RYSA Limited

# The Sheridan Care Home

## Inspection report

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## Ratings

| Overall rating for this service | Inspected but not rated |
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| Is the service safe? | **Inspected but not rated** |
| Is the service effective? | **Inspected but not rated** |
| Is the service caring? | **Inspected but not rated** |
| Is the service responsive? | **Inspected but not rated** |
| Is the service well-led? | **Inspected but not rated** |

# Summary of findings

## Overall summary

This comprehensive, unannounced inspection took place on 15 and 16 March 2016.

The Sheridan Care Home provides accommodation and care for up to 30 older people living with dementia. Nursing care is not provided. During our inspection there were nine people living at the home.

The registered manager was appointed in June 2015 and was registered in March 2016. 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. Registered providers of care homes are required by law to comply with relevant regulations.

Following our inspection of 21 and 22 October 2014 we served warning notices to the provider and registered manager in relation to care and welfare of people who use the service and records. These required the service to meet these regulations by 31 January 2015. We undertook an unannounced focused inspection on 23 February and 6 March 2015 to check that these breaches of the regulations had been addressed. We also checked whether the provider had followed their action plan in relation to the breaches in managing medicines, consent to care and treatment, and requirements relating to workers. These regulations were not met and we took enforcement action. We imposed a condition on the provider's registration. This means further people cannot move into the home without our agreement.

We undertook a comprehensive unannounced inspection during August 2015 to check the provider's progress and to check that the breaches of the regulations had been addressed. At that inspection we identified repeated breaches and four new breaches of the regulations.

During this inspection we found the provider had made some of the required improvements and was meeting a number of the regulations. However, we identified repeated breaches of regulation in relation to the care people received, medicines management, the levels of staffing and training, the application of the Mental Capacity Act 2005 and in the systems to assess and monitor the quality of the service.

People were not always kept safe at the home; one person required thickened fluids in order to ensure they were able to drink safely. The fluids in their room were not thickened and there was no guidance available for staff displayed in their bedroom regarding how to ensure this person received their drinks safely. This meant this person had been placed at risk and this was a breach in the regulations.

People received their medicines as prescribed and the medicines were stored securely. However, records relating to the stock, recording and storage of medicines were not correctly completed. This was a repeated breach of the regulations.

The provider did not use a recognised pain assessment tool. The majority of people living at The Sheridan

Care Home were living with dementia and would not be able to tell staff if they were in pain. Without a pain assessment tool in place to monitor people's pain levels there was a risk these people may not receive pain medicines when they needed them. This was a repeated breach of the regulations.

There were not always sufficient staff to fully meet people's needs. Staff told us they were not always able to spend time talking with people as they would wish. The manager was in the process of recruiting a member of staff. The level of assistance and support people living at the home needed in order to keep them safe meant at times during the day and at night the home did not always have sufficient numbers of staff on shift. This was a breach in the regulations.

The service was not fully meeting the requirements of the Mental Capacity Act 2005. People had Deprivation of Liberty Safeguards (DoLS) applications or authorisations in place. People were being deprived of their liberty unlawfully because the managers were not aware of or met the conditions in place. This was a repeated breach of the regulations.

Relatives knew how to make a complaint and complaints were investigated. Guidance information in the communal area had become obscured by other leaflets and was not visible. We brought this to the attention of a management consultant who removed the obstruction which enabled people to clearly see the guidance on how to make a complaint.

Staff were recruited safely and told us they received appropriate training. Some staff said they would like further specific training relating to caring for people living with dementia. Staff had not commenced the Care Certificate training but had received training through an independent training provider. We highlighted staff required further dementia training in order to carry out their roles effectively. This was a repeated breach of the regulations.

Although some improvements had been made the home was not always well-led. The manager had been providing us with a monthly action plan as to how they were going to meet the regulations. The systems in place for assessing and monitoring the quality and safety of the service were still not effective. This was because although we saw some improvements in people's experiences, the shortfalls we found had not been identified by the manager or provider.  This was a repeated breach of the regulations.

People and relatives spoke positively about the staff and told us they were always, "Kind and caring". We observed staff treated people kindly and showed people respect and dignity.

The completion of people's risk assessments and care plans had improved. People's care plans and care records had been reviewed regularly to ensure people received care relevant to their health needs. People's care records were stored securely.

There was a schedule of activities provided for people to promote their independence and engage with other people in the home. People were offered choice where possible to participate in the activities the home ran.

Staff told us they felt well supported and records showed staff were starting to receive regular supervision meetings and annual appraisals.

Staff and relatives had an opportunity to be consulted and involved in the home. Staff and relatives said they felt communication in the home had improved. Relatives said they were kept informed and involved in the care of their relative.

There were nine people living at the home at this inspection.  There have been a low number of people living at the home since our last inspection in August 2015. Where a service has low occupancy CQC is not able to award a rating.  This is because we are unable to assess how the provider would meet the needs for up to 30 people which the service is registered to provide care for.

The overall rating for this service remains as 'Inadequate', which was the rating awarded at the last inspection. The service is therefore in 'special measures'.

Following previous inspections we considered the appropriate regulatory response to our findings of repeated shortfalls. We have taken action in response to these failings and have cancelled the providers registration with CQC.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inspected but not rated**

Some people were still not kept safe at the home.

Risks to people were not always managed to make sure they received the correct care they needed.

Although the administering of medicines was safe the storage and stock recording of medicines was not consistently safe.

Staff were recruited safely.

Staff knew how to report any allegations of abuse.

### Is the service effective?

**Inspected but not rated**

Some people's needs were still not met effectively.

There were not always enough staff available during some shifts, especially the night shift.

Some people were unlawfully deprived of their liberty.

People were referred to specialist healthcare professionals when needed.

### Is the service caring?

**Inspected but not rated**

The service was caring. People were treated with respect and dignity and had their privacy and independence promoted.

People and their relatives told us staff were kind and caring.

Staff had some understanding of how people liked to be cared for.

### Is the service responsive?

**Inspected but not rated**

The service was responsive to people and their needs but some improvements were still needed.

People received the care they needed. Care plans were updated and included sufficient information about their care and support needs. This meant staff had up to date information about how to

care for people.

People knew how to complain. Information was displayed at the entrance to the home explaining how people could make a complaint.

## Is the service well-led?

**Inspected but not rated**

The home was still not always well-led.

The systems in place to monitor the quality of the service and drive forward improvements were not fully effective as they had not identified the shortfalls found during this inspection.

Staff and relatives were consulted about the service.

# The Sheridan Care Home

**Detailed findings**

## Background to this inspection

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

This inspection took place on 15 and 16 March 2016 and was unannounced. Two inspectors completed the inspection on both days.

Before the inspection we reviewed the information we held about the home, including notifications of incidents since our last inspection in August 2015. We also spoke with the local authority contract monitoring and safeguarding teams and sought feedback from GP surgeries who had involvement with the home. We requested and received a Provider Information Return (PIR) from the provider before the start of this inspection. A PIR is a form that asks the provider to give some key information about the service, what it does well and improvements they plan to make.

During the inspection we met and spoke with eight of the nine people living at the home and also spoke with three visiting relatives and a visiting healthcare professional. Because most people were living with dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with all four of the staff on duty during the two day inspection, the registered manager, a representative of the management consultants and the cook.

We looked at six people's care and support records and care monitoring records, all nine people's medication administration records and a selection of documents about how the service was managed. These included three staffing records, three weeks of staffing rota's, audits, meeting minutes, premises maintenance records, quality assurance records and a selection of the provider's policies.

Inspected but not rated

# Is the service safe?

## Our findings

Some people were still not kept safe.

At our inspection in October 2014, we found that staff had been giving a person who had recently moved into the home, a medicine that was not recorded on their medicines administration record (MAR) sheet. This meant the person could have been at risk from a medicine that had not been prescribed or staff not following the prescription instructions, and staff not recording the medicine they had administered. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now Regulation 12(2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the next inspection in February and March 2015, we found continuing shortfalls in the management and recording of medication. Staff had signed for some of a person's antibiotics as given but the tablets were still in the box. Another person did not always receive the pain relief they were prescribed prior to dressing changes, which left them vulnerable to pain. Records for skin creams and gels contained insufficient instructions regarding how and when to apply these. There was insufficient guidance for staff regarding the use of people's 'as necessary' (PRN) medicines, leaving people at risk of receiving too much medication. Where people needed medicines disguised in food or drink, there was no consultation with pharmacists to ensure this was done safely. The home's medicines policy made no reference to a requirement to involve a pharmacist in decisions regarding covert administration. These matters were a repeated breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now Regulation 12(2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection in August 2015 we found again that there were no instructions from a pharmacist for the covert administration of a person's medicines. The management team took immediate action to address this and sought guidance on how the medicines should be administered from the pharmacist. They told us following the inspection this document was with the pharmacist for completion. However, the document had been completed five weeks before the inspection. This meant they did not have confirmation that the medicines were safe to administer covertly to the person for five weeks. Some people's 'as needed' (PRN) medicine care plans were not in place for their pain relief. This meant staff did not have information as to when the person required their as needed medicines. These matters relating to medicines were a repeated breaches of Regulation 12(1) and 12(2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements in the way people were being administered their medicines. People received their medicines as prescribed and people's medicines administration records (MAR) were fully completed. For medicines that were to be given covertly, the GP's authorisation had been obtained and clear instructions received from the Pharmacist. People had 'as needed' (PRN) medicine care plans in place. Medicines were stored correctly, however the provider's records relating to the stock of medicines had not been correctly completed. When stock had been returned to the pharmacy the medicine stock book had not been updated. This meant there was not an accurate record available of what medicines were in stock

against those medicines that had been returned to the pharmacy. This shortfall meant if there were any discrepancies these would not have been picked up promptly. We brought this to the attention of the manager who showed us the completed medicine audit records. These audits had not identified the error in the medicine stock book. The manager updated and signed the medicine stock book during the inspection to confirm the correct levels of medicine.

The manager had implemented a system of recording the temperatures for the medicine storage room and the medicine fridge. Daily temperatures had been recorded, however the system did not give any guidance for staff on what the minimum and maximum temperatures should be and what action staff should take if the temperatures were out of range. Some medicines need to be stored within a strict temperature range, if they are stored above or below these ranges there is a risk the medicines would be compromised and would not be effective. The lack of guidance for staff meant there was a risk medicines may be rendered ineffective if they were stored at an incorrect temperature.

One person had been prescribed transdermal medication patches that were to be applied directly to their skin. A transdermal patch is a medicated adhesive patch that is placed directly on the skin to deliver a dose of medicine through the skin and into the bloodstream. The systems did not include the use of a body map for the person, to clearly identify to staff where to place the patches on a daily basis. This was important because patches needed to be applied to alternate sites on the body each day to prevent possible skin soreness. This person could be at risk of skin damage because there was no system to record where the patches were being placed. We brought this to the attention of the manager who told us they would ensure a body map system would be implemented straight away.

The shortfalls in the management and records relating to medicines was a repeated breach of Regulation 12 (1) and 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in October 2014, we found that risks were not always managed to ensure people's safety. These shortfalls in assessing and managing risks to people were a repeated breach of Regulation 9(1) and 9(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice that required the provider to meet the Regulation by 31 January 2015.

At the next inspection in February and March 2015, risks were still not managed to keep people safe. This was a repeated breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We imposed urgently a condition to restrict admissions to the home. This remains a condition of the home's registration.

At the inspection in August 2015, we found that risks to individuals and to the service were still not managed to fully protect people. We found staff lacked awareness about people's specific health conditions, information relating to people's health conditions was not complete and people were not always monitored regularly as stated in their care plan which placed some people at risk of not receiving the correct care and support. This shortfall in the safe management of individual risks was repeated breaches of Regulation 12(1) and (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that risks to individuals were still not managed to fully protect people. One person's care plan stated they required their fluids to be thickened to a 'custard thick' consistency in order to ensure they were able to drink safely because they were at risk from choking. We checked this person's bedroom, and found a beaker of plain water on their table; this water had not been thickened. There was no

guidance for staff available in their bedroom regarding how to ensure this person received their drinks safely. There were agency staff working in the home that may not know this person required 'custard thick' fluids. This meant there was a risk that staff could give this person plain water as a drink which could pose a choking risk and was a breach in the regulations. We discussed our concerns with the manager who immediately removed the jug of non-thickened water from the person's bedroom.

This shortfall in the safe management of individual risks was a repeated breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the staffing rotas for the period from 29 February 2016 to 21 March 2016. These showed there were either two, three or four care staff on shift during the day and two care staff on shift each night. The manager worked each day shift Monday to Friday on a supernumerary basis. The provider used a staffing dependency tool to establish staffing numbers for the home. The staffing dependency tool stated five of the nine people needed two staff to mobilise them with equipment safely. Two people living in the home were also cared for in bed and they also needed two staff to move them and provide personal care. This meant when two staff were assisting one of these people, one member of staff was caring for and supervising the other eight people. The people were living with dementia and some had complex needs and needed high levels of care, support and supervision to keep them safe. There were two people on shift during the night. This meant if both people were re-positioning any one of the five people who needed two people to assist them there would be no staff available on the floor to assist any other people.

The manager confirmed they were in the process of recruiting a further member of staff to replace a staff member that had recently left. The manager confirmed they used agency staff to cover staff absences on a day to day basis and to cover periods of annual leave and sickness. They told us they tried to ensure the agency sent them staff that had already worked at the home to ensure a consistency in care for people. Staff told us when there was three staff on shift they were very busy and felt the service ran better with four staff on each shift. They told us at times there had only been two staff on shift and it was very busy then. Staff told us when it was very busy they were able to care for people but did not get enough time to spend a lot of time talking and listening to people. This meant staff were not consistently given time to talk with people about their hobbies or what they had done in their lives, which is a beneficial for people living with dementia and increases the quality of the care they receive. We observed the manager spent a lot of time helping and assisting people throughout the two days of the inspection. We observed the manager position was not supernumerary during the time we spent at the inspection.

Staff told us and records showed they also did laundry duties when they were on shift. One staff member also did the relief cooking when the chef was on their day off. We discussed our findings with the manager and a consultant from the independent company the provider had employed. The consultant acknowledged that staffing levels based on our findings and people's needs were not enough. The manager said they would increase the staffing levels if there was a crisis. There were not always sufficient staff to fully meet people's needs.

The shortage of staff is a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at three staff recruitment records and spoke with two members of staff about their recruitment. Staff told us and records we reviewed confirmed all appropriate checks had been undertaken before they started employment at The Sheridan Care Home. Records showed the following pre-employment checks had been completed, proof of identity and right to work in the United Kingdom, up to date criminal record checks and references from current or previous employers. Staff told us they had spent a number of days

'shadowing' experienced staff to ensure they got to know people before providing care and support to them on their own.

There was a system in place to record, review and analyse any accidents or incidents that had occurred. The manager explained how they were able to learn from the accidents and incidents and gave examples of how they had put preventative measures in place to ensure people were protected from possible harm. For example, with the use soft crash mats to protect people from injuries should they fall.

Inspected but not rated

# Is the service effective?

## Our findings

At our inspections in October 2014 and the February/March 2015 inspection we identified shortfalls in arrangements for obtaining consent and making decisions in line with the requirements of the Mental Capacity Act 2005 were a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now Regulation 11(1) and Regulation 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection in August 2015, the service was not fully meeting the requirements of the Mental Capacity Act 2005. Most staff were not fully aware of the Mental Capacity Act 2005, making best interest decisions, or who had Deprivation of Liberty Safeguards (DoLS) authorised. The shortfalls of acting in accordance with the Mental Capacity Act 2005 were a repeated breach of Regulation 11 (1) (2) (3) (4) (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found there were shortfalls in the management of the DoLS for people. The DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. The safeguards should ensure that a care home only deprives someone of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them.

Some of the people living at the service had been assessed as lacking mental capacity due to them living with dementia. DoLS applications were completed and submitted to the local authority and had been authorised. Some people's DoLS authorisations included conditions that the registered provider and staff needed to adhere to. For example, one person had conditions that required the manager to provide regular updates to the local authority and another stated the person was to be supported to go outside on a regular basis. Another person had a condition for them to receive pet therapy as they had a love of dogs. Records showed the manager had not taken action to make sure these conditions were adhered to. This meant the conditions of the DoLS were not met and these people were being deprived of their liberty unlawfully.

The shortfalls in people being deprived of their liberty unlawfully were a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in October 2014 we identified a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff did have the skills and knowledge to meet the specialist needs of people living with dementia.

At the inspection in August 2015 staff did not receive adequate training to enable them to fulfil their roles effectively. Staff completed some core training, for example, medication, infection control and moving and handling. The home is a specialist dementia care home and records showed care staff had received dementia training. However, from our observations, and discussions with people, staff and relatives, we found the staff did not have the skills and knowledge in dementia care to be able to meet people's physical,

social and emotional needs. The shortfalls in ensuring staff received appropriate training and professional development, were a repeated breach of Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection the manager told us the newly recruited staff had not commenced their training for the Care Certificate. From April 2015 all new health and social care workers should be inducted according to the Care Certificate Framework. The Care Certificate replaced the Common Induction Standards and National Minimum Training Standards. Alternative training had been delivered using an independent training company and comprised of face to face training and computer based training.

Records showed staff had been provided with a three hour dementia awareness training session. Although staff were caring, they did not demonstrate they had the skills and knowledge to be able to provide person centred dementia care to the people living at the home. They were not aware of the importance of knowing people's life and social history in providing personalised care. Some staff did not communicate with people in a way that increased their wellbeing. For example, staff repeatedly told people that they were going out later and then did not take them out. They also said to one person that their family member was coming in to see them when they weren't. This meant people could become increasingly confused and anxious which could have a negative impact on their overall wellbeing.

The majority of the people living in the home were living with dementia and had complex care needs. One member of staff told us they had not worked in a dementia care home before and had found it to be a steep learning curve. They said they had received basic training in dementia but would like more detailed training so they could have a greater understanding of people who were living with dementia.

The shortfalls in ensuring staff received appropriate training and professional development, were a repeated breach of Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt supported to carry out their roles and told us the staff team were available and happy to help them if they needed guidance or support. Records showed staff had recently started to have supervision sessions with their manager. Staff said they found their supervision sessions to be useful and helpful. An annual appraisal had been completed for the member of staff who had been employed at the home since 2004, but this was dated 15/12/2009, there were no further records on file to show that this person had received further annual appraisals. The manager told us they were scheduled to review and complete all staffs annual appraisals and would be completing them very soon. This was an area for improvement for the provider.

At our previous inspections we identified concerns with the variety of food offered to people who had specialist diets. We also identified shortfalls in people's nutritional and hydration needs which resulted in a breach in Regulation 14 (1) (a)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements regarding the overall variety and nutritional value of food made available for people. The cook spoke knowledgably about people's likes, dislikes and which people needed specific diets such as pureed or fortified meals to maintain and/or increase people's weight. They showed us the systems they had in place for recording people's preferences and any allergies they may have. The cook described in detail how they managed the meals for people who preferred different types of finger food so that they could maintain their independence by being able to eat by themselves. Food was freshly prepared each day, the cook said they were given full support to purchase fresh meat and vegetables and all the

kitchen equipment was well maintained.

There was a four weekly menu cycle, which gave people a choice of meal each day. The cook said they generally followed the seasons with the menu, for example in warmer weather they would do more salads and pasta and in the winter months casseroles and stews would be prepared.

At this inspection we observed the lunchtime meal on the second day of our inspection. We observed people had varied experiences of their mealtime. Two people were taken to the dining room and were sat waiting at the table 25 minutes before the meal started. All seven people sat in the dining room needed support of varying levels in order to eat and drink safely. At the start of the meal people's experiences were chaotic. There were five members of staff supporting people to eat their meal which included the manager and a management consultant, this did not reflect the usual amount of staffing levels there would normally be on a daily basis. On three occasions staff stopped supported the person they had been assisting and started supporting a different person. They got up and walked over to support other people without explaining to the person that they were going. This would have been disorientating and confusing for people. One person became visibly agitated by the noise in the dining room. Staff repeatedly woke one person who was not responding. The manager had already spoken with this person and said they would come and support them with their meal.

Staff offered people a visual choice of meals by showing them two plates. One person who was living with dementia was not able to make this choice because they no longer had the ability to do so. However, the staff member persisted in repeatedly asked the person even though they were not able to make this choice rather than making the choice for them based on their knowledge of their food preferences. The person became upset and started to bite their hand. The management consultant then sat with the person and quietly reassured them and distracted them from biting their hand.

When the manager and management consultant were sat with people they then asked staff to stay with the person they were supporting and the atmosphere was then relaxed and conducive to eating. The manager and consultant sat and chatted with the person they were assisting to eat and other people at the table. They explained to the person what they were eating and drinking. They supported them at the pace they were comfortable with. The other staff supported people quietly and gently but did not chat with people. Towards the end of the meal other staff returned from supporting people elsewhere in the home and sat with people and chatted with them.

There were extra staff including two management consultants in the home during the inspection to assist with supporting people to eat and drink. Rotas showed that these were not the usual staffing levels. Two people needed support to eat in their bedrooms and four people in the dining room needed staff support to eat. This showed that when there were two or three staff on duty there would not have been enough staff to support people to eat and drink.

We observed one person was left on their own unsupervised in the lounge to eat their meal while people were supported in the dining room. This person was left for long periods of time and when they tried to eat their meal they knocked their plate to the floor. The cook came in to assist the person and prepared a fresh meal for them, but they were then left on their own again. A member of staff came in and sat with the person and with encouragement this person started to eat a little of their lunch. This showed if a member of staff had been available to support and encourage this person with their meal when they were given it, the person would have eaten their meal in a timely way without the lengthy delay they experienced.

Some staff did not demonstrate the skills and knowledge to support people who were living with dementia

to meet their nutritional needs. This was a breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were offered visual and verbal choices of drinks and the meals and drinks were served in coloured crockery. This was good practice and research has shown that people living with dementia can see food more easily on coloured crockery and may subsequently eat more.

Photographs of the main meal of the day were displayed in the dining area so people knew what was for lunch. Snacks of cakes, fruit and sandwiches were available in the main lounge in a small Perspex covered tray. This was so people could help themselves if they were able to.

At our inspection in February and March 2015 we found the failure to seek prompt medical attention was a repeated breach of Regulation 9(1)(b)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now Regulation 9 and Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection in August 2015 we found records relating to the ongoing care of people and their skin integrity were not adequately detailed to ensure people were not placed at risk of developing pressure areas. We identified staff were not aware of people who had pressure sores and they had not been given clear instructions on how to care for people's pressure areas.

At that inspection, records showed one person had fallen during the night and sustained a head injury. The staff on duty had not sought prompt medical attention and the home manager contacted the GP on their arrival the next morning. The home manager addressed the concerns with the staff member and informed all staff again of the need to seek medical attention. However, this lack of seeking prompt medical attention had been an area of concern at our inspections in October 2014 and February/March 2015 and staff should have been aware of the need to seek medical advice when a person sustains a head injury.

At the inspection in August 2015 we also identified people who had pain from health conditions did not routinely have their pain assessed using a recognised pain assessment tool. These tools are used to assess people's pain levels if they cannot tell staff that they are in pain. People living with dementia may not always be able to say or show when they are in pain. The home manager told us they planned to introduce this tool but at the time of the inspection this was not being used. This meant people may not have received pain relief when they needed it.

These shortfalls were a repeated breach of Regulation 9 (1)(a)(b)(c) (3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, the majority of people living at the home were living with dementia and were unable to tell staff if they needed pain medicines to manage their pain levels. The provider did not use a recognised pain assessment tool. Without a pain assessment tool in place to monitor people's pain levels there was a risk these people may not receive pain medicines when they needed them. We discussed our findings relating to medicine management and pain assessments with the manager who told us they would re-implement pain assessments for people immediately and ensure the medicine records and temperature guidance would be corrected.

This shortfall to implement and use a system of pain assessment was a repeated breach of Regulation 9 (1) (a) (b) (c) (3) (a) (b) of the Health and Social Care Act 2008 9 Regulated Activities) Regulations 2014.

At this inspection, records showed people were referred in a timely way to health professionals such as their GP, occupational therapists and district nurses when their health needs required it. We spoke with a visiting health professional who told us the staff followed instruction well and made appropriate referrals to their service.

During our inspection we conducted a tour of the home and saw improvements in the adaptations and design of the premises. For example, toilet seats were in contrasting colours which enable people living with dementia to identify the toilet within the bathroom easier. Clear pictorial signage was displayed on each door, stating what the room was, for example lounge, dining room and bathroom. People had pictures and photographs that were memorable to them placed on their own bedroom doors to help them orientate themselves around the home.

Inspected but not rated

# Is the service caring?

## Our findings

Relatives told us they had found improvements in the service during recent months. They said, "It's much improved, in the last three to four months, I used to worry all the time, now I can go home and not worry, I only hope it stays that way". People told us the staff were kind, caring and helpful. Relatives said, "We had a good Christmas here this year, the staff really made an effort, it was really nice".

During our inspection we observed staff supported people kindly and gently. We observed staff were caring in the way they interacted with people. Most of the interactions we saw from staff towards people were positive and people responded by smiling or looking at staff. However, because there were not always enough staff interacting with people, these interactions were often brief.

Staff respected people's privacy and dignity. When people had to be moved using a hoist, staff ensured mobile screens were used to protect people's privacy. Staff called people by their preferred names when supporting or assisting them and knocked on people's bedroom doors before entering them.

There were activities for people to take part in. During our inspection we observed people taking part in flower arranging, colouring and being supported to spend time sitting in the garden. The local vicar visited and conducted an Easter service in the lounge for those people who wished to participate. People had been assisted to make Easter bonnets and were wearing them during the service.

Staff were able to tell us about people's health needs but told us they did not have time to read the personal detail about them to learn about their life histories and previous livelihoods. This meant staff were not able to spend time reminiscing with people about their past lives and what had been important to them. For people living with dementia this is an important aspect of their daily lives and if carried out effectively can contribute positively to their overall wellbeing.

Relatives told us they were kept informed about their relative's health and felt involved in their ongoing care and health needs. One relative said, "Mum is always clean and dressed in nice clothes, we are shown her records and there is a chart if there are any injuries, they always phone us when the GP is needed, they are quick to get the GP in, it's all ok now, we feel involved all the time".

Care records and other confidential information about people were kept secured in a separate office. This ensured people's privacy was respected, as visitors and other people who used the service could not gain access to people's private information without staff being present. Conversations made by staff to health professionals took place in the office and could not be overheard by other people.

We observed staff interacted with people in a calm and kind way and gave reassurance when people became anxious or upset. One person wanted to walk around the home but needed assistance to do this. Staff spent time with this person, walking them around the home and into the gardens which calmed them down and decreased their anxiety levels.

Inspected but not rated

# Is the service responsive?

## Our findings

At our inspections of October 2014 and February/ March 2015 we identified shortfalls in the assessment, care planning and provision of care that people received. These shortfalls were a repeated breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now Regulation 9 and Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There have been no new admissions to the home because of the condition we imposed. This was because we identified serious concerns and shortfalls in the care people received. The condition of registration is that no new people may be admitted to the home without the written permission of the commission. This meant we were not able to assess fully how the service was assessing people's needs prior to them moving in to the home.

At the inspection in August 2015 we found people had care plans in place to direct staff but not all of these plans reflected people's current needs. Staff had said they were not confident moving all people who lived in the home and were using a piece of equipment they had been advised to stop using in May 2015. We identified staff were not aware of people's interests and personal histories and how they could use these to provide activities that were meaningful for them as individuals. These shortfalls in the providing care and support that people needed was a repeated breach of Regulation 9 (1)(a)(b) (c)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements in people's care plans. Care plans were clearly written and up to date and people had risks to their health assessed and monitored regularly. For example, if people were at risk of developing pressure sores, preventative measures had been put in place such as air pressure mattresses, pressure cushions and these people were re-positioned regularly. We reviewed six people's care plans in depth. Care plans were reviewed monthly or more frequently if people's needs changed. People's care records reflected their health requirements and gave staff guidance on how people preferred their care to be given.

People had soft toys or dolls to pick and hold if they wanted to. These provided comfort and stimulation for three of the people living at the home. The people held and talked with the soft toys or dolls.

When staff were sitting with people in the lounge and doing activities people responded positively. However, during our observation on the first day of the inspection staff only interacted with people briefly in short bursts. This was because staff were busy getting people up and they were in and out of the lounge. Because of the lack of activities and interaction from staff people withdrew into themselves and went to sleep. For example, in a 50 minute period one person only two brief interactions from staff. Another person shut their eyes and withdrew; they started to gently cry and then went sleep.

We spent time with one person who was being cared for in bed. Their bed was positioned so they could see into the garden and also see their television clearly. They told us they were comfortable and preferred to watch their television and have their newspaper. Their television was on their preferred channel and a copy

of their newspaper was in reach on their bedside table. When we asked this person if there was anything else they needed they said, "No, I'm all right thank you".

Another person was being cared for in bed and we observed their bedroom was as described in their care plan. For example, their curtains were drawn, soft music was playing and the person had a soft toy they were holding. They had pictures and photographs placed all around their room which were located where they could easily see them. Staff told us this was how the person liked their room and they found it calm and peaceful.

We observed that when staff were able to, people were given activities and staff spent time with people. People were given a range of activities to keep them occupied, such as colouring, listening to music, reading newspapers and magazines and some people had dolls and soft toys to hold and carry with them around the home.

One person's care plan stated they liked dogs and the relatives had asked if a dog visit could be arranged. There are a number of independent companies that visit care homes with friendly dogs that allow people to pet and stroke them, which people enjoy. Records showed this request had been made before Christmas, however the visit had not yet been arranged. The manager told us they were going to arrange for this service to be provided.

Relatives told us they knew how to complain. Guidance information in the communal area had become obscured by other leaflets and was not visible. We brought this to the attention of a management consultant who removed the obstruction which enabled people to clearly see the guidance on how to make a complaint. The provider's complaint procedure did not give contact details for The Local Government Ombudsman. The Local Government Ombudsman is the authority people need to contact if they have a complaint when they are paying privately for their care. We reviewed the complaints the provider had received since the last inspection in August 2016. There was a system in place to acknowledge, investigate and address complaints. Complaints had been acted upon and actions recorded but it was not clear if any learning from complaints had been taken forward or the results shared with staff. This was an area for improvement for the provider.

Inspected but not rated

# Is the service well-led?

## Our findings

At our inspections in October 2014 we identified shortfalls in how well led the home was. Following the inspection in October 2014 the provider returned an action plan. The plan stated the actions needed relating to medicine management, care provided to people, consent to treatment, record keeping and staff recruitment would be completed by 31 January 2015.

These improvements were not complete at the time of the inspection in February and March 2015, which took place before the provider's deadline. The failure to act on the warning notices given relating to the care and welfare of people, record keeping, and to address other breaches of the regulations meant the assessment and monitoring of the quality of the service was not effective.

These shortfalls were repeated breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not fully protected against the risks of inappropriate or unsafe care and treatment by means of the effective operation of quality assurance and risk management systems.

At the inspection in August 2015 we found continued shortfalls in how well-led the home was. There were some improvements overall in some people's experiences but we were not able to establish whether these could be sustained in the long term.

An independent firm of management consultants had been appointed by the provider to oversee and monitor the home and identify areas for improvement for the new home manager to address. Audits completed by the manager and the feedback from the management consultants had not identified the shortcomings found at the August 2015 inspection. Areas identified at the previous inspection had not been fully addressed; there were repeated breaches of the regulations and new breaches. For example some of the audits were inaccurate and did not reflect concerns we found.

The local authority service improvement team had been visiting regularly to provide support and guidance to the home.

At this inspection we reviewed a selection of the audits that had been recently completed by the manager and the management consultancy company to assess and monitor the quality of the service. Audits were completed on care plans, medicine management systems, infection control, fire safety, premises safety and nutrition. However, the medicine management audit had not highlighted the shortfalls we found in the medicine management system during our inspection.

The manager told us they had recently become the homes' registered manager. They said since obtaining their registered manager status they felt they had been given more control over how they ran the home. They told us the provider had however, prevented them completing specific risk assessments with some members of staff, when they, the manager felt the risk assessments were required in order to ensure the

safety and wellbeing of people.

These shortfalls in the governance of the service, failure to assess, monitor and mitigate risks and improve the quality of the service were a repeated breach of Regulation 17 (1) (2)(a)(b)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The previous inspection identified there was not an open and transparent culture within the management team.

At this inspection relatives told us they were kept up to date with events in the home and felt involved in their relatives care. Relatives told us they had read some of the previous inspection reports and felt the home was improving. They told us their understanding was the home had failed in regard to paperwork and record keeping.

At the August 2015 inspection it was identified the provider had failed to display the home's rating on their home or landing page of their website. From 1 April 2015 providers have to display the home's ratings. Because the rating was not displayed on the home or landing page of the home's website and this was a breach of Regulation 20A (2) (7) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the rating was displayed at the home and on the provider's website.

At our inspection in October 2014 we identified shortfalls in the record keeping. This was a repeated breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now Regulation 17(2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice that required the provider to meet the regulation by 31 January 2015.

At each subsequent inspection, in February/March and August 2015 we identified people's records were not accurately maintained and this placed people at risk of unsafe or inappropriate care. We found records were not stored securely and people's personal information was displayed in communal areas which did not protect their privacy. We identified people's records were not fully completed and lacked people's names, dates actions were taken and signatures. This meant it could not be established who had completed the record, who they related to and when the record was completed. These shortfalls in record keeping were a repeated breach of Regulation 17(2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements in the standard and completion of people's care records. The majority of records we reviewed had been completed, signed and dated by staff. People's records were kept secure and there was not any confidential information displayed in communal areas of the home.

At the August 2015 inspection we had not received notifications about the safeguarding allegations and investigations since the last inspection in February/March 2015. We did not receive a notification for all of the people who were subject to DoLS. Providers have to notify the commission about these events under Regulation 18 (2) (e)(4A)(a)(b) of the Care Quality Commission (Registration) Regulations 2009. This was a breach of the regulations. At this inspection the manager had made the appropriate notifications to the Care Quality Commission.

Staff told us they had staff meetings and felt comfortable to raise issues if they needed to. One member of staff told us the meetings often took place when they were not on shift, they said they made sure they read the minutes from the meetings so they knew what changes were to be made in the home. We reviewed a selection of team meeting minutes which were clear and had been made available for all staff to view.

Relatives told us they knew who to contact if they needed advice and guidance and staff said they had a clear understanding of the management structure within the home. Staff were knowledgeable about the provider's whistleblowing process and knew the process to follow if they needed to raise any concerns.

There was a system in place for people and relatives to express their views about the service. Relative meetings were held and records showed minutes from these meetings were typed and available for people to view. Relatives told us they felt they could raise any concerns or issues and they knew who to speak with and felt they would be listened to.

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 | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The provider did not have a system in place to assess if people were in pain and needed medicine to manage their pain.<br><br>This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

**The enforcement action we took:**

CQC has cancelled the provider's registration

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider did not have a safe system in place for the storage of medicine stock. Records relating to the stock of medicines had not been kept correctly. The system for storage of medicines did not give effective guidance for staff. There was no system for staff to record where people had medicines placed on their body. There was no guidance available for staff to ensure people were given their fluids in a safe way to avoid a risk of choking. |

**The enforcement action we took:**

CQC has cancelled the provider's registration

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider had not adhered to the conditions people had placed on their DoLS therefore people were being unlawfully deprived of their liberty. This is a breach of Regulation 13 of the Health and |

| | |
|---|---|
| | Social Care Act 2008 (Regulated Activities) Regulations 2014. |

**The enforcement action we took:**

CQC has cancelled the provider's registration

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider was not promoting an open and honest communication culture.<br>This was a breach of Regulation 17 of the Health and Social Care Act 2008 ( Regulated Activities) 2014. |

**The enforcement action we took:**

CQC has cancelled the provider's registration

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>There was not always enough trained, experienced staff on shift during the day and night to meet people's needs.<br>This was a breach of Regulation 18 of the Health and Social Care Act 2008 ( Regulated Activities) Regulations 2014. |

**The enforcement action we took:**

CQC has cancelled the provider's registration