Stilecroft (MPS) Limited

Stilecroft Residential Home

Inspection report

51 Stainburn Road
Stainburn
Workington
Cumbria
CA14 1SS

Tel: 01900603776

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 21 & 23 May 2018 and was unannounced on the first day.

At the last inspection in July 2017 the service was rated overall as Requiring Improvement as we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to infection control, trip hazards and issues around evacuation in the event of a fire. We judged that the systems to monitor quality in the home had failed to identify these matters in a timely manner.

We asked the provider to complete an action plan to show what they would do and by when to improve the key questions of Safe and Well-led to at least Good.

At this inspection we found the actions required to address these particular issues of the July 2107 inspection had been completed with the exception of on-going issues in Regulation 17 set out below.

During this latest inspection of 21 & 23 May 2018 we found two further breaches. Regulation 18: Staffing as we found there were insufficient staff to meet people's needs; Regulation 9: Person centred care as people were not receiving care that met all their needs and preferences. We also found that the service continued to be in breach of Regulation 17: Good governance because the provider and the service did not have effective quality assurance systems in place and Regulation 12: Safe care and treatment as hazards in the environment were not sufficiently identified.

The home continues to have the rating of Requires Improvement.

Stilecroft Residential Home (Stilecroft) is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home provides personal care and accommodation for up to a total of 44 people. On the day of the inspection there were 38 people residing at Stilecroft. Accommodation is provided over three floors and the Victorian building has been extended and adapted for the purpose. The ground floor unit specialise in supporting people living with dementia.

There was a registered manager in post. A registered manager is a person who has registered with the (CQC) 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.

We found that there were insufficient staff available to meet people's needs. We found that the registered person had not ensured sufficient numbers of suitably qualified, skilled and experienced persons were deployed in order to meet people's needs. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that at times there were not enough staff available to answer their call bell and provide support when they needed it. We observed that staff were very busy and were working under pressure. Care and support was mainly based around completing tasks and did not always take account of people's preferences or to meet their social and recreational needs. We found this to be the case in particular within the main house with staff also reporting being "over stretched" on this floor. At times some people had to wait to be given personal care, such as support to go to the toilet. The downstairs unit for people living with dementia we judged as having sufficient staff to meet people's needs.

We found insufficient staff levels had a detrimental impact on other areas such as record keeping. While people's health and support needs were documented in their care plans we found some records had not been fully updated or reviewed after changes to a person's condition had occurred, such as after a fall. We also found this to be the case with records for supporting people with behaviours that were challenging to the service.

We observed that some people were left for long periods of time without staff supervision or stimulation. Those people who used wheelchairs spent significant periods without being transferred to other chairs or given a change in position.

Staff were trained in end of life care and we saw evidence to show that this was being done with sensitivity. The home had links with the Hospice at Home team and had specifically developed plans to put in use when people were approaching the end of their life. However, some of the care plans to support people at the end of their life were incomplete and required more detail to inform staff.

The provider told us that the activity coordinator organised on average two trips out per month during the summer season and could use the mini bus shared with the providers sister home for this. However, on a day to day basis we found the majority of people did not leave the home unless friends or relatives took them out

The home had a part time activity person and people told us they enjoyed the sessions she put on. This person also offered additional support to people at mealtimes and with drinks.

We made a recommendation at the last inspection that the service seeks expert advice from a reputable source in developing a dementia care strategy for the home, that would encompass staff training, approach, the environment and activities. This had not been put in place.

People were not provided with care that met their individual support needs and preferences. This included being offered appropriate opportunities or meaningful activities based on person-centred care that met their needs and reflects their personal preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of people told us that the quality and choice of the meals on offer had deteriorated over recent weeks. We were told that the food supplier had recently been changed and the provider was addressing quality issues with the new supplier. We found the meals did not look appetising, fresh fruit was not freely available and snacks offered to people were of a poor nutritional value.

We found that the nutritional assessments on admission were basic and needed to be in more detail and following on from this people's preferences and nutritional support needs needed to be recorded in more detail.

We found this to be a breach of Regulation 9: person centred care as people were not being offered a choice of food and drink that meets each persons preference and assessed nutritional and hydration needs to support their well-being and quality of life.

At the last inspection we pointed out hazards in the environment and on this inspection we continued to find that people were exposed to potential hazards. A near miss had occurred in February 2018 whereby a person had managed to drink a small amount of a potentially hazardous substance.

This is a breach of Regulation 12: Safe care and treatment as the provider had not done all that was practically possible to mitigate risk.

Local health care practitioners were called on to see people and to give advice. People also saw other health care professionals like chiropodists and opticians, and referrals to other healthcare professionals had been made. We did receive feedback from a number of professionals about the not always receiving referrals in a timely manner and communication not always being effective.

People who lived at Stilecroft and their relatives told us staff were caring and their privacy was respected by staff. We saw and heard positive interactions between people and staff throughout our inspection. However, people's dignity was at times compromised due to having to wait for personal care and by some of the responses from staff.

We made a recommendation about ensuring the home has measures in place to protect people's dignity.

People told us that their family could visit whenever they liked and were made to feel welcome.

The processes used for identifying how best interest decisions were made for people who lacked the capacity to make complex decisions for themselves had not always been recorded. We found the records on people's capacity to make decisions could be improved.

We have made a recommendation about assessing people's capacity to make decision and recording of this to ensure the guidance outlined in the Mental Capacity Act 2005 is followed. People were only deprived of their liberty if this had been authorised by the appropriate body or where applications had been made to do so.

Where safeguarding concerns or incidents had occurred these had been reported by the registered manager to the appropriate authorities and we could see records of the actions that had been taken by the home to protect people. Staff understood how to recognise and report abuse which helped make sure people were protected.

Staff had completed a variety of in-house training that enabled them to improve their knowledge and were supported to take national care qualifications. We found that some of the in-house training was at a basic level. For example, dementia training was at a basic level. Staff worked between both areas of the home and some staff needed more training on dementia care.

Suitable arrangements were in place to ensure that new members of staff had been suitably vetted and were the right kind of people to work with vulnerable adults. Staff received regular supervision to support them in their job.

Systems were in place for the safe administration and disposal of medicines. The majority of records

showed people received their medicines as prescribed and in their preferred manner.

We made a recommendation about the safe use of prescribed drink thickeners and recording of some medicines.

The provider had a suitable complaints policy and procedure in place. However, we made a recommendation about recording informal and verbal complaints, as well as written formal ones, and how these were addressed.

Since the last inspection the provider had improved areas of the home. For example, refurbishing the bathrooms.

We found that the provider and the service did not have effective quality assurance systems in place. For example, for ensuring that the care given in the home was up to date best practice, or that surveys about the quality of the service were analysed and actions communicated to participants.

Some staff spoke of having gone through a period of poor staff morale and not feeling listened to by the organisation and provider. The majority of staff we spoke with did not feel comfortable about speaking up about issues or concerns.

We found that the service did not currently promote an open and supportive culture where staff and others could freely speak up about how to improve the service.

However, there was a newly formed senior management team in place who were enthusiastic about working together and improving teamwork amongst the staff team. We found that this senior team, including the registered manager, would benefit from having updated qualifications and training in management and leadership.

The management team agreed to undertake a full review of the dependency levels of people to check how many staff were required to meet people's needs. Staff roles, tasks and layout of the building were also to be reviewed to see that staff were deployed in the most effective way possible.

We found the provider still to be in breach of Regulation 17: Good governance.

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.

At times there were insufficient staff available within the home to provide support to people with their personal care in a timely manner.

Medicines were being administered and recorded appropriately. Risks in the home were not always identified.

Staff had been trained to recognise and report any harm and abuse. Appropriate checks had been undertaken to ensure suitable staff were employed to work with vulnerable people.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training however, more specialist training was required in dementia care and for behaviours that may challenge the service.

Staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA). The assessment of people's capacity was not recorded in sufficient detail.

People did not always receive suitable nutritional support. There was limited choice at mealtimes and many people were dissatisfied with the quality of the meals and snacks on offer.

Is the service caring?

Requires Improvement

The service was not always caring.

The majority of people spoke positively about staff. However, we found a lot of staff interactions were often task-focused with little time for one to one interactions.

People's dignity was not always upheld due to having to wait for personal care.

People reported that their visitors were welcomed into the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Activities in the home had not been designed to meet the needs of the individual.

The support provided to allow people to engage in the local community was limited.

Complaint management needed to be reviewed.

Is the service well-led?

Inadequate

The service was not well-led.

At the time of this inspection there was a registered manager. There was a newly formed senior management team in place who were keen to improve teamwork in the home. The senior team needed to strengthen management and leadership qualifications and update their training.

We found that the provider and the service did not have effective quality assurance systems in place to monitor the quality and standard of the service.

The systems and service did not encourage people and staff to air their views and have a say in the running and development of the service. There was not an open culture amongst staff.

Stilecroft Residential 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 comprehensive inspection took place on 21 & 23 May 2018 and was unannounced on the first day.

The inspection team consisted of two adult social care inspectors 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 last inspection, the registered manager completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service to plan our inspection and the areas to look at.

We also looked at the information we held about the service and information from the local commissioners of the service. We also looked at any statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law.

Some people who lived at the home could not easily tell us their views about their care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. It is useful to help us assess the quality of interactions between people who use a service and the staff who support them.

During the inspection we spoke with the registered manager, the operations manager, 16 people who used the service, 12 relatives and or visitors, 13 staff including ancillary staff. We also spoke with four visiting health professionals. We observed how staff supported people who used the service and looked at the care records and medication records for 12 people living at the home.

We looked at the staff files for six staff that had been employed. These included details of recruitment, induction, training and personal development. We were given copies of the training records for the whole team. We also looked at records of maintenance and repair, the fire safety records, food safety records and quality monitoring documents.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in July 2017 we found a breach of Regulation 12: Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because risks associated with the environment had not always been identified or managed.

At this inspection we found the provider and registered manager had taken action. These actions included seeking professional guidance on fire safety and appropriate risk assessments for the evacuation of people in the event of an emergency. Cumbria Fire and Rescue visited shortly after the inspection in July 2017 and they were satisfied with the action taken to ensure people remained as safe as possible.

People living in the home who we spoke with in the main building said that there were not enough staff to meet their needs in a timely manner. They told us, "There isn't enough of them [care staff], the girls are so busy." Another person said a very similar comment, "There isn't enough staff. There is only three and that is ridiculous, they do try but they are so busy, they can't come for quite a while if you push the buzzer." While another person said to us, "They are a bit short sometimes, a bit pushed but they do try. They do come, well they come to tell you when they will be back, then they come when they can."

A relative said, "Basically there's not enough staff. Especially with toilet needs. People are waiting and waiting to go to the toilet all the time. There's a buzzer on the wall but most people can't reach it and when you visit they ask you to find staff for them." And another said, "We put our [relative] in here to be cared for and they are not getting the care and attention they deserve." And another relative said, "We have noticed the difference between the EMI unit and here" (upstairs). When (relative) was down there (EMI unit) to begin with and they [staff] could do more little things but up here they are really stretched and you can see the difference. It's not that (relative) isn't fed and cared for but nothing extra is done."

In the main building where 27 people lived we saw that the senior carer was busy from before breakfast until 10.30 doing the medicines round and was therefore unable to help the other two care staff on duty. The layout of the main building also made supporting people problematic. The main building for 27 people had a lounge, conservatory and separate dining to the front of the home, with bedrooms to the first floor. To the rear of the building, down a long corridor, there was a further lounge/dining room with more bedrooms along this corridor and off on another corridor. This area of the home for 27 people had two care staff and one senior care staff on duty.

We looked at the staffing rotas for the last four weeks and the dependency levels that the registered manager sent into the organisation's head office each week. The registered manager told us that staffing levels were set at the organisations head office using a nationally recognised staffing dependency tool. When we checked the list of dependency scores given to us by the registered manager for the main building we saw that 15 people were assessed as requiring two staff members for personal care due to requiring the use of a hoist, stand aid or they had complex needs. A further nine people required one staff member and three people required prompts and supervision.

Personal care can take some time to do in a way that makes the person feel reassured, calm and unrushed in carrying out the procedure in a safe manner following the correct guidance. We concluded that this would be very difficult to achieve and would certainly be very rushed. People in the home and staff told us that this was the case in the main building. Staff would need over 5 hours in the morning to give people a level of support for ten to fifteen minutes per person to carry out each person's morning routine.

We also noted when we checked people's files and notes that some dependency scores did not appear to reflect increases to people's needs. This meant that the wrong scores could have been used to calculate the service's staffing levels. People's needs may have scored higher if the tools had been used correctly. Potentially this meant that the level of monitoring required and staff interventions were not as high as they should be to offer the support people needed in a safe, timely and unrushed manner.

One staff member said, "People have to wait but we do try to prioritise and see to those most in need of help. This morning one person was up and dressed but needed help to go for breakfast in the dining room but had to wait until we were free." We spoke with this person later in the day and they said, "I had to wait for an hour and half for staff to come. I'd had my tea early the day before so I'd had nothing all night so was really needing my breakfast. It throws all the rest of my meals out then. There isn't enough staff to come and help."

All the staff we spoke with said the levels were not sufficient to meet people's needs on the unit for 27 people. A number of staff members said that staffing levels had been reduced in the last few months and told us that each shift was down by one care staff. More than one staff member told us that people's support needs were increasing and becoming much more complex. One said, "There's probably only one person who doesn't really need hands on care just prompts. People's care needs have increased horrendously recently." Another staff member told us, "We try to get four people showered a day. The list is held in the office. It can be awful trying to meet people's needs." Another said, "We would like to give people showers who are doubly incontinent but this is usually a full body wash instead. Most people get a shower at least once a week though. Mornings are the hardest as everyone needs help at the same time. Most people like to get up about 8.00 to 9.00 and there's only two of us to see to everyone."

We observed in the main building that staff were constantly busy and moving from task to task with little or no time for personal interaction. Buzzers were frequently going off and we heard that when staff attended to the buzzers they often told people they would be back shortly, but this could be up to 20 minutes later. We saw that several people were unattended in the rear lounge for periods of up to 35 /40 minutes. We observed one person trying to get out of a chair that was reclined and this looked unsafe as they were trying to step over the raised foot stool. We alerted staff to this. When we checked this person's care plan it stated "always monitored in chair by staff." Another person had slumped down in their chair almost falling off and looked very uncomfortable. We also observed two people having an argument who were sitting side by side, they were trying to lash out at each other and were shouting. A member of staff entered the lounge and tried to defuse the situation and left saying they were going to find more staff. These two people continued with the argument until staff arrived a few minutes later. We also alerted staff that we had noted two people had full catheter bags.

We were told by relatives, people living in the home and by staff that one person was given the buzzer for the back sitting room and they could ring it if people needed staff assistance. However, over the two days we were in the home we saw this person was fast asleep in their chair and the above incidents occurred when they were asleep.

We frequently heard people shouting, "Help, help!" and "I need to go to the toilet please" and being told by

staff that they would be back in a minute and this request taking over 10 minutes before they returned. We heard staff say, "Coming for you next [name] don't panic."

We also noted a high number of people sat in wheelchairs for most of the day, including at meal times. In the main dining room there were 12 people sat in wheelchairs and in the back sitting room 5 people who were sat in wheelchairs. Staff reported not having time to carry out the transfers needed using a hoist and that it was easier to take people to the toilet or to push to the table if they were in a wheelchair. It is recognised good practice to frequently offer people a change in position, even when pressure relieving equipment is in place. Ideally this should be to a different chair or onto a bed but a minimum requirement would be to support a person to stand and sit down again at least every hour. This minimises the risk of skin breakdown and pressure sores developing. pressure sore management processes, which includes turn charts and position change charts. The home did have a pressure sore management processes, which included turn charts and position change charts. However, we observed that this was not being used to monitor those people sat in wheelchairs.

We judged that there were sufficient levels of staff in the dementia care unit and that the 11 people on this unit benefitted from having two members of the team in the unit at all times, along with a senior carer who was responsible for dispensing medicines. Staff in this unit said that they sometimes went upstairs to help out. However, some people had started to express concerns about this. One person who had a relative living on the EMI unit told us, "Well it's not quite right really, there is not enough of them for what they need to do, I'm not saying (relative) is not looked after because they are but it's not as good as it should be." A staff member said, "There isn't enough of us really, sometimes there is just two of us down here. as we are asked to go upstairs to help out." A friend of a person on the ground floor unit said, "The care is good but [name] is never taken out by staff."

The management team agreed to undertake a full review of the dependency levels of people to check how many staff they needed to meet people's needs and adjust staffing levels accordingly. The registered manager said that they would also consider the roles of staff and whether they were being effectively deployed and managed to best effect.

We found that the registered person had not ensured sufficient numbers of suitably qualified, skilled and experienced persons were deployed in order to meet people's needs. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how medicines were managed and observed them being given. Medicines were stored appropriately and administered by people who had received the appropriate training to do so. We also looked at the handling of medicines liable to misuse, called controlled drugs. These were stored, administered and recorded correctly. Regular checks on controlled drugs were carried out.

We found that suitable care plans, risk assessments and records were in place in relation to the administration of medicines. We saw that there were plans in place that outlined when to administer extra, or as required, medication. There were procedures in place for the ordering and safe disposal of medicines.

We observed a tin of thickening powder was seen unattended on the drink trolley and another tin on a sideboard. This is used to thickened drinks so that people with swallowing difficulties did not take fluids onto their lungs and is prescribed by a GP for the use of one person only. This tin had the labelled torn off and when asked, staff said they had used it for everyone who needed to have their drink thickened. This product should only be used for the individual it is prescribed for and should be labelled with their name and the amounts to be used. The practice of sharing is not safe and is open to error, and to the person not

receiving their prescription and treatment. It is also not safe to leave the tin unattended as people can ingest this and have known to choke on the powder. The registered manager ensured the tin was removed and said that staff should be aware of this and she would follow this up as a training issue with staff.

We recommend that the service seek out the latest good practice in safe medicines management.

We saw that risk assessments were used to support people. The risk assessments included risks specific to the person such as for moving and assisting, mobility, nutrition and pressure area care. We did point out to the registered manager that we found some substances in the lounge area which potentially could be hazardous, additional to the thickening powder, such as alcohol and tubes of paint used for art work. She agreed to risk assess these products. The cupboards and stock rooms holding hazardous cleaning products were found to be locked.

There had been an incident early in the year, February 2018 and after the last inspection, whereby a person managed to get hold of and drink some potentially hazardous hair products. Medical advice was sought and the person did not come to any harm. At the last inspection we raised with the registered manager, and wrote in the inspection report, "We did, however discover some potential hazards in the environment. Some cupboards in the home were not locked during our visit. This included an upstairs store cupboard that was left open with cleaning materials and large amounts of alcohol hand rub on view. The door to the steep cellar steps and the laundry was unlocked and easy to access. The registered manager dealt with these issues when we made her aware."

We took from this that lessons had not been learnt and that the home continued to be in breach Regulation 12: Safe care and treatment. The provider was not doing all that was reasonably practical to mitigate risks.

Staff had received training about safeguarding and knew how to respond to any allegation of abuse. Staff had a good knowledge of how to recognise the signs that a person may be at risk of harm and how to escalate concerns to the registered manager or to external organisations including the local authority, who lead on any safeguarding concerns. Staff were aware of the whistle blowing procedure which was in place to report concerns and poor practice. When new staff were appointed thorough vetting checks were carried out to make sure they were suitable to work with vulnerable people who needed care and support.

We looked at six staff files for recruitment and saw that most of the necessary checks on employment had been completed. References had been sought and we noted that they were usually from the most recent previous employer in accordance with the homes recruitment policy. Criminal Records Bureau (CRB) and Disclosure and Barring Service (DBS) checks had been conducted. The Disclosure and Barring Service allows providers to check if prospective employees have had any convictions, so they can make a decision about employing or not employing the individual.

The provider had an infection control policy in place that was available to all care workers and staff. We saw that staff followed hand washing regimes and used protective gloves and aprons when assisting people with personal care. Communal areas and people's rooms were clean and hygienic. There were no malodours in the home. People living in the home and their relatives told us that the home was always clean.

We saw the use of colour coded mops for cleaning and there were good stocks of cleaning products, which helped staff to maintain standards of hygiene and cleanliness throughout the home. All cleaning products were in a locked cupboard to ensure people's safety. During the course of our inspection we saw that data safety sheets for the cleaning material used, as per the requirements of the Substances Hazardous to Health (COSHH) Regulations. COSHH is the law that requires employers to control substances that are hazardous to

health.

Bathrooms and toilet areas were clean and contained wall mounted liquid soap and paper towel dispensers. Bathroom areas had been upgraded and now had wipe clean panels and non-porous floor coverings which were recommended for the purpose. We pointed out to the head of housekeeping that communal towels were being stored on an open shelf in shared bathroom areas that also contained toilets. This can pose a risk of cross contamination. They agreed to address this.

The home had been awarded a four out of five star rating from Environmental Heath for food standards in the home. This was due to there being only one sink in the kitchette area and no separate hand washing facilities for staff. The provider informed us that this had now been addressed but the rating had yet to be updated.

We could see that where any repairs or faults had been highlighted they had been acted on. There was a cleaning schedule in place and records relating to premises and equipment checks to make sure the both premises and equipment were safe and fit for the people living there. People living in the home and their relatives commented on there having been scaffolding at the home for a number of years. We asked the registered manager and operations manager to forward the development plan that was in place for improvement to the building so that we could monitor progress. This was sent into us shortly after the inspection.

Requires Improvement

Is the service effective?

Our findings

The majority of people that we spoke with told us that the quality and choice of the meals on offer had deteriorated in the last few months. We found the meals did not look appetising, fresh fruit was not freely available and snacks offered to people were of a poor nutritional value. The registered manager told us the food supplier had recently changed and the provider was addressing quality issues with the new supplier.

People told us, "The food isn't as good as it was mind you, I needn't bother with the tea, the breakfast is good though and it depends on the cook, there is one that just burns the toast." Another person said, "The foods gone downhill and it can depend on which cook you get." One person told us that she had asked for a banana with her breakfast but another person had had the last one. There was a fruit bowl in the front dining room but not one in the back lounge/dining room. People told us that they would like more fresh fruit. One person told us that they sometimes had tinned peaches and ice cream but that they would prefer fresh strawberries.

On the first day of the inspection the main mid–day meal was sausage, mash potatoes, carrots and peas. We heard people saying, "Don't eat the sausage it's awful, no taste and rubbery." And then a number of other people joined in saying that it wasn't very nice. The pudding offered was ice cream or yogurt, to which one person replied, "Oh no not again." Two people had been given the alternative meal at mid-day which was scrambled egg and both said they hadn't asked for it. One of them said, "What's this? It's not what I asked for and it's not very nice, very dry and cold." We noted that many plates were only partially eaten. On the second day of our visit the main meal was meat balls, mash potatoes, carrot and peas. People again told us that it wasn't very nice. People did however tell us they enjoyed the pudding, which was crumble with cream. Some people said they would have preferred it with custard.

We observed that not all people received timely support with their meals and their experience was not very person centred. At times, the dining rooms were unsupervised for short periods of time. We observed after being seated with the support of care staff people sat at the table and waited 25 minutes before they received their meals. There was no heated trolley to take meals out to the back lounge/dining room. People in this dining room complained to us that the food was rarely hot.

We noted on the days of the inspection that the meals people were offered were closely spaced together. Most people were had breakfast in the dining room at 8.30-9.45 am. Lunch was served at 12.00. Tea was served at 4.30 pm, typically a lighter meal of soup and sandwiches, with a supper at 7.00- 8.00 a hot drink and biscuits. We saw a drinks round at 11 am, with tea or lemonade offered and biscuits and another drink round at 2.00 pm which was a packet of crisps and lemonade. We noted that particularly in the rear lounge people were being offered diet lemonade as a cold drink and were not routinely offered water. We saw that the home had a water cooler in the front sitting room but this was along distance from some areas of the home. We found that the snacks and drinks being offered were of a poor nutritional value.

We found that the nutritional assessments on admission were basic and needed to be in more detail and following on from this people's preferences and nutritional support needs required to be in more detail. The

resulting care plans also needed more detail on types of high calorie and fortified foods, as well as weight reducing foods. People needed to be offered more appetising and nutritional snacks. When we spoke with the kitchen staff and with the registered manager we were told that no one has training on meeting the nutritional needs of older people.

We raised our concern about people not routinely being offered water and instead being given lemonade with the manager who said that because it was diet lemonade she had no concerns. We sought advice from a senior dietician about this practice of offering people diet lemonade. They advised us, "It is not good practice to offer fizzy drinks routinely, fresh water should be offered at all times. I don't feel diet soda needs to be on the trolley, especially for those with weight loss as this may fill them up / cause bloating etc without any kcals. And also for those that are healthy / overweight as this is not good practice to be encouraging fizzy drinks. I wonder how many patients chose diet lemonade? The home should offer fresh drinking water routinely at meals/ snack times. Perhaps they could offer this first and if patient declined then they could offer alternative drinks. It would be a good idea to offer full cream milk or fortified drinks as a choice on the trolley, especially if they have people who are low weight in the care home."

While the home offered full cream milk the drinks trolley offered only tea or coffee and the diet lemonade mentioned above. We did not see any fortified drinks on offer such as smoothies, milk shakes or milky coffees.

Records used for recording weight loss were not consistent. Some records were held in people's files in different places and some records held in the office. The records we checked found weight loss in some people that had not triggered weekly weights or fluid/food balance charts being put in place. And some had a change to their dependency scores without stating the reason. This meant we could not always tell what actions had been taken. We did see that some people who were at risk of weight loss had been referred to the dietician and appropriate actions had been taken, resulting in increased frequency of weight monitoring. Some people had been prescribed high calorie 'shots' as a supplement however there were no detailed written measures about how to increase people's weight through food and drinks.

A visiting healthcare professional told us, "We have had an issue with communication very recently. There has been occasions where dietician referrals are being made by the visiting nurse and not the home. Weights are being recorded by the home but recognition of process seems to be missing as to triggers and the actions needed when people are losing weight."

We found this to be a breach of Regulation 9: Person centred care as people were not being offered a choice of food and drink that meets each persons preference and assessed nutritional and hydration needs to support their well-being and quality of life.

People were supported in managing their health and wellbeing needs by appropriate referrals being made to external services. A relative told us, "The doctors and nurses come in if my relative needs them." We also saw that people had chiropody, podiatry, optician visits and some people had occupational therapists or physiotherapists visit.

We spoke with two visiting professionals and received some mixed comments about the service. These areas related to not always finding staff when they visited to update them on people's needs and the other was that records were not always up to date.

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.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The 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. At the time of the inspection appropriate authorisations were in place and relevant applications had been made to the local authority for people living at the home whose liberties were being deprived.

We saw that people and their relatives had been involved, consulted with and had agreed with the level of care and treatment provided. Best interest meetings had been held to assist people who were not always able to make more complex decisions for themselves. However, we did not see that the best interest decision process had been recorded consistently for people living in the home. We also found that people's capacity was not being recorded in a consistent and clear way. Checks had not always been made to confirm if those people consenting on people's behalf had the legal rights to make decisions. The registered manager started to check people's legal rights on the day of the inspection.

We found the records on people's capacity to make decisions could be improved. We recommend that the provider take advice about assessing and recording of people's capacity.

We saw new employees received relevant written information about their role and responsibilities to support and guide them through their induction into the service. Staff told us they had received induction training prior to working with people who used the service. They told us they had undertaken a week long period of induction in which time they received training in essential topics relating to their work. Staff we spoke with told us they received regular supervisions to support them in their roles and often had their competencies checked.

Staff said that they were encouraged to gain qualifications in care and that the service used distance learning, e-learning and face to face training. We asked for a copy of the training matrix for the home and we were sent a comprehensive training, supervision and appraisal record. Staff had received regular updates on important aspects of their work such as first aid.

The home had a unit that specialised providing care to people living with dementia. We found that the environment had been adapted to help people navigate the building, such as door signage, appropriate plain floor coverings and eye catching wall decorations. There was easy access to a secure garden area. However, we found that staff in this unit, and elsewhere in the home who were supporting people living with dementia, had only a basic dementia awareness training. We found that some of the interactions we observed indicated a lack of understanding, such as managing some behaviours that may challenge the service. We found that the home had very few dementia friendly activities and adaptations in the rest of the home, where a significant number of people were also living with dementia.

We did not see that the home was making use of current best practice best such as that from NICE (National Institute for health and care excellence).

We recommend that the service seeks expert advice from a reputable source in developing a dementia care strategy for the home, that would encompass staff training, approach, the environment and activities.

Requires Improvement

Is the service caring?

Our findings

People told us the staff who worked in the home were all "kind" and "caring". One person who lived in the home said, "The staff treat me well." Another said, "The girls are very good, very kind and they do ask what you want." People told us that their family could visit whenever they liked and were made to feel welcome. There were no restrictions as to when people could have visitors and we saw relatives and friends coming and going throughout the inspection. The staff appeared to know visitors and relatives and had good relationships with them.

However, we did get other less positive feedback from both people living in the home and their relatives about the time staff had to spend with people. This again was dependent on which floor people resided on. People living in the home and their relatives, we spoke to told us that staff were often rushed and didn't have time for conversations. One person who spent a lot of time in their room told us, "It's so nice to speak to someone (meaning the CQC person), I sit here all day and I don't get to speak to anyone. Staff used to come and sit and talk to me but they don't now."

A relative said, "Staff are busy and [name of relative] says doesn't want to bother them." And another said, "They [staff] try their best but there doesn't seem to be enough of them. You can sit in the lounge and not see any for ages. When I'm visiting I often have to go and fetch staff because somebody wants to go to the toilet."

Staff were aware of the importance of supporting people to maintain their independence. However, the support and care offered by staff we saw on the inspection was often rushed with little time to spend on positive interactions and conversations. We found that due to the lack of staff availability to support people that this had a knock on effect to how they could treat people in a dignified manner. As noted in other domains we were told by people in the home and their relatives that people had to wait to receive personal care. Dignity was not always maintained. We also heard people on numerous occasions shouting out to be taken to the toilet and being told, mostly politely, that they would have to wait. We heard one person being told not to "panic" as it was their turn next. We saw another person taken into the toilet but then staff leaving them while they went to find other staff to help. People should not have to shout out and wait to be taken to the toilet. This is undignified treatment.

We recommend that the service seeks training for staff in providing dignified care and that good practice in this area is sought from reputable source, with consideration given to staff becoming dignity champions.

We also found that at times people's ability to make choices was comprised. For example some people were offered a bed bath or a body wash instead of a shower or a bath. We heard people saying that the meal offered to them was not what they had asked for. A relative also said that choice at mealtimes was limited and that their relative often said it wasn't what they liked or asked for.

We saw that when staff had more time in the afternoons, and in the downstairs unit, the interactions between staff and people living in the home demonstrated genuine affection, care and concern. Staff made

the most of care tasks to chat to people and ask them if they were okay. We noted that they used touch to enhance interactions with people in a reassuring and calming way. When staff did make use of the opportunity to chat to people whilst carry out tasks we saw that people became animated and visibly lit up with these positive interactions.

We took from this that staff did know how to treat people with dignity and respect and that what we were told and observed was due to not having sufficient staff deployed to meet people's needs in a timely and dignified way. Staff told us they had received training in values and respecting people.

We did see throughout our inspection that staff knocked on doors to private areas before entering. People who spoke with us told us the staff "always" knocked on their bedroom doors before entering their rooms. One person said, "They [staff] tap on my door before they come in, they are respectful."

Staff were aware of keeping records locked away and knew about professional boundaries in their relationships with people. When staff were around there was a pleasant atmosphere. Staff clearly knew people and the names people wished to be addressed by and used these consistently.

People's individuality was respected were possible. We observed that people looked well groomed and where dressed in clean well matched clothes. They all wore slippers or shoes where possible. Ladies had jewellery on, handbags to hand and their hair was regularly set by the visiting hair dresser, gentlemen had watches on and were shaved. We heard one carer offering a good range of choice to one person on what they would like to wear that day saying, "Would you like your pink, blue or purple cardigan today." Each person's room was made individual to their own tastes and many people brought items of furniture or pictures and ornaments with them.

At mealtimes we saw that people were offered aprons and napkins to protect their dignity. We saw that tables were laid out pleasantly with flowers and condiments. One staff member was heard to says, "Would you like a napkin to protect your lovely clothes." During lunch we observed that staff sat alongside people who needed support with eating and drinking but at times were called away to assist elsewhere. We saw one person trying to open a yogurt pot with one hand and was struggling, another person stepped in to help. This person had no special equipment to support independence at mealtimes and the yogurt had not been transferred to a bowl which may have been easier and more considerate of their needs.

The registered manager of the home knew about local advocacy services that could be contacted if people required support to share their views about the service they received. Advocates are people who are independent of the organisation who can support people to make important decisions about their lives and to share their views.

The shortfalls and issues in this key question of 'Is the service Caring?' have been incorporated into the breaches of Regulation 18 Staffing and Regulation 9 person centred care.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we made a recommendation that care planning was reviewed and more detail put into some of the plans, especially when people are living with dementia. On this inspection we found that this still needed to happen. At the last inspection we discussed the development of plans so that some of the plans would have more detail if a person displayed behaviours that challenged the care delivery. We had also judged that some of these care plans would benefit from very specific details on how to re-orientate and reassure people. We were also told on the last inspection that the home was developing a dementia care strategy and this was to encompass staff development, therapeutic activities, signage and use of equipment. When we asked the registered manager and the operations manager about the strategy they said it hadn't been developed yet. However, we did see that areas of the dementia unit had been made more dementia friendly. We advised that the service seeks out national good practice in dementia care such as those recommended by NICE.

Assessments, care plans and risk assessments had been developed with the person who was to receive support and that person had signed to confirm their agreement with the support planned. We discussed with the registered manager the need to have a more detailed nutritional assessment carried out in the first few weeks of arriving at the home.

Each person who lived in the home had a care plan that contained information for staff about how to support them. The care plans contained information about the things people wanted staff to help them. These documents also contained personal information about people's interests, hobbies and life history however we found that some of these lacked detail or had important information missing. We found little reference to people's emotional, psychological, relationship and sexual needs.

We found that the quality of the care plans and records varied. Some of the records we looked at had not been fully completed and some records had not been reviewed regularly. For example, we saw from a monthly review that one person's dependency level had increased significantly but we could see nowhere in the care plans as to why this was. And in some records people were assessed as requiring the help of two staff for moving and handling but in other places in their files as only needing one staff member for the same care task. We contacted adult social care as part of this inspection and one of the comments professionals made to us was that when they visited the home to carry out reviews they had found care plans not to be up to date and they now used daily records to find out the current needs of people in the home.

We saw that people being cared for at the end of their life were treated with dignity and respect. One person had been cared for in bed and staff had been sensitive to both their needs, and those of their relative's. Records that had been held in the person's room showed regular input from staff. The home liaises and works with GP, district nurse team and the Hospice at Home service to gain support for people at the end stages of their life. However, people's end of life preferences and choices were not always recorded in their care plans. We noted that one person's file had stated 'not for hospital' but there was no individual care plan for end of life stages that would set out what this meant. For example, we would expect to see a care plan that gave instructions to staff about mouth care, about any changes to do with a person's medicines

specifically for the end stages of their life and any details of funeral arrangements.

We also found that the records for supporting people whose behaviour may challenge the service continued to lack detail. For example on the triggers to watch for and steps staff could take to distract, divert and reassure when a person may become agitated or display aggression. We saw how staff supported people on the day of the inspection and this was not always appropriate with people being told to behave. We heard one staff member saying, "Stop that, stop that, No! No!" When we checked this persons care plan we could see no instructions of what triggers to look for and how to avoid confrontations and what to do when they occurred. Specialist teams, such as the community mental health team had given advice about working with individual people however these were not always written up into people's care plans so that staff could be consistent and appropriate in their approach.

This meant we could not be sure the records were current and accurately reflected people's needs. We discussed the issues we found with the records with the registered manager and provider. They arranged for the records to be reviewed to ensure they gave more detailed guidance for the staff.

The service needs to look at how they can develop an effective care planning system that ensures that changes to people health or care needs were updated so that staff have the most up to date instructions to meet people's needs.

We received mixed feedback about the activities provided in the home. However, people were very positive about the activity co-coordinator employed in the home and her efforts to put on as many events as possible but we were told she was pulled away to help out with other things in the home.

People living in the home said, "There isn't much to do really, there are some things on in the afternoon sometimes, we do get singers sometimes too" and another person told us, "My friend comes to take me out shopping" while another person said, "No the girls [care staff] here can't take you out." Another person said, "We generally play something of an afternoon, cards or bingo, just whatever we want, it depends on how many come down(to back sitting room)." Another person said, "It's hell in here. People sat around staring at each other all day with nothing to do."

The home had a designated activities coordinator who worked four weekdays 10-4pm but not at weekends. This person also offered additional support to people at mealtimes and with drinks. In the afternoon they said they had and more time to spend doing group and individual activities.

People told us they liked the larger events put on by the home, like outside entertainers and singers and these tended to be every month. There had been a Royal wedding party at the weekend with staff dressing up. We were told that arm chair exercises were planned for that afternoon. One person living in the home said, "Oh yes we've started doing that again, we used to do it but it stopped. I enjoy doing them." However, this activity didn't take place as staff were busy doing personal care tasks and the activity co-coordinator did a couple of people's nails later in the afternoon instead.

The provider told us that the activity coordinator organised on average two trips out per month during the summer season and could use the mini bus shared with the providers sister home for this. However, on a day to day basis we found the majority of people did not leave the home unless friends or relatives took them out.

We found that people had little opportunity to engage in their local community or to leave the home either as part of a group or individually with staff support. Some people told us that they hadn't been out for some

time. Asked if people who did not have relatives ever went out, staff said that sometimes at weekends they tried to take people out for a short walk or into the garden.

We judged that for many people their quality of life was affected due to a lack of support to engage in meaningful activities, to have contact with other people and the wider community. This meant that some people were at risk of being socially isolated and lacked stimulation. We observed a number of people spending long periods either alone in their bedrooms or sitting in the same chair for two to three hours with no activities apart from the television. Some people pursued their own hobbies and enjoyed reading, listening to music or watching TV in their own rooms.

The provider told us, and we were shown that a survey had been sent out to find out people's opinions of the activities and excursion offered by the home and on receipt of this they told us they would make amendments to the activity programme.

We also found that there was little in the way of equipment or adapted environment for people living with dementia. While this had improved somewhat downstairs in the unit for people living with dementia the rest of the home had little adaptation and there were significant number of people who would benefit from more clear signage and dementia friendly environment. We did not see that people's life history had been used to develop things like scrapbooks, picture books or flash cards to help stimulate and engage people. We found out that two people had played a very central lifetime role in a church but when we looked at their files there was no mention of this or how they could be supported by the home in this.

The service had failed to seek out current best practice in relation to delivering an appropriate programme of stimulating and engaging activities both in groups and one to one for people living with dementia.

People were not provided with appropriate opportunities or meaningful activities based on person-centred care that met their needs and reflects their personal preferences. Care plans and support did not always reflect people's current needs and had not always taken into account nationally recognised evidenced based best practice. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a complaints procedure and we saw that complaints had been managed in accordance with the home's procedures. Everyone we spoke with said they knew how to make a complaint and would speak with any member of staff. One person told us, "I would speak to [name of manager]." We were also told, "I would speak to staff. I have no complaints." The registered manager told us they preferred to deal with people's concerns as and when they arose.

We made a recommendation about recording informal and verbal complaints, as well as written formal ones, and how these were addressed.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager in post, as required by their registration with the CQC, at the time of this inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

When we completed our previous inspection on July 2017 we found concerns relating to the running of the service and rated this key question of Well-led as 'Requires Improvement'. We had found a breach of Regulation 17: Good governance because some areas of the auditing and quality monitoring had not been effective. During this inspection we found this continued to be the case. We found some areas at the previous inspection, and mentioned in the report, had not been actioned. Such as ensuring care plans were updated when changes to people's health occurred and in developing care plans to include managing behaviours that may challenge the service.

We were also concerned that the home had yet to develop a dementia care strategy with plans to set out the approach to people living with dementia. This again was recommended in the last inspection report. We did not see any evidence of the service referring to national good practice guidelines, such as those promoted by NICE (National Institute for health and care excellence) in for example oral care, falls management and dementia care. We would expect this as the home had a unit specifically for the care of people living with dementia and many other people in the home were also living with varying degrees of dementia.

The Business Development plan for Stilecroft stated a Vision of "Providing exceptionally trained and well motivated staff." However, the home did not have a staff development programme that promoted staff developing roles such as being champions in specific areas. Such as in areas of a dementia champion or a dementia friend, or dignity champion, or end of life champion. Champions are staff who have a specific interest in particular areas and are central in bringing best practice into a home, sharing their knowledge, acting as role models and supporting staff to provide people with good care and treatment. We found that training offered to staff in these areas was at a basic awareness level.

We found that the senior team, including the registered manager needed to complete or update their management training. They would benefit from training in leadership, supervisory management, people management and the effective use of quality assurance systems to improve the quality of the service. We were also concerned that most of the training given to staff was in-house and delivered by the registered manager who does not hold formal qualifications as a trainer in all these areas.

We made this recommendation at the last inspection about improving the quality of staff supervisions: "We recommend that the registered manager review the supervision and appraisal arrangements so that all staff continue to receive both formal and informal support that reflects their job role and allows good practice to be maintained."

The registered manager carried out all staff supervisions and we found these continued to be of a basic standard and did not address staff development. We discussed with the registered manager whether this could be one of the areas delegated, with the appropriate training, to other senior staff in the home.

Records in use were not all consistent in their detailing of people's needs. Finding current information for staff about how to support individuals took time as it was not always recorded in the same place. We saw that people's health and support needs were documented in their care plans. But we found some information lacked detail and was not always up to date. The best interest decision process had not been recorded consistently for people living in the home. We also found that people's capacity was not being recorded in a consistent and clear way. This exposed people to a risk of abuse of their rights.

We found that the registered provider had not ensured that CQC had been notified of the all the accidents and injuries that had occurred in the home as they were required to under the regulations. We looked at records from January 2017 to the date of the inspection and found that there had been a failure to notify CQC. For example we had only been notified of two people who had fallen and required medical interventions. We identified five incidents that should have been reported to us in the sample of records we looked at. The failure to notify CQC meant we had not been able to check that the registered provider had taken appropriate action at the time of these incidents and accidents so that, if needed, action could be taken to protect the person or their rights.

The registered manager and provider are required to report in line with Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4). The failure to notify us of injury as outlined in the registration regulations is a breach of the registered provider's condition of registration and this matter will be dealt with outside of the inspection process.

The Business Development plan for Stilecroft stated its Aims and Objectives as "To provide an excellent quality of care to all its residents. Residents are encouraged to live their lives to their fullest and are given every opportunity to lead as normal a lifestyle as possible. Stilecroft provides a homely atmosphere where residents will receive a consistently high-quality care reflecting their needs and wishes."

However, throughout our inspection we were told by people living in the home and by their relatives that they had experienced a drop in the quality of the service offered by the home recently. Relatives whose family members had been at the home for some time told us that things had deteriorated recently and were keen to point out that it used to be better, such as with the food, staffing levels and outings. One relative told us, "The home was really lovely when my [relative] first came here a couple of years ago but things have gone downhill. I think it's penny pinching." And another relative said, "We put our [relative] in here to be cared for and they not getting the care and attention they deserve." And another said, "It feels like there's been a lot of cut backs recently and we are paying a lot of money for this home." We were concerned that a drive to increase profits was beginning to affect the quality of the service.

Staff also reported that staffing levels were their biggest concern and this had affected staff morale. One staff member told us, "If staffing was sorted out this would be a different place to work. Now it's really difficult trying to meet everyone's needs." Some staff said they had raised this with the provider but that "nothing had changed."

Staff in the home told us that they didn't feel listened to by the provider, although most said the registered manager 'tried her best'. We were also told by the staff team that they didn't feel comfortable about speaking up. Some staff had not felt confident about using the providers channels to raise concerns either with the registered manager or the provider and had contacted us directly. We spoke with the registered

manager and operations manager for the home and they said that they were currently addressing staff morale issues. They said a number of staff had left and they had been working on team building. They also said that the restructuring and strengthening of the senior team was seen as positive development. The registered manager spoke of a recent team building get-together at her house.

We received mixed feedback from health care and social care professional about working with the home. While we found the home had been actively involved in local health care pilot schemes, we were also told by a number of health and social care professionals that the home was often defensive and not easy to work with. They told us, "They were quite dismissive in our attempts to include them and said they had all the training they needed".

The majority of people living in the home and their relatives said that the registered manager was approachable and that she sorted out any problems or concerns as best she could. One person told us, "[The registered manager] comes round and talks to us." A relative said, "They do ring me if there is anything wrong, I have filled in questionnaires in the past." Some people told us that the registered manager was "very busy lately". One person said, "No I haven't really seen the manager, no I don't have any information (about the home)." And another relative said, "We don't see the manager really, in fact not really at all."

The operations manager visited the home on a regular basis and recorded her observations and discussions in some detail. She checked care planning and delivery, medicines and the environment on a regular basis. The auditing and quality monitoring systems that were in place were now adequate in identifying concerns relating to the safety and most areas of quality of the environment of the home. The oversight of quality and safety in the home was also monitored regularly by registered manager and provider. Maintenance checks were being done regularly. We were given copies of the last three Quality Monitoring reports. We again found these to be very basic for a home that had been rated as Requires Improvement. Where issues had been identified there were no actions and dates for these to be met by. For example one stated, "Staff saying very heavy workload and would like another member of staff" and another "Night staff drill and evacuation is required" with no actions or who this had been delegated to.

The company also used surveys to seek the views of people in the service and of visitors to the home. These were sent out in batches and surveys were also available in the home at all times. The registered manager held residents' and relatives' meetings and the activities organiser also ran residents' meetings. We were told that the residents and relatives meetings were poorly attended. However, some people said they had repeatedly complained about the lack of car parking and had wondered why the scaffolding was still up after being in place for over 2 years. Relatives said it was an "eyesore".

We did not see any evaluation of the surveys sent out and we made a recommendation that the service collates these views and shares these with people whose views had been sought with the actions taken to resolve any issues raised.

We recommend that the service looks at ways of developing a more open, transparent culture in the home that makes use of both the views of people in the home and those of the staff team. The provider may wish to note a recent CQC report, 'Driving improvement: Case studies from nine adult social care services June 2018'. This report refers to how services have improved their CQC rating. One case study highlighted stated: "Leadership and culture go hand in hand. It's the leader's job to shape the culture of an organisation. Involving staff is one of the best ways to drive improvement."

We found the provider still to be in breach of Regulation 17: Good governance.

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 9 HSCA RA Regulations 2014 Person-centred care People were not receiving care that met all their needs. Care plans and support did not always reflect people's current needs and had not always taken into account nationally recognised evidenced based best practice. People were not being offered a choice of food and drink that meets their preference and assessed nutritional and hydration needs to support their well-being and quality of life. People were not having in-depth nutritional assessments of their needs. 9(1)(3)(a)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not doing all that was reasonably practical to mitigate risks. Lessons learnt from incidents were not used to make sure that action was taken to prevent further occurrences and make improvements as a result of investigations. Regualtion 12 (2)(a) (b)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems to monitor the service was not affective in assuring the quality of the service offered to people living in the home. Records were not being kept up to date, including those relating to people's capacity, legal protection and rights. Feedback from people using service, their carers and others such as staff was not always listened to, recorded and responded to. It was not being analysed and used to drive improvements to the quality of the service. 17(1)(2)(d)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to make sure that people's care and treatment needs could be met. The provider had not identified the approach they were using to support people, and how this reflected current legislation and guidance, in considering the different staffing levels, skills and competence required to meet people's needs. To include leadership requirements. 18(1)