Castletroy Care Home Limited

Castletroy Residential Home

Inspection report

130 Cromer Way
Luton
Bedfordshire
LU2 7GP

Tel: 01582417995

Date of inspection visit:
29 August 2018
30 August 2018

Date of publication:
31 October 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 29 and 30 August 2018. The inspection was unannounced. Castletroy Residential Home 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.

Castletroy Residential Home provides personal care and accommodation for older people. Many people living at the home were living with dementia. Castletroy Residential Home is registered to provide care for up to 69 people. At the time of this inspection 61 people were living at the home. Castletroy Residential Home comprises of a purpose-built building offering accommodation over two floors.

Following the last inspection, 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. We found that some improvements had been made in relation to the safety of the building. However, we found other areas of concern.
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.'

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

There was a registered manager in place. 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.

There had been concerns raised in June 2018 about the evening and early morning staff getting people up early. When we inspected the home on 29 August 2018 we found this to be the case. People were up early and most of these people were found to be asleep in the reception areas of the home. Some people had been partly dressed in the early hours of the morning and put back to bed. These people were fast asleep. The management of the home had not responded to the concerns raised previously in a robust way.

People were not being supported with their health and well-being. One person had sustained a head injury. We found action had not been taken in a quick enough way to seek advice from a professional. Another person's weight had suddenly decreased, no advice was sought from a professional. Staff were not following the advice of professionals to prevent a person from choking. People's medicines were not always being managed in a safe way.

Robust recruitment checks were not completed to ensure staff were always safe to be around people. There were infection control risks which could put people's health at risk of becoming unwell.

We found that people were not always being treated in a way which promoted their dignity or in a way which respected them as individuals. Not all staff were consistently kind and thoughtful towards the people they were supporting.

There were institutionalised practices at the home which did not put people first. In terms of getting people up early and dressing people in day clothes. Rather than their night clothes, if they had had an incontinence episode during the night. How some people's rooms were presented. How some people were supported to eat their meals and have their medicines. The management of the service had not fully explored what people's backgrounds were or who they were as people. People did not have meaningful end of life plans in place to ensure that people were supported in a way which was important to them at this part of their lives.

There was a poor culture among the staff team in terms of putting people's needs first and failing to identify poor practice. Quality audits were not effective at identifying issues and finding solutions. The management team were responsive to the issues raised from this inspection. However, the provider was not completing robust audits to support the management team.

These issues constituted breaches in the legal requirements. There were numerous breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

People had risk assessments which identified the risks which they faced and there were plans for staff to follow. Activities took place most days at the home. There had been outings and social events to involve the community. A complaint had been well managed and people found the registered manager approachable. Most staff were kind and caring towards the people at the home. People and their relatives spoke positively about the staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

A safeguarding concern was raised about staff practice from this inspection.

People's medicines were not always being administered and managed in a safe way.

There were infection control risks.

Staff recruitment checks were not complete.

People had risk assessments in place.

Is the service effective?

Inadequate

The service was not effective.

There were shortfalls in staff knowledge and practice which effected people's safety.

Staff competency was not being assessed or monitored effectively.

Staff were not always following the advice of professionals to keep people safe.

People were not always being supported to drink enough.

People's dining experiences were not being monitored in an effective way.

Is the service caring?

Inadequate

The service was not always caring.

The service was not always respectful of people.

People's independence was not always being promoted by staff.

Practical action was not always taken to support people.

Relatives felt welcomed at the home.

Is the service responsive?

Inadequate

The service was not responsive.

People were being got up early in the mornings or were partially washed and dressed to benefit staff.

People's rooms were not always personalised.

People did not have meaningful end of life plans in place.

People's care assessments were not person centred.

Activities were taking place but staff did not consistently spend meaningful time with people.

Is the service well-led?

Inadequate

The service was not well led.

There was a poor culture among the staff team.

There were elements of institutionalised practice at the home.

Quality monitoring audits were not effective.

The provider was not completing robust audits.

Castletroy 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 inspection took place on 29 August and 30 August 2018 and was unannounced on the first day.

The inspection team consisted of two inspectors, a specialist advisor who was a registered nurse, and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service

Before the inspection as part of our planning we had been in contact with a representative from the local authority contracts team. They told us about their recent visit to the home. We looked at the notifications that the manager had sent us in the last year. Notifications are about important events that the provider must send us by law.

We did not receive a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. This was because we did not request this to be sent to us.

During the inspection we spoke with 14 people who lived at the home, 10 people's relatives, five members of care staff, the chef, two deputy managers and the registered manager of the home. We looked at the care records of 13 people, and the medicines records of people at the home. We also looked at the recruitment records for three members of staff. During our visit we completed observations of staff practice and interactions between people at the home and the staff. We also reviewed the audits and safety records completed at the home.

Inadequate

Is the service safe?

Our findings

At our comprehensive inspection in February 2017 we found that people were safe at the home. In January 2018 a focussed inspection took place following concerns about the hygiene and safety of the building. This led to a breach of regulation 15 of the Health and Social Care Act 2008 in relation to premises and equipment used at the home. At that inspection on 29 August 2018 it was found that some improvements had been made in this area. However, concerns were still identified with infection control and people's safety.

People who used hoists and slings to be transferred from one position to another were not being protected against the spread of infection. People who used slings did not have their own slings. This had the potential to make people ill. This risk to people's health had not been identified by the registered manager. Staff were storing people's slings and moving belts bunched close together hanging on hooks. One sling had a brown stain on it. A moving belt had food stains on it. This practice of 'bunching' the slings together, which were not always clean, increased the risk of infection spreading. When we spoke with the registered manager about this they told us, that the owner of the home would not buy people their own slings as it would be too expensive. People's safety in this instance had not been made a priority. In this way the service was not protecting people from becoming ill.

Some of these slings washing instructions had worn off over time and parts of the slings were frayed. This could mean that they were unsafe to use. The hoists had been serviced recently by an outside company. However, one of the hoists handle grip, where people would hold onto had significantly deteriorated. A person could not have gripped this. This was also a risk to the spread of infection. Another hoist was rusty on its base, this could also be a risk to spreading infection, as this area cannot be safely cleaned. The registered manager did not have robust systems to check the safety of these pieces of equipment. We also noted that fans in people's rooms were dirty.

In June 2018 we received concerns from several sources that the staff who worked the evening and early morning shift were getting people up, washed and dressed in the early hours of the morning. The local authority safeguarding team responded to this concern. They visited the home on one occasion at 04:00 am and found this had not happened on that day. When we inspected on 29 August 2018 and arrived at 06:00am we found that this practice was taking place. One person was in bed fully dressed. This person was fast asleep with their light off. Two other people were partially dressed in bed asleep. We also found six people were up and dressed in the reception areas of the home. Four of these people were asleep either in their wheelchairs or in armchairs. In addition to this, we found two people were up and dressed sitting in their rooms. One of these people were staring in a vacant way at the wall in front of them, they looked unkempt.

We entered one bedroom at 06:28am and a person was up and dressed sitting in their chair. We asked them if they wanted to be up so early, especially as it was still dark outside. They said, "Well… the night staff get you up…you know." They told us that they often got woken up at 05:00 am. They went onto say they did not mind this as it helped the staff out. This person was living with dementia it was unclear if this person was making a conscious choice to get up at this time or they were being encouraged by staff to do this.

When we spoke with day staff we asked them if they were aware of the practice of night staff getting people up early or dressed. Three members of staff said they did not know of this practice. Two other members of staff indicated that they did know of this practice. One of them told us that, "It helps the morning staff, as there was not enough time to get people up."

Management systems had also failed to protect people from potential abuse and breaches in their dignity and respect. This practice is indicative of a poor culture among the staff team. As a result of these concerns we raised a safeguarding referral with the local authority.

During our inspection we identified that a person had fallen hitting their head and had bruised their face and head one morning. We looked at the incident record for this event. Professional health advice had not been sought when it was identified by staff that this person had fallen hitting their head. A health professional was eventually spoken with later that day. We asked a deputy manager why there was a time delay before seeking professional advice given that this person had sustained a head injury. We were told that the said professional was planned to visit that person later that afternoon. So, the deputy manager decided to wait for them to visit. This action could have put this person at risk of complications resulting from their head injury. It was a concern to us that staff on duty had not sought medical advice sooner, in order to do everything possible to ensure this person was safe.

After this event the service had not analysed this incident. This person had said they may have fallen against some furniture in their room. However, the management team had not taken these views into account. They had not considered if other action was needed to prevent a similar fall or injury happening again for this person. They had also not analysed the information to see if wider lessons could be learnt from this incident. For example, considering the person had sustained a head injury, was professional advice required sooner. This evidence formed the first part of a breach of regulation 12 of the Health and Social Care Act 2008.

People's medicines were not managed safely. We looked at people's medicines during the inspection. When we visited people's bedrooms we found two people had prescribed creams open and without their lids on them. We found that none of people's creams had a date recorded on them as to when they were opened. This is important because these creams had a shelf life once they were opened. Using these creams after this point could reduce the efficacy of these products in helping people to get better. One person's cream had been dispensed in February 2018 and it was not clear when this had been opened. We spoke with a deputy manager about this to see if it was in date, they said, "It should have been thrown away." This was later removed from this person's room by a member of staff.

We also found that people had multiple prescribed creams and gels being stored in their bedrooms. These products should be stored at certain temperatures. The temperature of one person's room exceeded the maximum safe storage for their cream. Good practice would have been to store these items in the medication store room, until they were required. Again, the poor storage of these creams and gels could reduce the effectiveness of these items in helping people to get better.

The service did not have a safe system to administer people their creams. The service had 'body maps' where it showed staff where to apply the creams. However, these maps were kept away from people's bedrooms, so they were not readily available for the staff when they needed them. This meant that people were potentially put at risk of not receiving these prescribed creams as directed by a medical professional.

We spoke with a deputy manager about these issues. They said they had identified the issues about the dates of opening of creams and gels not being recorded. They were working on a plan to manage this issue,

but no real action had been taken. At the time of our inspection staff did not know if people's creams were in date. The service had also not identified the storage issue and practice issues in relation to people's creams, which we had.

Later in the inspection we checked if people had been given their medicines as they had been prescribed. We did a count of seven people's 'as required' medicines and looked at their Medication Administration Records (MAR) to see if they tallied. We found that six people's medicines did not balance. For example, one person had six less particular medicines than they ought to have had left, with no record of these being given. We spoke with a member of staff about this, they said, "Someone must have forgotten to record this." Another person had 18 particular medicines missing. There was not an accurate record of these people's medicines. It was not clear if people had in fact had these medicines to help manage their health needs.

We looked at controlled drugs at the service. We found two out of the three samples of people's controlled drugs which we looked at had too many or too few of these drugs. The deputy manager investigated these cases and in both of these cases it was identified as a recording failure by staff. However, this questioned how effective the systems were at the home to monitor and ensure people had their medicines and controlled drugs, as prescribed by the GP. We spoke with the registered manager about these issues, they agreed that more regular audits were required. However no other action was suggested in terms of reviewing staff training in this area to ensure these issues did not happen again.

We therefore concluded that we could not be confident that people were receiving their medicines as prescribed and in a safe way. This evidence formed the second part of the breach of regulation 12 of the Health and Social Care Act 2008.

Staff did not demonstrate a good understanding of safeguarding procedures. We spoke with staff and asked them about their understanding of how to protect people from experiencing abuse and harm. Four members of staff out of the five we spoke with, told us what these potential signs could be that a person was potentially experiencing harm. However, one member of staff was unclear on this. Out of the five members of staff we spoke with two were aware of the outside agencies they could also report their concerns to such as the local authority safeguarding team. However, three were not. One member of staff said if they found a member of staff harming a person they would confront that member of staff. This is not good practice as this could undermine a potential safeguarding investigation.

We also asked staff about their understanding of discrimination. One member of staff out of the five we spoke with had some understanding of what this meant. One member of staff said they had not had training on this subject. Staff had not considered what this potentially meant for the people who were living at the service. Staff had not considered if people living at the home were vulnerable to experiencing discrimination.

The above issues constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with felt that there was enough staff. Although, one person's relative felt more staff was needed. We observed there to be enough staff about the home during the day. However, we did not see staff spending time with people, such as chatting and passing the time of day with them. We were also told by some staff that the practice of the night shift getting people up early helped the morning shift with their workload. We concluded that there was an issue with staff practice rather than staffing levels.

During the inspection we looked at how staff were recruited. We found that all staff had a Disclosure and

Barring Service (DBS) check in place before they had started working at the home. Staff had provided proof of their identities, and references had been obtained. However, we noted that although it was stated on people's references that they had been verified, it was not clear how these checks had been completed. In one member of staff's work reference it implied that the referee had worked with them, but it was not clear, in what capacity. Two out of the three staff files we looked at, did not have full employment histories recorded. These are all important checks to ensure people are safe, around staff. We spoke with the registered manager about these issues who agreed the importance of these checks.

There were various safety checks taking place in relation to the building. These included regular and up to date fire safety checks. However, we found that some safety records were not complete. These included the daily checks staff completed in relation to the safety of the hoists, and whether people had call bells in reach. We spoke with a deputy manager about this, who made changes to the documents used by staff, to make these checks more robust. However, we still needed to give further input into how to do this.

The service had a contingency emergency plan in place. We looked at this plan. However, there were areas which were not clear. It stated if they had a sudden reduction of staff then agency staff would be used. It did not include which agency would be used and their contact details. There was no evidence to say that the plan had been shared with all staff who may have to deal with an emergency. This plan had been reviewed. These issues had the potential in certain situations to undermine people's safety in the home.

At this inspection we looked at people's risk assessments. We found that these were completed in some detail. There were corresponding plans for staff to follow to manage the risks which people faced.

Despite all these concerns relating to people's safety, people said that they felt safe living at the home. One person said, "One of the most positive thing is I do feel safe, compared to being at home." Another person said, "It's a really good place, much better than hospital." A person's relative told us that, "I have no concerns for [name of relative's] safety, [relative] has a pressure mat beside their bed."

Inadequate

Is the service effective?

Our findings

At our comprehensive inspection in February 2017 we found that people received effective care. When we inspected the service in January 2018 we did not look at this area. However, during this inspection we found that the care people received was inadequate.

We identified shortfalls in staff practice when we visited the service in the early morning. We found some people could not reach their emergency buttons in their rooms. We entered one person's bedroom and a member of staff rushed in saying, "That shouldn't be like that." They pulled a pressure matt from under a person's bed. This person would not have been able to put their pressure matt under their bed themselves and was reliant on the matt is to alert staff if they got out of bed, as they were at risk of falls. This meant that this person could have fallen and been unable to alert staff.

One person, who was assessed as being at high risk of choking, was prescribed a thickening agent to go into all of their drinks. We looked at their beaker of drink and jug of juice, and it was clear that neither contained the thickening agent in them. We spoke with two members of staff about this. They first said that it was normal practice for staff to add thickener to the jug of juice. We spoke with a deputy manager about this. They were unable to tell us how staff ensured the correct ratio of thickener to water was added. We asked the deputy manager and they said they could not confirm if the fluid had been thickened or not. Thickening agent being added to a jug of fluids is contrary to the professional guidance from Speech and Language therapists (SALT). This means that this person could have choked when drinking this fluid. When we spoke with the management team about this, we were later shown a A4 piece of paper explaining to staff how this product should be administered. We were not confident this issue had been resolved by these actions. Poor staff practice in this area put this person at risk of choking, more action was required to make sure this person was safe when having their drinks.

We also saw that the same person had been given ice cream to eat. It is not safe to do this for this person according to the guidance from SALT. As this item of food can change to normal fluid thickness in the mouth and increase the risk of the person choking. This meant that the shortfalls in staff practice had exposed the person to a further risk of choking.

We found shortfalls in how people's prescribed creams and medicines were being administered and managed. Some staff were not correctly checking that people had in fact received their controlled drugs safely. We initially found two out of the three samples of people's controlled drugs which we looked at had too many or too few of these drugs. The deputy manager investigated these cases and in both of these cases it was identified as a recording failure by staff and these people had received these medicines. However, the recording of the administration of these medicines was not effective.

One person was at risk of developing a break down to their skin. They had a 'tissue viability action plan' in place. This was to use a pressure relieving cushion. We observed that this person was sitting in one of the lounges from the early morning to lunch time. They were not sitting on a pressure relieving cushion. We asked a member of staff, who was with this person, if the person should be sitting on a cushion. They did not

know. We spoke with the deputy manager who said that, as this person was walking about, they did not need this. However, we had seen them sitting all morning. This information was not reflected in their care plan. Poor staff practice and awareness in terms of this person's needs could lead to this person developing a breakdown to their skin and becoming unwell.

When we entered one person's bedroom they were asleep in their bed. An armchair had been placed next to their bed restricting them from getting out of bed. We spoke with a member of staff about this. They told us that this is to stop this person from falling out of bed. They then moved the chair to the other side of the room. This is not safe practice. This meant that this person could have fallen out of bed and got trapped between the bed and chair and been injured. No member of staff had raised this practice issue with the management of the service. This person had been assessed for bed rails but no action had been taken to ensure these were in place. This person had a lowering bed, but no crash mat was in place. Poor staff practice was exposing this person to the real risk of them falling out of bed and getting hurt.

Staff competency was not being monitored and assessed by the management team. With the exception of 'medication administration', there were no recorded checks on staff practice. The 'medication administration' competency check did not evidence how the assessor reached their conclusion that the person was competent in this area of their work. We spoke with the registered manager about this who agreed with us on these issues. They later produced a competency assessment they were intending to use in the future.

During our inspection we noted that on three occasions a member of staff had washed the floors of the communal rooms, and left these floors wet. This was a potential slip hazard. On each occasion a sign was put near the entrance of these rooms, warning of this hazard. However, people living with dementia or eyesight issues may not have seen and reacted to these signs. On one occasion we observed that one of the lounge floors had been washed, it was left visibly wet, and there were three people sitting in this room. We spoke with a deputy and another manager about this. They initially explained that these were new floors and cleaning staff were getting used to them. It took some time for this issue of risk to be understood by these members of staff. No initial plan was formulated to ensure people did not slip on these surfaces after they were washed. Therefore, people were still being exposed to this risk of getting hurt and sustaining an injury.

We also identified a part of the hallway carpet was ripped. This could cause a person to fall. When we raised this with a deputy manager they said that only one person walked in this area. They also told us that this carpet was being replaced. We needed to tell them that action was required now. They said that they would resolve this issue.

We did see some positive examples of staff providing effective care to people. For example, when people needed to be transferred using a hoist and when people became distressed with one another. Staff also spoke positively about their training and inductions. Staff gave examples of some of the training they had received and told us why it had been positive. However, given the above issues we concluded that there were areas of staff knowledge and practice which were not adequate and which were putting people at risk.

The above issues constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the issues and shortfalls which we identified about staff practice, people spoke positively about the staff who supported them. One person said, "Carers I have are fantastic, hardworking people, they are worth

a ton more money than they get." Another person said, "If I am in pain they get me a paracetamol. I can't say a bad thing about anyone here." A relative told us that, "[Relative] is well looked after, [relative] has not had any previous accidents."

During this inspection we looked at whether people had enough to eat and drink. We saw that when people were at risk of being an unhealthy weight, plans were put in place to monitor this issue. People's weights were recorded and staff checked what people ate and drank. However, we looked at one person's record and saw that on 28 August 2018 they had been weighed and had lost 31.4 percent of their body weight in the last month. The recorded response was to monitor and increase their calories. There was no contact with this person's GP to raise these concerns and seek advice about how to respond to this. We raised this with a deputy manager. They later told us that they had made contact with this person's GP who would be visiting this person. However, we needed to prompt action in order for it to happen.

We also noted that two people were not being assisted to have sufficient fluids. One person's record stated that they were to have 2040mls in a 24-hour period. However, only 260mls was recorded. There was no reference to senior staff being alerted to this or any actions taken. On another day we saw recorded that this person had had 30mls of fluid at 06:45am, 30mls at 08:02am, with no other fluids recorded as given until 13:00. Both this person and another person was seen to be unable to reach their drinks on the table next to them. This lack of fluids could have caused these people to become ill.

We found one person had an uneaten plate of sandwiches by their bed. We asked why this food was there and if it was their evening meal. The member of staff said it was a night time snack. We later learnt this was in fact this person's evening supper, which potentially staff had not supported this person to eat.

We saw one member of staff assisting a person with their meal. They entered their bedroom with two plated up meals, these were for two people. During our observation this member of staff appeared to rush this person when eating their food by supporting them at a quick pace. They also discouraged them from eating one item of food on their plate and then suggested they had dessert before they had finished their main meal. This person indicated that they wanted to eat their dessert independently, but this member of staff ignored this, and fed this to the person. We asked this member of staff if they were now going to visit another person in their room as the additional plated up food, could be cold now. They told us that they would now go back into the kitchen and get a hot meal for the other person. Another person had a pureed meal, which we saw was all mashed together, with no thought having been given to make this look appetising.

When we considered people's dining experiences we had mixed observations. We found that in one dining room staff chatted to people as they ate and ensured they had had enough to eat. However, in the other dining room people ate quickly and staff did not try and chat or engage with people. One person was sitting in a reclining wheeled chair and was supported to eat their meal. When the member of staff left this person, they remained in the same position. No staff member asked if they wanted to move. We observed a member of staff administering medicines at lunch time. They asked one person if they wanted their inhaler whilst eating. Another member of staff started to clear the table and leant over a person who was still eating. Two different groups of staff were seen chatting and laughing with one another in the corners of the room at different times. They could have used this time to be with people and engage them in social conversation.

When staff were serving dessert, which consisted of four options and which looked appetising, next to the desserts on the trolley were the used plates from lunch with leftover food on them. In the other dining room there was a table near people, and in their view, which contained the dirty plates and a bucket which staff had used to put the leftover food in. We concluded that people's dining experiences had not been considered. The registered manager had no oversight or quality checks on this aspect of people's care.

Elements of this support was institutionalised practice, which did not put people first.

The above issues constituted a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people about their views of the food. One person told us, "I like food, nothing wrong with that, if I don't like something, they [staff] always offer a jacket potato." Another person said, "The food is lovely, I get enough, we always have dinner and a pudding."

Despite the issues we saw with how some staff were supporting people to eat and drink we did see some positive examples. We saw three other members of staff supporting people at their own pace, taking their time, and talking with the person. One member of staff was supporting one person to eat and said, "I can smell mint in this, it smells really nice."

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

When we spoke with five members of staff four gave examples of how they promoted choice when they supported people with daily needs. One member of staff said, "People can still make decisions for themselves, it's within their right to do so."

We looked at people's records who may lack capacity to make certain decisions. We saw recorded in some cases a 'best interest process' had been followed to reach a specific decision. In some people's records it stated that a named relative had certain legal powers to make decisions on their relative's behalf. However, the service had not obtained proof of this. We also found three examples of when people's relatives were making decisions on their relative's behalf when they did not have the legal powers to do so. In these situations, the service was not promoting people's rights in this area. We spoke with a deputy manager and registered manager about this who told us that they would resolve these issues.

People had DoLS authorisations in place. We did not see that people's movements about the home were being restricted. However, one person lacked capacity and was at risk of falling out of bed. A DoLS was in place for this person to have bed rails up when they were in bed. However, when we visited this was not in place. The service was not adhering to this recommendation. We spoke with the registered manager about this, they were not aware of this. They told us they would ensure that the DoLS recommendation was adhered to. They did not have systems in place to check that DoLS authorisations were being followed.

We therefore concluded that further work was required for the service to be compliant with the DoLS. The above issues constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

During our comprehensive inspection in February 2017 we found that people were treated in a caring way. When we inspected in January 2018 we did not look at this area. During this inspection we found some positive evidence that the service was caring, however we also found some issues which concerned us. We found some staff were not caring in their responses and support to people and that the management of the service did not ensure a caring culture or approach to people.

People's preference were not always considered by staff. We found instances where people were being supported to get up early or assisted into day clothes when they had had an incontinence episode during the night rather than into clean night wear. At these times people's dignity was being ignored by the staff who did this and staff who knew of this practice but did not report it to managers. In these situations, people were not being respected and valued.

Staff did not ensure that people had their call bells in reach at night time. We found that these were some distance away from people. This is not caring practice.

We saw that one person started to get distressed in the dining room at the end of lunch saying that they wanted to go to the toilet. This person continued to say this until they were taken outside of the dining room. They were left to wait for a member of staff. At this point they continued to get upset. A member of staff then started talking to them to reassure them that help would be on its way. Eventually the same member of staff who had taken them outside of the dining room returned and took them to the bathroom in a hurried way. This person's distress should have been made a priority and it was not.

Another person had asked a member of staff about lunch. This member of staff then stated in a sharp, direct way whilst standing over the person, "I did say I would tell you, when it is lunch time." This person looked shocked by this and said, "Oh, alright." This person looked upset. Their shoulders slumped down and they lowered their head. We later saw this member of staff walking with another person, with their hand under their armpit. We spoke with the registered manager about this. They couldn't explain this practice, but said they would speak with this member of staff.

We later observed another person getting distressed, we saw a member of staff say to another member of staff, "Leave her, she'll calm down." However, another member of staff went up to this person and gave them a cuddle and kissed them fondly on the cheek. This person relaxed straight away.

Outside of these observations, we did see staff to be thoughtful and kind towards the people they supported. For example, we walked past one person's room and saw a member of staff sitting with this person holding their hand. We saw some staff being gentle and thoughtful when they supported people eat their lunch.

Despite what we found people spoke positively about the staff. One person said, "I like living here, they [staff] are kind, they look after me." Another person said, "They [staff] are wonderful, they [staff] are very kind

to me." A third person said, "This really feels like my home because of the lovely carers."

We saw staff supporting some people to walk about the home. One person told us how staff supported them to remain independent with their personal care needs. However, we observed a member of staff not promoting a person's independence when they were supporting them to eat.

The staff we spoke with told us how they promoted people's dignity and their privacy when they supported people with their personal care tasks.

People's relatives told us how they were encouraged to visit their relatives and to visit the home. One person's relative said, "They [staff] are welcoming when we visit the home, they [staff] are inclusive."

We concluded that although there were some positive examples of staff being kind and respectful to people, there were also examples when this was clearly not the case. People were not being consistently treated in a respectful and caring way, which valued them as people.

Inadequate

Is the service responsive?

Our findings

During our comprehensive inspection in February 2017 we found that the service responded to people's needs. When we inspected in January 2018 we did not look at this area. During this inspection we found that the service failed to provide responsive, personalised care and the service provided was inadequate.

We commenced this inspection at 06:00 am due to receiving concerns that people were being supported to get up in the early hours of the morning. When we visited we found eight people were up, some of these people were fast asleep in their chairs in the reception areas of the home. One person was fast asleep in their clothes in their bed. Two people were partially dressed in bed wearing clothing on the top part of their bodies only. One person said they were got up early by the night staff.

When we walked around the home from 06:00am we noted that the main lights were on in the corridors. Most people had their doors wide open, which had also been propped open. Staff on duty were making lots of noise. One person's door was wide open, their bed was near the door, just outside were two swing fire doors. We saw three members of staff individually walk through these doors in a space of 30 minutes. Two, out of the three members of staff, let these swing doors shut which made a loud banging noise. One member of staff closed them gently. All these members of staff should have closed these doors gently. We asked a member of staff about a person who was asleep with their door open and an armchair pushed against their bed. This member of staff went into their room turned their main light on and started to lower this person's bed. This person was fast asleep, we asked the member of staff to leave the room and turn the light out. They said to us, "Oh sorry." Staff were not valuing the home as people's own home and own personal space.

We concluded that it would have been difficult to sleep in this atmosphere, even though it was still dark outside. The deputy manager told us that the person asleep in bed in day clothes, (a jumper and trousers) had experienced an episode of incontinence in the early hours of the morning, so that's why staff had changed this person into their day clothes. We needed to explain this was not acceptable, and that this was institutionalised practice. They agreed. Many of the people at the home were living with dementia and needed support with orientation of the time of day. We believe these practices were for the benefit of the staff not the people living at the home. It made their work easier for them, it did not put people first.

We spoke with the registered manager and the deputy managers about the practices we had found. They advised us that some people like to get up at 05:00am to start their day. We looked at the care records and assessments of a sample of the people who were seen to be up early. None of the records described this as their preference, or provided an explanation as to why a person may want to do this. One person said that they liked to get up early, their assessment and care plan also did not explore this.

We then looked at the daily notes for people. The night staff had recorded that they had supported these people to get up, but the times given were much later, about 07:30 am. The registered manager said that this time was the time people notes were being written on the home's electronic system. However, this still showed that people were getting up before 07:00 am for staff to be able to complete their notes before they

finished their shift. There was no recording if staff had encouraged people to remain in bed a while longer, or that they had explained to them it was early. There was no thought given that people may not want to get up and then straight away get washed and dressed. The registered manager agreed staff should be evidencing these conversations. Given what we saw we believed that these conversations were not taking place and these options were not being explored with people.

We saw numerous examples of people not being respected as individuals. We visited people in their bedrooms and we found some of these rooms were personalised, however some were not. One person had a note on an A4 size of paper on their en-suite door reminding staff to take their dirty laundry away. We saw incontinence pads left on people's bedside tables with their room numbers written on them in black biro. One person had a plastic folder holder on their wall, containing information about the service. A member of staff had put two new incontinence products in this holder. People had quantities of prescribed creams stored in obvious places in their room. One person wore a catheter, we noted a new catheter bag was placed on their bedside table, they had boxes of these items on display on their desk under their window. In the main bathroom there was a poster showing what the different types of faecal stools looked like. We entered the lounge in the afternoon and several people were sitting in a circle, a large group of staff were conducting handover in this lounge, rather than a private office space. One member of staff left as we entered this room and said in a loud voice, "I'll do the turns now." This related to repositioning people who were in bed. These are all examples of non-personalised practices. The management and staff were not consistently supporting people in a person-centred way and respecting and promoting the service as their home

During the inspection we looked at people's care assessments. These identified some elements of people's interests and backgrounds, but these were basic. People's assessments did not explore people's backgrounds, achievements or interests in a meaningful way. The purpose of this would be to get to know people and ensure the service met their social needs. For example, one person who was living with advanced dementia, was described as an artist, there was no plan in place to see if this person would engage in some way, with this lifelong interest. Another person had been a boxer, the service was not supporting this interest. Two people had not been born in the UK, no consideration was given about how the service could explore or meet these people's cultural backgrounds.

People had end of life plans in place. However, these were not in detail. In people's assessments it mentioned if they held religious views or belonged to a denomination of the Christian faith. This information was not explored in their end of life plans to say what the person's spiritual needs were and how they wanted these needs met. Other information was also missing and not explored in terms of what support people wanted when they were dying. When we raised this with the registered manager and deputy managers they said they had this information. They showed us a person's care plan who had recently passed away. We needed to point out to them that this information was still missing. It had stated that this person had been given ice cream, we asked the member of staff what flavour was it, they said, "Vanilla" we asked what was this person's favourite flavour of ice cream, they said they did not know. One person was at end of life when we inspected the home. Their plan lacked personal information. Even though this person had lived at the home for a long time and had a relative who was involved in their life, a meaningful end of life plan had not been created. The management team were not ensuring that this planning reflected people's needs and wishes. They were not checking that this was taking place.

The above issues constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we saw examples of activities taking place in the morning and in the afternoon. We

noted that there were two activity co-ordinators working on the first day we inspected the home. In both activity sessions we observed people really engaging with the activities provided. People appeared to be enjoying the activities. We were told about trips that had taken place and events held at the home. One person told us, "We had a lovely fete. I went in the garden every day this summer." Another person told us that, "There is always something to do, jigsaws, puzzles. There is a club I like, we sit and chat." However, these activity co-ordinators did not work on Sundays and only one worked on a Saturday this meant that activities were not available to people every day.

Apart from the planned activities we did not see staff having a social chat with people, apart from in one dining room at lunch time. One person had asked many different members of staff what was happening that day, they each said they did not know. No staff took the opportunity to use this as a chance to chat with this person or ask them what they wanted to do. Later, a group of people were supported to go into one of the lounges. The activity co-ordinator was present. People were told, that they had to wait for the rest of the people to come to the lounge. The same person was still asking staff what was happening. People sat in silence or watched two members of staff talking with one another, waiting for the activity to begin. We provided feedback to the registered manager that something could have been arranged to engage with people at this time, especially the person who was so eager to be doing something. The registered manager agreed with us.

There was a complaints process in place. There had not been many complaints made this year. We looked at the most recent complaint. We could see this was thoroughly investigated. The relative making the complaint was met with and they were written to. Robust actions were taken from this complaint to correct the issues raised.

Inadequate

Is the service well-led?

Our findings

During our comprehensive inspection in February 2017 and found that the service was well led. We completed a focussed inspection in January 2018 after concerns were raised and found areas in the leadership of the service which required improvements to be made. During this inspection we found improvements had not been made and the leadership and management of the home was inadequate.

There were multiple breaches of the Health and Social Care Act 2008 identified at this inspection. We therefore concluded that people were not receiving a safe, effective, caring service that was responsive to their needs, because the management oversight of the service was not adequate.

The management team had failed to address the issue of staff getting people up early and dressing people in their day clothes in the early hours when people had had experienced an episode of incontinence. Despite concerns previously raised in June 2018, which were shared with the registered manager by the local authority and the CQC, the leadership of the service was not robustly monitoring the practice of night staff. The registered manager agreed that their early morning quality checks of 04:00 am were too early to identify this poor practice. A deputy manager was aware that some people were up at 03:00am and 04:00am but had not investigated or reported this. Despite concerns previously raised in June 2018, which were shared with the registered manager by the local authority and the CQC, the leadership of the service was not robustly monitoring the practice of the night staff. Some action had been taken by the leadership of the home, but this was not effective, as this poor practice was still taking place.

Quality monitoring systems were not effective. We identified issues with staff knowledge and practice in relation to preventing people from choking, and following professional guidance to keep people safe and preventing people from becoming unwell.

We identified issues with the administration of people's medicines and the storage and administration of people's prescribed creams. Although, the monthly medication audit was not due to be completed when we inspected the home, this questioned how effective staff practice was in this area, and whether previous audits had robustly dealt with practice issues. The medication audits had not identified and resolved the issue of the management and storage of people's prescribed creams.

During our inspection we identified shortfalls in people's care assessments and care plans. These were not person-centred documents. We found some people's relatives were potentially making decisions on their behalf without the legal powers to do so. One person's DoLS authorisation was not being met. Two people had received considerably less fluids than they ought to have had. One person's sudden weight loss had not been referred to a professional to investigate. People's care records were not being audited to check they were complete documents and to ensure issues were being identified and addressed appropriately. People's records were being completed after the event, even though staff showed us that they could complete people's electronic records using hand held devices at the time events occurred.

Systems to respond to accidents and incidents were not being well managed. When a person had

experienced a head injury, this event had not been analysed after the event to see if other action was needed, or if lessons could be learnt for another time. Systems to check that people's hoists were working and call bells in reach were not effective. People's dining experiences were not being reviewed or checked.

Certain practices were not person centred, for example how staff displayed people's continence products in people's rooms. One lounge had a strong smell of urine to it. We saw people sitting in that room watching TV on the first day of our inspection. Although, the following day this carpet was being replaced, the service had not considered the issue, that people still had to be about this smell. There was another lounge on the same floor which was not being used. This had not been considered as an alternative. We identified institutionalised practices in addition to the practices of the night staff which the services audits had not identified and addressed.

When we raised issues the management of the service made plans to address these issues. In relation to staff getting people up early a memo was sent to all night staff, and a meeting arranged. When we found that a person was not having their thickener agent a guidance sheet was created for staff to follow. When we found issues with how call bells, hoists, and the competency of staff were being managed, new forms were created. This was positive and showed that the leadership wanted to improve. However, often the actions taken were not robust enough to really resolve the problem. The fact we were identifying issues showed that the provider's systems to monitor the quality of the service were not robust, as these checks and audits should have identified the issues which we found.

The above issues constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager in place. The registered manager was aware of all the important events that they must notify us about by law.

Despite the issues we found about the leadership of the home people spoke positively about the registered manager. One person said, "I know the manager, [manager] is ever so friendly." A person's relative told us that, "I know the manager, [manager] has an open-door policy."

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 The provider had not ensured that the care and support people received meet their needs and reflect their preferences. Regulation 9 (1) (a) (b) (c) (3) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent was not always being obtained in line with the MCA 2005. Regulation 11 (1) and (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that care and treatment was provided in a safe way. Regulation 12 (1) and (2) (b) (c) (e) (g) (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had not ensured that people's fluid and nutritional needs were always being met and monitored.

Regulation 14 (1) (2) (4) (a) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were inadequate systems with ineffective leadership to ensure compliance with the legal requirements. Regulation 17 (1) and (2) (a) (b) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured staff were competent, suitably qualified and skilled to complete their work. Regulation 18 (1) (2) (a).