RYSA Limited

The Sheridan Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This comprehensive, unannounced inspection took place on 17, 18 and 19 August 2015.

The Sheridan Care Home is a dementia specialist care home without nursing for up to 30 older people living with dementia. There were 11 people living at the home during our inspection.

There was a registered manager in post, as required by the home's conditions of registration. The registered manager is also the representative of the registered provider. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had appointed a home manager in June 2015 and they plan to register as the manager.

After 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

Summary of findings

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 have imposed a condition on the provider's registration. This means further people cannot move into the home without our agreement.

At this inspection we identified repeated breaches and five new breaches of the Regulations.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

During this inspection we raised safeguarding alerts with the local authority who are responsible for investigating any allegations of abuse. This was because of our concerns about the safety of some people living at the home. This was in relation to an unidentified person staying at the home, fire safety, some people's weight loss and the lack of staffs' knowledge about the medical emergency procedures for one person.

People were not kept safe at the home. An unidentified person had been staying at the home without full information as to their identity. This placed people living at the home at risk. This was a new breach of the regulations.

Risks to people were not fully assessed and management plans were not always in place to minimise these risks. This was repeated breach of the regulations. For example, some staff were not aware that one person had epilepsy and the plans in place did not describe the person's seizures.

People's care plans were not updated or did not include all the information staff needed to be able to care for people or staff did not always deliver the care. People did not always receive the care they needed. Their health care needs were not always met because the healthcare support they needed was not delivered. People who were living with dementia, needed support to move, were at risk of falling, had vulnerable skin and or had lost weight were particularly at risk. These were repeated breaches of the regulations.

Medicines were not managed safely because some medicines were being administered without consultation with a pharmacist, some creams were not correctly labelled and some people did not have plans for their as needed medicines. This was a repeated breach of the regulations. The stock management for medicines had improved.

Staff did not know enough about people as individuals to be able to provide personalised care.

People's mealtime experiences were varied. Some people were supported sensitively whilst others were not given the support they needed to eat. People did not all receive the fortified fluids and food they needed to increase or maintain their weight. This was a new breach of the regulations.

The service was not fully meeting the requirements of the Mental Capacity Act 2005. Staff were not fully aware of the principles of the Mental Capacity Act 2005, making best interest decisions. They did not know which people were being deprived of their liberty and who 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.

Other risks to people in the home were not managed. Fire and emergency systems were not safe and rooms with hazards in them were left unlocked. The registered provider took action to address these shortfalls during the inspection. Other environmental hazards had also not been addressed. This was a new breach of the regulations.

Most staff did not have the knowledge, experience or communication skills to be able to understand and communicate effectively with people who were living with dementia. Staff were not confident in how to safely move people. This was a repeated breach of the regulations.

Summary of findings

Records about people were not accurate, some were not dated or named or stored securely. This was a repeated breach of the regulations.

The home's rating was displayed in the main foyer of the home but it was not displayed on the home or landing page of the website for the home. The information not being displayed on the homepage of the website was a new breach of the regulations.

The registered manager/provider had not notified us about the safeguarding allegations and all of the people who had been deprived of their liberty. This was a new breach of the regulations.

The home was still not well-led and the management culture was not open and transparent. The registered manager/provider 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 registered manager/provider.

Staff knew how to report any allegations of abuse but the policy needed to be updated.

Staff were recruited safely and following the increase of staff during the inspection there were enough staff on duty during the day to meet the needs of people. However, there was not any way of assessing staffing levels to meet people's needs. Staff told us they were well supported and had one to one support meetings with the home manager.

People and relatives spoke highly of the caring qualities of the staff. Overall, we saw that staff treated people kindly. However, staff did not always respect people's privacy and dignity and promote their independence.

There were activities provided for people to participate in should they wish.

Relatives knew how to make a complaint and complaints were investigated. However, it was not clear how learning from complaints was shared with staff.

Staff and relatives meetings were held. Staff and relatives had an opportunity to be consulted and involved in the home.

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.

Summary of findings

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 

People were still not kept safe at the home.

Risks to people were not managed to make sure they received the correct care they needed. Other risks in the building were not managed or addressed.

The management and administration of medicines was not consistently safe.

Staff were recruited safely.

Staff knew how to report any allegations of abuse.

Is the service effective?

Inadequate 

People's needs were still not met effectively.

Staff did not have the right skills and knowledge, training and support to meet people's needs.

Appropriate arrangements were not in place to obtain people's consent or, if they were unable to give consent to particular aspects of their care, make decisions on their behalf in line with the Mental Capacity Act 2005. Some people were unlawfully deprived of their liberty.

Some people did not receive the food and drinks they needed to make sure their nutritional needs were met.

Some people did not receive appropriate support to meet their health care needs to ensure that they kept well. Most people were referred to specialist healthcare professionals when needed.

Is the service caring?

Requires improvement 

The service was caring but need some improvement. This was because staff did not always respect some people's dignity, privacy or promote their independence.

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?

Requires improvement 

The service was still not responsive to people and their needs.

People did not always receive the care they needed, their care plans were not always updated and did not include sufficient information about their care and support needs. This meant staff did not have up to date information about how to care for people.

Information about complaints was displayed and people knew how to make a complaint.

Summary of findings

Is the service well-led?

The home was still not well-led.

There were ineffective systems in place to monitor the quality of the service and drive forward improvements.

Staff and relatives were consulted about the service.

Inadequate

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 17, 18 and 19 August 2015 and was unannounced. Two inspectors and an expert by experience attended on the first day, with two inspectors on the following days. An expert by experience is a person who has personal experience of using services or caring for someone who lives with dementia.

Before the inspection we reviewed the information we held about the home, including notifications of incidents since our last inspection in February and March 2015. We also spoke with the local authority contract monitoring and safeguarding teams. Owing to our ongoing action in relation to the provider we did not request a Provider Information Return (PIR). 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 10 of the 11 people living at the home and also spoke with two visiting relatives. 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 also spoke with a visiting GP and district nurse.

We spoke with four staff, the home manager, a representative of the management consultants and the registered manager/provider.

We looked at six people's care and support records and care monitoring records, all 11 people's medication administration records and documents about how the service was managed. These included staffing records, audits, meeting minutes, maintenance records and quality assurance records.

Following the inspection, the registered manager sent us information we asked for about policies and procedures, staff rotas, and staff training.

Inadequate

Is the service safe?

Our findings

People were still not kept safe.

An unidentified person not connected with the home had been allowed to stay there without consideration of the risk that someone unknown could pose to people. An unoccupied room contained clothes, used sheets, toiletries, razors and other personal effects. The home manager told us someone had been staying there for a couple of days but was unable to tell us the person's name and had no personal information about them. They said the person was a new staff member from another home. The registered manager later confirmed this, but could not recall the person's last name and had no details about them on site. They went to get details from the person's recruitment file, including a record of the person's Disclosure and Barring Service (DBS) clearance, from the home the person worked at. The registered manager told us he understood our concerns about an unidentified person staying at the home and potentially having unsupervised contact with people.

A visiting health care professional told us this was the first time they had visited the home. They had been let in without being asked to show their identity card. Even though a health care professional had been expected, there was a risk that an unauthorised person could have been allowed to enter the premises.

The failure to check people entering or staying on the premises was a breach of Regulation 13(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 was a cholesterol-lowering medicine in the blister pack supplied by the person's pharmacy. 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. People's MAR for creams and gels were sometimes incorrectly written so that they did not have pain relief gel or moisturising cream as often as prescribed. 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 this inspection we found again that there were no instructions from a pharmacist for the covert administration of a person's medicines. The registered and home manager took immediate action to address this and sought guidance on how the medicines should be administered from the pharmacist. The registered provider 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.

A person had an almost full container of cream that had not been labelled with the date it was opened. The expiry date was illegible. This meant we could not be sure the cream was being used within its use by date. 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.

Inadequate

Is the service safe?

These matters relating to medicines are repeated breaches of Regulation 12(1) and 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home manager had ensured all excess stocks of medicines and creams had been returned to the pharmacist. Overall, there was an improved medicines stock management system in place.

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 this inspection, we found that risks to individuals and to the service were still not managed to fully protect people.

One person had a care plan for their epilepsy. They had not had any seizures since moving into the home. The seizure care plan included that the paramedics should be called if the person had a 'grand mal seizure'. However, there was not any description of what a 'grand mal seizure' was. This meant that staff did not have full information as to when they needed to call the emergency services. Some staff were not aware this person had epilepsy. The plan included the person was to be checked every hour. However, records showed they were only checked every two hours when they were in their bedroom. The lack of staff awareness about the person's epilepsy, lack of information and the person not being checked hourly placed them at risk of not receiving the correct care and support when they had a seizure. We fed back our serious concerns to the home and registered manager about these shortfalls. The home manager showed us an updated plan on the final day of the inspection.

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

Fire risks were not managed safely. Smoke detectors had been deactivated in two vacant unlocked rooms, one of which was in the process of redecoration. The home manager told us this had happened while the rooms were being painted. However, there were no decorators on site during the inspection, and no-one had taken action to make the detectors work again. The home manager took immediate action when we identified the smoke detectors were covered and uncovered them. Additionally, fire records that would be passed to the fire brigade if they attended in an emergency, contained details of people who no longer lived at the home. Similarly, the provider's emergency folder contained out of date details regarding which people lived in the home. We drew this to the registered manager's and home manager's attention and they updated the fire records. Furthermore, we were not asked to sign in and out of the home during the three days of the inspection. Similarly, a person who had been staying at the home (but not using the service provided) had not signed in or out. There was a risk that in the event of an emergency staff would not know who was on the premises and that fire fighters might be placed at risk by searching for people who were not there. We referred these matters to the local fire and rescue service.

Vacant and unused rooms were not all kept locked and some contained hazards that could pose a risk to people if they were to enter unsupervised. This was likely because people were living with dementia and some of them were independently mobile. One such room that was in the process of being redecorated contained paint and other hazardous chemicals, as well as a pile of furniture. Another unlocked room contained razors and a box of matches. We drew this to the provider's attention and the rooms were locked.

Other environmental hazards had not been addressed. There was exposed electrical wiring in a person's room. We drew this matter to the home manager's attention. Over the back stairs, which are used by staff rather than people, a ceiling rose had slipped and exposed some electrical wiring. Outside there was a trailing electrical or aerial cable that could pose a risk to people if they used the garden. Although many wardrobes were secure, in some rooms

Is the service safe?

these had not been fixed to the walls and there was a risk they could be pulled over. A window was unrestricted upstairs, with a risk that people might fall from it, although it was not in a communal area. Some windows downstairs were also unrestricted and opened widely, posing a risk to the security of the premises. We drew the exposed electrical wiring in the person's room, the unsecured wardrobes and unrestricted windows to the home manager's attention. A maintenance person attended at the end of the inspection to fit restrictors to the downstairs windows.

The downstairs bath lift hoist had a sticker showing it had been serviced in November 2014 and that it next required servicing by June 2015 to ensure it remained safe for use. At the inspection, the registered manager was unable to show us confirmation from the contractor that this had been undertaken. The registered manager said they would arrange for the bath lift to be serviced. Following the inspection, they advised us that the lift had been serviced but that the contractor had not applied an updated sticker.

Other hoists in use at the home had been serviced within the past six months, as required by health and safety regulations. People who needed hoisting had their own slings labelled for them in their rooms. Care plans specified which sling should be used for which purpose.

Weighing scales had been brought in from another nearby home a few weeks beforehand as home's own scales were not working. The scales would have required recalibration after being transferred, to ensure that people's weights were measured accurately, but no contractor had been commissioned to attend to this.

Bags of open dried food stuffs were stored directly on the floor in one of the ground floor cupboards. Food standards guidance includes that dried goods should be stored correctly e.g. in a suitable room, off the floor, and in covered containers.

These shortfalls relating to the safety of the premises and equipment were breaches of Regulation 12(1) and 12(2)(d) and (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the staffing rotas and staff signing in records for the week prior to the inspection. There were three staff on duty during the day and two staff at night. There were five of the 11 people who needed two staff to safely move them with equipment and two people were 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 10 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.

The home manager confirmed that additional staff had been called in during the first day of inspection and extra staff were on duty the second day of inspection. Staff told us there were enough staff to meet people's needs. However, this contradicted what we observed on the first day of inspection. Staff were hurried and people were not supported when they needed assistance. For example, one person was repeatedly calling out from their bedroom in the morning and staff were not available to respond. In contrast, people received care quickly and promptly on the second and third day of the inspection when there were more staff on duty. The home manager told us the increased staffing levels would be maintained but we have not been able to see whether this has been sustained.

There was not any formal way of assessing people's dependency to ensure they were enough staff on duty to meet their needs and this was an area for improvement.

We looked at five staff recruitment records and spoke with two members of staff about their recruitment. The regulations require staff recruitment records to contain a full employment, with a satisfactory written explanation of any gaps. One staff member's file did not contain information about their employment prior to 2003 or written explanation of all gaps. The staff member concerned was able to explain the gaps. Following the inspection, the home manager provided us with written about the employment history and gaps, which they confirmed had been included on the staff file. Other staff files contained the required information.

Care staff were recruited through an agency that undertook pre-employment checks and their records included up to date criminal record checks, fitness to work questionnaires, proof of identity and right to work in the United Kingdom and references from appropriate sources, such as current or most recent employers.

English was not the care staff's first language and one member of staff had difficulty understanding us and locked us outside when we had specifically asked them not to.

Inadequate

Is the service safe?

They had difficulty understanding some of our questions about people and their care needs. This staff member had recently started receiving lessons in English arranged by the registered manager. Other staff were able to communicate with us more easily. Relatives told us that some staff understood them better than others. We were told by the home manager that all staff whose first language was not English would now be able to access English lessons so they could communicate with and understand people's needs better.

Contact details of the local authority safeguarding team were displayed in people's bedrooms in the event people, their families or staff might wish to raise concerns about people's safety. Staff we spoke with were aware of how to raise concerns with their management and with outside agencies such as the Commission or the local authority safeguarding team. However, the safeguarding policy made reference to and gave the contact details of the Independent Safeguarding Authority (ISA) which ceased to exist in December 2012. The policy also made reference to the previous CQC Guidance for Compliance that was replaced in October 2014. This meant the safeguarding policy was not up to date and did not include all of the correct information for staff.

Inadequate

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 this inspection, 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. This included the home manager, who had been at the home seven weeks, who was not able to tell us who was subject to DOLS.

For most people whose records we looked at, capacity assessments had been completed so specific decisions could be made in people's best interests. However, this was not consistent and some decisions had not been in accordance with the Mental Capacity Act 2005. For example, one person had bed rails in place. There was no mental capacity assessment or best interest decision recorded anywhere in the person's care records about using bed rails.

For another person, the registered manager had completed a DNACPR (Do not attempt CPR) decision form for signature by the GP, without a mental capacity assessment or best interest decision to support why the registered manager was completing this documentation instead of the GP. A third person had a best interest decision recorded about the use of a bed sensor to alert staff when they got out of bed. However, the mental capacity assessment was completed but not dated so not possible to be sure when it had been undertaken. There was no supporting mental capacity assessment or best interest decision to support why the registered manager was completing this documentation instead of the GP.

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.

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 included they must be have regular opportunities to leave the home supervised by staff. Another person had very specific conditions that included providing updates to the local authority and reviewing the person's care plan with their representative. The registered and home manager were not aware of these conditions. They 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 this inspection staff did not receive adequate training to enable them to fulfil their roles effectively. Staff completed some core training, for example, medication, infection control, moving and handling, fire safety, health and safety and food hygiene. The registered manager sent us the training overview record but this did not include one of the staff members who worked at the home. The home is a specialist dementia care home and the training overview record showed care staff had received dementia training.

Inadequate

Is the service effective?

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 training overview record included that the seven staff were completing the care certificate, which is a nationally recognised induction qualification. However, it was not evident who was assessing the staff completing the care certificate. Some staff we spoke with were not aware of the care certificate and if they were undertaking the qualification. One staff member told us this had not been offered to them. We saw in staff records that one member of staff had completed one standard of the care certificate workbook.

We asked for a training plan but this had not yet been developed. A health professional from the in-reach team (specialist dementia support team for care homes) told us the home manager had recently asked for some training. They also told us the service had been slow to take up advice and the home manager had been prompted to seek advice by another visiting professional.

Staff had been provided with moving and handling training. However, two staff identified they needed more training in safely moving people. One staff member told us they were not sure what equipment to use for one person whose mobility was variable.

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.

The most recently recruited care staff told us they were recruited through an agency and on their arrival into the United Kingdom they completed a week induction programme before starting work at the home.

Staff told us they felt supported by the registered and home manager. Staff had attended a one to one support meeting with the home manager.

People's mealtime experiences were varied. Some people were supported in a sensitive and encouraging way by some staff. For example, one person was gently encouraged to eat by the home manager offering to sit with them and eat their lunch at the same time. The home manager sat and chatted with this person and they ate well. However, this support was not consistent. On the first day of the inspection some staff did not explain to people what they were eating, give them choices of food and drinks and they did not give people the opportunity to sit at a table for their meal.

One person was given a meal of meat, mash, diced vegetables and sprouts that they ate with their fingers. Staff did not sit with the person and offer them any cutlery to eat with or prompt them to eat. Their meal went cold over a period of 45 minutes and staff did not offer to reheat the meal or check with the person whether they were happy to eat cold food. This person's care plan included, 'make sure the food is not too hot or does not go cold'. Staff later told us this person would use a spoon if it was placed in their hand. This was supported by their care plan that detailed they needed their food chopped up and if they were struggling with a knife and fork they would use a spoon or their fingers. This person had been identified as at risk in relation to their eating and drinking. They had lost 6.6kg over the previous six months and had seen the GP relation to this weight loss.

Following the inspection, we received feedback from the local authority that this person's relatives had continued to raise concerns with the staff at the home about the types of food the person was given. This was because they were not given foods they could eat with a spoon or with their fingers in a dignified way.

The staff member who was cooking was not aware that this person's food needed fortifying as detailed in their care plan. This is where additional creams, milk powder and cheese are added to people's foods to increase their weight. This person did not receive the support they needed to maintain their nutritional intake.

On the second day of inspection another person told staff they didn't feel well and didn't want the main meal. The registered manager offered the person alternatives and gently encouraged them to try a sandwich. They sat with them for short time chatting with them and encouraging them to eat. The registered manager left the person as they were eating. However, shortly after the person stopped eating their sandwich and another member of staff asked the person whether they had finished and took their sandwiches away. The registered manager returned and questioned where the person's sandwiches had gone. The person said they would eat some more when the registered manager asked them and subsequently ate the fresh

sandwiches that were made. This showed us that if the person had been supported by the same staff member throughout their meal they would have been more likely to eat it.

A third person had been identified as being nutritionally at risk. Their eating and drinking care plan detailed they should be weighed weekly but this had not happened. This meant staff were not monitoring this person's weight so they could identify whether they were gaining or losing weight and whether they needed to take further action.

The staff member cooking told us they were fortifying one person's meals. However, the care plans for two other people we looked at detailed they also needed their food fortifying. The staff told there were no other people on specialist diets apart from one person who was vegetarian and this was the person whose meals they were fortifying. We looked at this person's records and saw they had only eaten mashed potatoes, vegetables and cheese over a period of week for their main meal. The records did not include what additional fortification if any had been added to the person's drinks and food. In addition the records did not show whether the person was receiving their prescribed nutritional drinks twice a day. This meant we could not be sure they had received the fortified foods and drinks as detailed in their plan to make sure they maintained or gained weight.

People were not offered any condiments with their meals so they could adjust the taste of their food to their liking.

Staff offered people regular snacks of fruit and biscuits throughout the day. There was also a tray of fresh fruit pieces and snacks for people to help themselves to food when they wanted it. However, this was placed on a high shelf that was not visible when people were sat down and the access to the tray was blocked by walking frames during the inspection. This meant those people who walked about the home and used more energy did not have easy access to additional food and drinks to maintain their weight.

At our previous inspections we identified concerns with the variety of food offered to people who had specialist diets. At this inspection one person was vegetarian and we reviewed their food records for one week and as previously identified they only ate potatoes, vegetables and cheese for their main meal.

These shortfalls in meeting people's nutritional and hydration needs and providing the support they needed were a breach in Regulation 14 (1) (a)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's mealtime experience was much more positive on the second day of inspection and people were given the opportunity to sit at the dining room table if they wanted to. People ate better with the additional staff support and there was a relaxed atmosphere during the mealtime.

Coloured crockery was used throughout the home. 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.

One person had their drinks thickened during the inspection and staff were aware of how to thicken this person's drinks as detailed in their safe swallow plans written by their speech and language therapists (SALT).

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.

Where people's skin was vulnerable people were sat on pressure cushions as detailed in their care plan. People who were cared for in bed on air mattresses had these checked daily to see if they were working. However, as previously identified at our inspection in February and March 2015 records did not detail what the setting or the person's weight was so staff could check people were being cared for on a mattress at the correct setting for their weight. This potentially placed them at increased risk of developing pressure areas.

The home manager told us on the first day of inspection that no-one had any pressure damage or sores to their skin. They told us one person had a skin tear that the district nurses had seen. This person had a body map completed in July 2015 and updated on 14 August 2015 that showed they had a pressure sore on their heel. The record included the wound had been dressed by the district nurse and they advised keep the person's heel lifted. However, this detail was not included in the person's care plan. Staff were not aware of the person's pressure

sore and they had not been given clear instructions as to how they should care for this person's pressure areas. This placed them at risk of not receiving the appropriate care they needed.

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 verbalise if 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.

The home manager and records showed that one person had fallen during the night and sustained a head injury. The staff on duty had not sought 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 was 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.

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.

We spoke with a visiting GP who told us the staff now sought medical attention appropriately and that this had improved over recent months.

Requires improvement

Is the service caring?

Our findings

People's independence was not actively promoted. For example, we did not see people being involved in activities of daily living such as making drinks, laying tables or helping with other tasks around the home.

Staff were not able to tell us about people's histories and personal preferences. They were knowledgeable about their care needs but not of the importance of needing to know information about people as individuals.

Staff did not ask one person whether it was ok if a member of the inspection team stayed in the bedroom whilst they received personal care. Although staff were caring and spoke kindly with the person this did not respect the person's privacy.

People's confidentiality not always respected. During inspection, we observed the registered manager in the lounge discussing people's histories and personal information on the telephone.

These shortfalls in promoting people's independence, knowing people as individuals and maintaining people's privacy and dignity were an area for improvement.

People and relatives were positive about the care provided by the staff. Comments from people who were asked about the kindness of staff and if they were happy included, "Very much so, Very, very good", "Oh they're kind enough, no complaints" and "I like living here". Two relatives told us, "Staff are very sweet with her and caring with her. Other family members also tell us this".

During the inspection people, who were able to walk independently, moved freely about the ground floor. Most people spent their time in the communal areas and there was a relaxed atmosphere. People interacted with each other and staff. When people were unsettled staff quickly responded and reassured people. For example, one person was upset because they thought another person had their glasses on even though they were wearing theirs. The staff member reassured the person and fetched their spare pair of glasses to show the other person had not got them on.

Staff spoke positively and with fondness about the people they cared for. The smiled when they spoke with people and people responded to this. One person a nick name for one of the staff and people and the staff laughed and joked about this.

On the second and third day of inspection the staff were less rushed and we saw more warm and positive interactions from the staff.

Staff provided privacy screens for one person in the lounge when a heath care professional visited.

Two relatives told us they were free to visit whenever they wanted and that they were always made welcome by staff.

Requires improvement

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.

People had care plans in place to direct staff but not all of these plans reflected people's current needs. The home manager told us they were in the process of reviewing people's assessments and care plans. Some staff were not fully aware of people's needs or the directions in their care plans and then subsequently did not provide the care or support needed to people.

A member of staff told us they were not confident moving one person safely because they leant forward. The staff member told us because they found it so difficult to support this person at times they left them sitting in their hoist sling in the mornings. This practice could cause pressure areas or skin damage if the person was left sat in the sling. However, during the inspection we did not observe this practice.

Another member of staff told us they were also not confident moving this person and one other person. The second person had been visited by an Occupational Therapist (OT) on 27 July 2015. The OT told us staff were still using a piece of equipment they had been advised not to use in May 2015. In addition the person's moving and handling care plan had not been updated to reflect the guidance previously given. The home manager told us they were planning to update the care plan but had not yet done this. However, this placed the person at risk because staff did not have the correct direction and information to be able to move the person safely.

One person was accommodated in a double room and the person they had previously shared with had moved out. In the bathroom there were two toothbrushes in different pots in the bathroom cabinet. It was not clearly identified which toothbrush belonged to person currently living there. There was a risk that person was being supported to brush their teeth using the wrong person's toothbrush. We drew this to the attention of the home manager, who arranged for the person to have a new toothbrush. However, a new toothbrush had not been provided by the second day of inspection. The staff had signed the care records to show they had supported the person with their oral hygiene that morning but this was unlikely because there was not a toothbrush or mouthwash in their bedroom. This person's care plan included they needed full assistance with brushing their teeth. The registered manager purchased a new toothbrush later that day.

Care 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. The home manager told us they had been working with people's families and representatives to record people's preferences and life histories but this was not yet complete.

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.

There was a monthly programme of activities displayed and this had been shared with people's relatives at a recent relatives meeting.

During the inspection people were given opportunities to be kept occupied and this was an improvement in comparison to previous inspections. Staff provided different activities for people in the main lounge. People participated in armchair exercises, had some tactile items to hold and feel, listened to music, played cards, read magazines, books and newspapers and played ball games. One person who was cared for in their bedroom had classical music playing. Their relatives told us there was always music of the person's choice playing when they visited and that the person appeared to react positively to the music. Another person cared for in bed had the television on which they could see at times when they were positioned in certain ways. Staff chatted and joked with this person when they were supporting them to eat and with personal care.

Requires improvement

Is the service responsive?

Complaints information was available in the main foyer of the home. The two relatives told us they were aware of how they could make a complaint. We reviewed the complaints received since the last inspection in February/March 2015. The home manager had investigated one complaint since they started working at the home in June 2015. The complaint had been acknowledged, investigated and actions taken to minimise the risk of reoccurrence. The recording and investigation of complaints had improved since the last inspection. However, it was not clear how the learning from complaints was shared with staff. This was an area for improvement.

Inadequate

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 would be completed by 31 March 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 this inspection we found there continued to be 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.

Following last inspection, the registered manager/provider had appointed a firm of management consultants to oversee and monitor the home. We spoke with a representative of the management consultants. They told us they had been visiting to monitor the home and identify areas for improvement for the new home manager to address. We asked for copies of and further information about these monitoring visits but were only provided with the audits the home manager had undertaken. However, audits by home manager and the feedback from the management consultants had not identified the shortcomings found at this inspection. Areas identified at the last 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. One audit identified all windows met regulations which contradicted our findings.

We requested the registered manager/provider send us the Quality Assurance policy. However, this was not provided following the inspection.

Following our last inspection the local authority service improvement team had been visiting regularly to provide support and guidance to the home. They recorded overall improvements at their last monitoring visit in July 2015. However, both they and the safeguarding team had continued to identify shortfalls and some areas for improvement.

There was not an open and transparent culture within the management team. The home manager told us they were attempting to improve the home and had applied to be the registered manager. However, they told us they had not seen notice of decision to impose the condition to restrict new admissions into the home. This notice of decision documentation included more detailed information about the concerns and shortfalls identified at last inspection. This meant they were unaware of these concerns and had not been able to act on them.

The registered manager/provider told us the home manager was not aware of the unidentified person who was staying in the home. We observed the registered manager/provider telling the home manager, "you don't know anything ok". However, the home manager had already told us earlier that they were aware of the person staying at the home. They told us they did not know the person's name and they had told the registered manager/provider the person could not stay at the home.

Following our last inspection in February/March 2015 we required that the registered manager/provider give us a monthly update. Following this inspection the registered provider sent us an action plan detailing they had addressed the shortfalls we identified during the inspection.

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.

From 1 April 2015 providers have to display the home's ratings. The home's rating was displayed in the main entrance of the home. However, this may not have been visible to all of the people who lived or visited the home because of its location. Providers also have to display the

rating on main or landing page of their website. 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 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 the next inspection in February and March 2015 records were still not maintained and this placed people at risk of unsafe or inappropriate care.

At this inspection, the care and health records for a person who had moved out of the home in May 2015 were in the bedroom shared with one other person. These records were not stored securely and were visible and accessible to other people and staff. In the ground floor toilet there was a sign on the wall that included the names of people who paid for their own pads. This included the names of people who were no longer living at the home. This information was private and should have been kept securely and not been displayed in a public area.

The registered and home manager told us there were two sets of care records for people. One set was a practice set and the others were the actual records. They told us this was so staff could practice their writing skills on the records kept in the cupboard in the main lounge and then the actual records were kept in the office. These were written by staff and the home manager supervised. We raised concerns about this practice as information was not consistently recorded about people. The registered and home manager informed us this practice would stop and only one set of records would be kept.

There were gaps in the recording of some people's care monitoring records and this meant we could not be sure they had received the care and support they needed. For example, one person's personal hygiene record had not been signed for two days the week of the inspection.

Some people's records were not named, dated and signed. This meant it could not be established who had completed the record, who they related to and when they were completed. For example, one person's mental capacity assessment was not signed or dated. Another person's bowel monitoring record and personal hygiene record was not named.

Some records were inaccurate. For example, one person's records, who was cared for in bed, included they had their cup of tea at 10.30 am but they had not had their drink at this time. We saw the care worker going into the person's bedroom at 10.36 am to give them their cup of tea. In addition their records later included the person was lying on their right side but they were lying on their back. This person was not able to reposition themselves.

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.

We have not received any 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.

Since the last inspection there were improvements in consulting with and involving people's representatives and staff.

The home manager had held a relatives meeting in August 2015 and distributed a questionnaire. The three responses received were positive and one included the comment, "I have always had my views acted upon". This was supported by the two relatives we spoke with who said they felt able to approach staff and managers with their concerns.

Two relatives said they had been kept up to date with the concerns identified at the last inspection by the registered and home manager.

Staff told us and we saw that staff meetings had been held. The home manager had introduced a new format and the minutes included the agenda, topics discussed and the agreed actions.

Staff told us the home manager listened to them and acted on any concerns they had. They gave an example of a wheel chair that needed repairing and this was quickly acted on.

Inadequate

Is the service well-led?

Staff were clear on the management structure in place at the home and who they reported anything to. The home manager told us they and the staff were keen to change, they were committed to the home, the people living there and making improvements needed.

Staff knew how to whistleblow and raise any concerns to both the provider and external organisations.

The home manager had developed accident and incident and analysis monitoring records to ensure that any patterns were identified so action could be taken. They had also implemented a system to ensure that any accidents were cross referenced and reported to the HSE (Health and Safety Executive) where appropriate.