the three staff who had not had a supervision since starting their role would have one in this month. Staff spoke with told us they had received supervision sessions which they said they found helpful. They told us they felt supported and listened to. Whilst the acting manager was undertaking supervisions this had not been embedded and no plan to take these forward had been developed.

One person told us they had a choice of meals and they could ask for something else if they didn't want what was on the menu. They said, "If I don't like the meal I can always choose something else". Staff told us people chose their meals the day before and we saw that other alternatives were provided if they did not eat the meal chosen or wanted something else. Staff appeared to have a knowledge of people's preferences but we observed one occasion when the person was given an alternative without being provided with a choice first. The staff member noticed that a person had ordered something from the menu that they did not like. Two staff decided to give the person an alternative but did not ask the person first.

People's nutritional risk and weights were monitored regularly. Action was taken should any significant change be noted, including increasing the frequency of monitoring their weight and involving the GP and/or dietician. The cook was aware of the need to fortify foods if required. Fruit and snacks were available for

people should they want these. Care plans had been developed to guide staff however these at times were not accurate and the recording of the consistency of diet was not always clear. For example, one person's care plan stated they had a soft diet; however staff told us, and we observed that the person was given a pureed diet . A second person care plan said they had a normal diet when we observed and were told by staff they had a soft diet.

We saw where people were losing weight, supplements were provided and people's weight had begun to increase. Staff monitored people's food intake where it was assessed that this may pose a risk to the person. However there was no guidance for care staff which would support them to recognise a person's ideal intake in order that they could easily identify if this was not sufficient.

We observed people being encouraged to take fluids throughout the two days we were visiting. Staff told us they monitored people's fluid intake however these records gave staff no indication of the target amount of fluid a person should be taking or if they needed extra encouragement. Staff told us this was shared in handover but it was not recorded. There was no evidence to guide staff about when they may need to consider alternative action if a person fluid intake was not sufficient and not improving. The acting manager told us this would be discussed by the nurses in handover.

Records showed health and social care professionals visited the service as and when required. Care records held feedback from GP's, speech and language therapists, social workers, occupational therapists and dieticians. Staff identified people's needs and involved health and social care professionals appropriately.

Requires Improvement

Is the service caring?

Our findings

Most people who lived in the home found it difficult to communicate. However one told us they thought the staff were nice. A relative told us, "Normally staff are friendly.".

The atmosphere in the home was calm and friendly however our observations of staff interactions with people was mixed. Whilst staff demonstrated an understanding of people they did not always respond to people's distress promptly. At times staff lacked the skills to communicate effectively with people who were living with communication difficulties and did not always demonstrate a caring attitude.

For example on one occasion we observed a person clearly distressed and calling out for help whilst seated in the lounge. Staff in this room did not respond to their calls for 15 minutes and when they did they asked why the person was crying and told them not to but did not wait to find out why before returning to support another person with their meal. The member of staff approached this person on numerous occasions over the next 15 minutes and whilst asking what was wrong they did not allow anytime between the questions for the person to respond. On a second occasion a member of staff said to a different person, "Can I take this away from you?" referring to a clothes protector that was being used. The clothes protector was removed at the same time as the staff member was asking the question meaning the person had no time to process the question or respond. On a third occasion three members of staff asked one person who appeared agitated and confused, questions without allowing time for the person to respond. After approximately five minutes a fourth member of staff discovered what the person wanted.

Staff did not always focus their attention on the person they were supporting. For example, we observed meal times and staff were often interrupted or distracted when supporting people to eat their meals. For example, on one occasion we observed a staff member ask a person who needed support to eat their meal, if they could sit with them. The staff member told the person they had chicken soup when in fact it was mushroom soup. They then left the person who had not eaten their meal. On two other occasions we observed staff members bring people's meals into the room, tell them their meal was there and then move to other people to prompt them to eat. The people whose meals had been bought in required physical support to eat their meals. Staff returned to them after seeing other people. For one person the staff member gave them some of their meal, before getting up and moving to another person to given them some of their meal and then returning to the first person.

However we did also observe some positive and caring interactions between staff and people. On another occasion we observed one staff member provide support to a person with their meal. They described the food on the plate and said things like, "Here is some swede, would you like to try it?". This staff member encouraged this person's independence by supporting them to eat without physical assistance. They asked the person, "Is it okay if we eat together?". Then they encouraged the person by saying, "What would you like next, some vegetables?". The person then ate their meal on their own. On another occasion we heard comments from a person which indicated a positive relationship had been developed with a staff member. For example, we heard a staff member asked a person if they could sit and have lunch with them, the person replied, "hurry up it is not the same without you".

We also observed how staff managed some distressing situations for people in a calm, caring and discreet manner. For example, one person became unwell when in the communal area. Staff used privacy screens and stayed with the person the whole time. They were calming and professional throughout, talking to the person discreetly before asking if they wanted to return to their room. On another occasion a person had been incontinent and staff discreetly supported them while domestic staff promptly removed and cleaned the furnishing.

People's privacy and dignity was mostly maintained and staff had a good understanding of the need to ensure people were treated with respect at all times. Carers knocked on residents' bedroom doors and waited to be invited in, or checked by opening the door and calling to the resident. Notices were hung on doors letting people know if the person was receiving personal care and doors remained closed during this time. Privacy screens were used when moving and handling took place in communal areas and in shared rooms. However, on one occasion we saw a person in their room in bed. The doors were open and the privacy screens were not blocking the view of people who may walk past. The person's clothing and bedcover were not covering this person.

The acting manager told us resident meetings took place and we saw the last one occurred in April 2016. Records detailed that people were consulted about aspects of the home and their opinions recorded. Where they had expressed a wish this had been respected however this was not recorded.

The previous meeting held in March 2016, discussed concerns that people had raised during a survey. The records detailed an action plan with date for the actions to be completed. We saw and the acting manager confirmed that some of these actions had not been completed yet. For example, a staff board and photos of key workers in people's rooms to help them recognise their key worker was due to be done by 30 April 2016 but had not been completed. The acting manager, who moved to the service in May 2016, told us they had requested a camera to action these points. They also planned to hold a further resident meeting following our inspection visit.

A relative meeting had been arranged in July 2016 however no one had attended. The acting manager was arranging a further meeting following our inspection visit.

Requires Improvement

Is the service responsive?

Our findings

Relatives confirmed that they had recently been involved in their loved ones care plans. One said, "Both myself and brother are involved in my mother's care plan". A third said they felt fully involved with the care plan but felt that they needed to ask if there were any changes. This relative told us, "On the whole I am quite satisfied with the care here". A visitor to the service told us, "I think they [person] are well looked after, especially in the last few months".

At the last inspection the registered person had failed to ensure care and treatment was designed with a view to meet people's personalised needs. At times care records lacked the guidance staff needed. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a requirement notice and received an action plan which said the provider would introduce a new system for care planning and would be compliant with this regulation by 6 September 2015.

At this inspection improvements had been made and there was no longer a breach of this regulation. Staff had knowledge of person centred care and were able to tell us what this meant. They were aware of the support people needed. Staff felt care plans had improved and felt these provided sufficient information to support them in their role.

No new people had moved into the home recently as the Commission had, in May 2016, placed a condition on the provider that they could not admit anyone new to the home without our permission. Whilst we saw that people who had lived at the home had pre admission assessments completed these were difficult to read and comprehend because of poor handwriting and gaps in the record. The acting manager told us they intended to ensure that if anyone new came into the home a complete, thorough and understandable preadmission assessment would be completed.

The acting manager told us how they had spent a lot of time with staff to help them understand the need for complete, clear and person centred care plans. They said they were working with staff to improve the care plans and this work was on-going. Nurses confirmed this. Care staff told us they didn't write care plans as this was the responsibility of the nurses, but said they were asked for their views.

Most care plans had improved and were more personalised since the last inspection, however this needed embedding throughout the service. For example, one person's personal hygiene care plans detailed how they liked to get up early and be washed and dressed before breakfast. This included detail such as they preferred to wear trousers and jumper, which we saw them wearing on both days of our inspection. For a second person their plan was detailed and gave guidance to staff about their abilities and preferences but also the areas that could be difficult for them. A third person's records detailed how to minimise any risks involved if they fell and a piece of equipment to be used. The person often didn't like this and could become distressed over using the equipment. The plan guided staff to respect this and monitor more closely at these times. Staff could clearly describe what they did in this situation. However nutritional care plans were not always accurate in detailing the consistency of diet a person needed and risk assessments used were generic in content and not specific to the person. For example, one person had a risk assessment for the use

of a sensor mat that had not been personalised. This detailed the use of a sensor mat but staff were actually using two mats when the person was in bed and a chair mat when they were seated. This was mentioned in the care plan, but not contained in the risk assessment.

Staff responded to people's changing needs. For example, we saw for one person that a change in their behaviours led the staff to request the GP review their medicines. For two people who became unwell during our inspection staff contacted the GP to visit that same day. A nurse described how they had robustly challenged a GP to prescribe liquid medication for a person who had swallowing issues. Relatives confirmed they were kept informed in these situations and we observed nursing staff keeping relatives updated.

Activities had improved since our last inspection. A relative told us involvement with activities had improved. One person told us they get bored and didn't feel there was much to do, however we observed they chose not to get involved with the activities. One activities coordinator said they met with relatives to get ideas to stimulate their loved ones. There was a list of set activities but they said "Activities are set each day according to the mood and capability of the resident"'. They told us about monthly special events, for example; a fete, and a BBQ. They said if the weather was nice they would take people out to the beach, and local pubs. We observed one person go out during our inspection visit. Activity staff confirmed they had not received any training specifically relating to an activity co-ordinator role but were hoping for this. They were motivated and energetic. They worked to engage people and encourage them to participate. During our visit we observed people doing a jigsaw, reading a magazine, singing and taking part in a quiz.

The complaints procedure was available and relatives and people confirmed they knew how to make a complaint. One relative told us, "We get complaints resolved by one of the higher ups", implying the acting manager or provider. One relative told us they felt comfortable raising anything. Staff described how they would support people who had a comment or complaint to make. A complaints file was maintained and this included a log of complaints. Some records were available to show how a complaint had been addressed including correspondence with the person making the complaint and at times the Local Government Ombudsman.

Inadequate

Is the service well-led?

Our findings

Relatives and staff told us that the service had improved since our last inspection. One said, "There has been a big shake-up here since last February. I feel comfortable telling them (staff) anything, it is cleaner, brighter, better signage, there is more involvement with activities".

A change in the management team had taken place since our last inspection. The registered manager had resigned from their post and a new acting manager was in place. This person was not registered with the Commission but had submitted an application form.

Staff told us they felt the acting manager was approachable, listened and encouraged suggestions. One told us, "I find the manager and the owners very approachable". They said that 90% of their feedback had been "taken on-board and implemented" including things outside of their tasks. Staff said that the acting manager was making improvements and one said they felt that when they raised concerns these were now being addressed immediately. The nominated individual and acting manager told us they had needed to work with the staff team to change the culture and attitude in the service. They said they felt this was improving but as a result of some of the changes staff turnover had increased slightly. Staff spoke positively of changes that had been made and felt the acting manager was supporting the service to make improvements. Two staff told us that some staff had been resistant to the changes and unwilling to work with the acting manager. These staff told us it was chaotic and disorganised when they first started but that this was now much improved. Staff told us they felt the most positive change was an increase in face to face training for them.

The nominated individual, acting manager and a director were unable to demonstrate a consistent understanding of how the regulations applied to people using the service, for example supporting people who lacked capacity to make decisions for themselves'. The acting manager, nominated individual and a company director (who we were told was in the home every day and saw had undertaken provider audits) had not identified the concerns we had. The acting manager told us it was not until we had suggested they look at the previous inspection reports of the home to find out where our concerns were that they and the director had gone through these in detail. We asked why this had not happened sooner and the nominated individual said, "The team didn't take it seriously".

At our inspection in May 2015 we found the registered person had not ensured effective quality assurance procedures were operated. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served a warning notice to the provider following this inspection. At our inspection in December 2015 we found insufficient improvements had been made the breach continued. This breach informed the imposed condition to restrict the provider from admitting any new people to the home without CQC's permission.

At this inspection, sufficient improvements had not been made. The acting manager told us they had not completed formal audits of care plans each month. They said they looked at some of the care plans on a random basis and then told the registered nurses what was needed. This was not recorded anywhere. We

identified concerns relating to the care records of people including care plans and risk assessments which were inconsistent and not an accurate reflection of the care being delivered. For example, one person's mobility needs had changed. The records were unclear but staff confirmed the support being provided which was in line with the advice given. Whilst the care plans were being reviewed and entries made on evaluation records, to reflect what support was needed, the care plans were not always amended. Medicines records lacked specialist pharmaceutical advice when medicines were being administered covertly. Daily monitoring records did not reflect the care plans were being adhered to. For example, a second person's care records instructed staff to help this person reposition every two hours when they were in bed. Staff spoken with confirmed this was what they did however, we could not be confident that this repositioning took place in line with the care plans because the records did not reflect this. An effective auditing system would have identified these concerns and planned action to make improvements.

The Commission had been receiving monthly reports from the provider of care plans and risk assessment audits. We received the last one at the end of August 2016 from the acting manager and compared this to our findings. We found this audit to be ineffective. For example, this stated that no concerns had been identified in relation to one person's consent and capacity documents on 25 August 2016. However we found these did not reflect appropriate consent was sought or that the MCA 2005 had been applied correctly.

A nutritional audit completed on 20 August 2016 by the acting manager asked "Are preference recorded and any 'special Dietary Needs' confirmed and record in care plan?". The acting manager had documented "Yes can be seen in individual nutritional care plans". However four people's nutritional and dietary care plans provided inconsistent advice about the consistency of the meals they required and these care plans did not contain preferences. For example, one person meal consistency should have changed on 17 August 2016 following a review by a Speech and Language Therapist. However the care plans had not been changed An effective audit would have identified these concerns and planned action to make improvements.

A care audit last conducted on 26 July 2016 asked if consent to share information was recorded. The acting manager had documented that resident's next of kin had signed these. However the acting manager had not identified that it was not appropriate to seek consent from people's relatives if they did not hold appropriate legal authority to provide this. An effective audit would have identified these concerns and planned action to make improvements.

A training audit carried out in August 2016 identified training that had taken place and training that was required however, it did not identify that the training had not been applied to practice. For example; the acting manager had received training in safeguarding and knew how and what needed to be reported, yet had not reported incidents to either the Local Authority of the Commission. Staff and the acting manager had completed training in the Mental Capacity Act 2005, however the principles of this had not been applied in practice. An effective system and process to review training would have identified these concerns and planned action to make improvements.

A provider visit had taken place on 5 September 2016. This had reviewed the action plan from the previous visit. It said, "Care plans are up to date and they have been typed so that it is easy for family, service users and advocate to read". Of four people's care plans that we looked at in detail we saw these were dated pre the 5 September 2016. They were not always accurate or up to date. This audit stated that "resident records" were "compliant", however we found concerns relating to the consent sought and capacity assessments. In addition the audit stated that there had been no notifiable incidents however we found incidents which should have been notified to the Commission. The audit stated that staff recruitment and induction records were compliant. However we found gaps in some recruitment records and no evidence of inductions.

Feedback from relatives had been sought through April, May and June 2016. The feedback had been reviewed and action taken had been documented for some issues and not others. For example, this detailed how they had discussed concerns one relative had shared and this had been resolved. It also addressed an adequate rating for food and activities by detailing the review of the menus and additional activity staff. At the time of the inspection the director told us they had not analysed the other surveys but would send these to us once completed. They sent us the section titled action plan which did not show us the scores they received or the questions asked. However we noted that the resident survey action plan stated the results were 'very good, good or average'. It didn't identify what people found to be average or the number of people who gave this rating. It stated that menus were planned to suit people and that the survey would be sent again in October 2016.

A failure to ensure quality assurance procedures were operated effectively and records were clear and accurate was an ongoing breach of Regulation 17 of the Health and Social Care Act 2008.

Records and staff confirmed that staff meetings took place. Staff said they found these helpful and felt the acting manager was trying to make improvements to the home. Records showed the acting manager had identified concerns and had raised this in the last staff meeting, reinforcing the need to make improvements.

Registered providers are required to notify the Commission of a range of significant incidents, which occur within the home. The provider did not always ensure they notified CQC of such events. During the inspection we found records for one person indicating an allegation of physical abuse had been made about one person using the service towards this person. For a further person we found records of a series of unexplained bruises. The acting manager and a member of staff told us how they felt these had occurred which indicated a potential abuse situation. They had not notified the Commission of this.

A failure to notify CQC was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents For a further person we found records of a series of unexplained bruises. The acting manager and a member of staff told us who they felt these had occurred which indicated a potential abuse situation. They had not notified the Commission of this. A failure to notify CQC was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person had failed to ensure consent is sought from appropriate persons and the Mental Capacity Act 2005 is understood and applied correctly. 11(1)(2)(3)

The enforcement action we took:

We imposed a condition on the provider requiring them to undertake audits of people's care plans, risk assessments and care records, to undertake analysis of incident/accidents and report to the Commission on the action taken as a result every month.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person failed to ensure systems and processes enabled appropriate reporting and investigation of potential safeguarding issues placed people at risk of abuse. They had failed to ensure DoLS was understood and that people could not be deprived of their liberty unlawfully 13(3)(5)

The enforcement action we took:

We imposed a condition on the provider requiring them to undertake audits of people's care plans, risk assessments and care records, to undertake analysis of incident/accidents and report to the Commission on the action taken as a result every month.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person failed to ensure quality assurance procedures were operated effectively and records were clear and accurate. 17(1)(2)(a)(b)(c)

The enforcement action we took:

We imposed a condition on the provider requiring them to undertake audits of people's care plans,

risk assessments and care records, to undertake analysis of incident/accidents and report to the Commission on the action taken as a result every month.