Crystal Care Services Ltd

Inglewood Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Inglewood care 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.

Inglewood care home is a purpose-built care home in a residential area of Redcar and Cleveland. The service provides residential and nursing care and support for up to 48 older people, some of whom lived with dementia, Parkinson's disease or a physical health condition. Bedrooms and communal areas are provided over two floors. Each person has access to an en-suite bedroom and there are gardens to the rear of the service. There were 43 people using the service on the first and second day of the inspection and 39 people on the third day of the inspection.

A registered manager had not been in post since 29 September 2017. A manager was in post on the days of inspection and they had started their employment in November 2017. They had submitted an application to become a registered manager four days prior to the inspection. 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.'

Inglewood care home is an established care home, however was newly registered under Crystal Care Services Limited on 12 July 2017. Inglewood care home had been in breach of health and social care regulations since 2014. Although a new provider was in place, further concerns were identified at this inspection about the safety of people using the service.

At the last inspection on 4 April 2016, we found improvements were needed to the quality assurance of the service. We asked the provider to complete an action plan to show us the improvements they planned to make, including timeframes.

There were insufficient staff on duty to provide safe care and support to people. Staff were unable to meet people's needs. Health and safety checks of people were not regularly carried out when needed because staff did not have time. They had been incidents where people had hit other people. This meant people were at risk of harm from the behaviour of other people. The systems in place had not safeguarded people from harm. Care records were not routinely updated when incidents took place. Practices in place to ensure lessons were learned were not effective.

Staff understood the different types of abuse. However, staff did not recognise that their failure to manage the risks to people and keep them safe, placed people at increased risk of physical abuse, organisational abuse and neglect. Improvements to medicines were needed. There were gaps in records and medicines were not always available when people needed them. Infection prevention and control procedures were not followed.

People who needed an adapted diet because of their nutritional needs and swallowing risks did not receive the correct diet or hydration. Records did not clearly indicate the correct diet and fluids which people needed. Staff knowledge was poor. People with adapted diets did not have a choice of meal. Records of the food and drinks people had consumed were not up to date or reviewed to make sure people's intake was sufficient.

Staff were not supported with regular reviews during their induction. Supervision, appraisals and training were not up to date. People did have access to health and social care professionals, however guidance from them was not always followed or clearly presented in care records.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff worked in line with the Mental Capacity Act 2005. However, Mental Capacity Act assessments had been carried out instead of best interest decisions. People had routinely received vaccinations without best interest decisions being recorded. Staff knowledge about whether people had a current deprivation of liberty safeguard (DoLS) in place was poor.

Some updates to the environment had taken place which included a new boiler system and updated to some bedrooms and communal areas. However further improvements were needed. Flooring had lifted, paintwork and woodwork was scuffed. Relatives and staff struggled with wheelchairs because no ramp was in place to access the garden. The dining room on the first floor was too small to accommodate people. The environment did not support people living with dementia or sensory impairments.

Although staff failed to manage the risks to people and knowingly gave people the wrong food and fluids to eat, we did observe positive interactions between people and staff. Staff did not always have the knowledge needed to provide the most appropriate care to people, however we did observe staff seeking people's permission. Staff maintained eye contact when speaking to people and dignity was maintained when personal care took place. Outside of personal care, dignity was not always maintained. Staffing levels impacted upon this because staff did not have oversight of people. Care records did not show that people were actively involved in planning and reviewing their care. There was no evidence of people's voice in reviews.

Information in care records was not always accurate or up to date. These records were not always updated when incidents occurred or when people experienced changes in their health condition. Staff were not aware of the information contained in these records to be able to support people with care which reflected their needs, wishes and preferences. Some people were being supported with end of life care at the time of inspection. Staff were aware of peoples wishes and anticipatory medicines were in place. Training in end of life care was not up to date.

Mixed reviews were received in relation to activities. People and relatives knew how to make a complaint, and records showed they had been dealt with appropriately.

An ineffective auditing system was in place. Our findings were not in line with some of the audits carried out. Where action plans had been put in place, they had not been addressed. Action plans in place by other health professionals had not been addressed.

Staff told us they were able to approach the management team when they needed, and all spoke positively of them. The service had some links with the local community and worked alongside health and social care professionals. Notifications had not always been submitted without delay.

We found multiple breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to requirements relating to registered managers, dignity and respect, safe care and treatment, nutrition and hydration, the premises and equipment, good governance and staffing. We also identified a breach of the Care Quality Commission (Registration) Regulations 2009 for failing to submit notifications without delay.

You can see what action we told the provider to take at the back of the full version of the report.

This is the third consecutive time the service has been rated Requires Improvement."

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.

People were not protected from the risk of harm. Staff practices increased the risk of abuse to people.

Robust practices were not in place to manage behaviours which challenge. No analysis of accidents and incidents had taken place.

There were insufficient staff on duty and there was insufficient oversight of staff.

People did not receive medicines as prescribed. Infection prevention and control procedures needed to be improved.

Is the service effective?

Requires Improvement

The service was not effective.

People were not protected from the risks of malnutrition, dehydration and choking.

Best interest decisions had not always been carried out. Where decisions had been made, they had not always been recorded.

Supervision, appraisal & training was not up to date.

Many aspects of the environment needed to be repaired or updated.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was impacted because of inadequate staffing levels.

Staff were kind and caring in their approach with people, however staff were too busy to spend time with people.

People were not routinely involved in planning and reviewing their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff were not familiar with people's care records and their individual needs. Care records were not always legible.

Mixed reviews had been received about activities.

Complaints had been made and records were in place to show they had been addressed.

Staff were aware of people's wishes and medicines were in place for end of life care

Is the service well-led?

Requires Improvement

The service was not well-led.

Ineffective quality assurance procedures were in place.

Staff did not follow procedures for security and confidentiality.

Staff were not working together as a team and their practices put people at risk of harm and abuse.

There was a manager in place who started in November 2017 and submitted her application to register in July 2018. Notifications and safeguarding alerts were not submitted without delay.

Inglewood 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 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.

We carried out an unannounced inspection on 3, 9 and 11 July. Two adult social care inspectors attended on 3 July 2018 and one adult social care inspector attended on 9 and 11 July 2018.

Prior to inspection, concerns had been raised with the Commission in relation to medicines, cleanliness, staff practices, activities, nutrition and record keeping. We incorporated these concerns into our inspection plan and reviewed these areas during the inspection.

Before our inspection we reviewed all the information we held about the service. We examined the notifications received by the CQC. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescales. We also contacted Redcar and Cleveland local authority Commissioning team, Health Watch, South Tees Clinical Commissioning Group (CCG) and South Tees NHS infection prevention and control team. We used the information shared with us as part of our inspection planning.

We did not ask the provider to submit 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.

During the inspection We spoke with four relatives, one visitor and three people. We also spoke with the regional manager, manager, clinical lead, two nurses, six carers, two domestic members of staff, two chefs, one kitchen assistant and a volunteer.

We reviewed aspects of 18 people's care records, four recruitment and induction records, eight supervision and appraisal records, the training matrix for all staff and records related to the management of the service.

We carried out observations of practice during inspection in communal areas. We also visited people in their room with their permission. We carried out a short observational framework for inspection (SOFI). This method of observation is used to capture people's experiences who are not able to voice them.

Inadequate

Is the service safe?

Our findings

Robust procedures were not in place to ensure the safety of people using the service. Ten incidents of harm caused by people towards other people or staff had taken place between March and July 2018. No analysis of these incidents had been carried out to identify any patterns or trends in the people involved in those incidents, whether additional actions or training were needed and whether staff had followed the correct procedures when dealing with these incidents. Care plans and risk assessments had not been routinely updated when incidents took place. Safeguarding alerts had been made, but not always submitted in a timely manner. Referrals to health professionals had been carried out when support was needed. An effective system was not in place to make sure lessons were being learned following these incidents.

Staffing levels impacted upon staff's ability to manage people who displayed behaviours which challenge. One staff member told us behaviours which challenge for one person could "Come out of the blue. [Person using the service] can go for staff. This normally happens at busy times of the day. They [person using the service] doesn't have a door sensor in place so we are not always aware when things happen. They can take three staff. We struggle with another resident, because they can take four staff and there are only four of us and a nurse on the floor." If incidents occurred and these staff numbers were needed, then staffing levels would become unsafe. We asked staff if they were able to summon for help during these types of incidents and we were told they did not. The provider told us that staff carried an alarm at all times.

Some people who displayed behaviours which challenge on the first floor were placed on 15 minute observations as a measure to reduce the risk of harm to other people. Throughout inspection, staff on the first floor were not visible and could not carry out the 15 minute observations needed to protect people. Records of these checks showed staff were not actively monitoring people to reduce the risk of harm. We could see that staff were busy during these times. Action had not been taken to minimise the risk of harm to people

People who were nursed in bed because of their health condition were at increased risk of harm from other people because door sensor alarms were regularly turned off. We routinely observed staff switching these sensors off when going into people's rooms to provide assistance, however they forgot to turn them back on. We were able to go into people's rooms without setting the sensor alarms off.

People who were nursed in bed because of their health condition needed to be turned regularly to alleviate skin pressure. Care records differed in the times which positional changes needed to be carried out. For example, a care plan for one person stated turns were to be two hourly, yet another care plan for the same person stated four hourly. Records of positional changes showed they were carried out between two and four hours. A review had not been carried out since 28 May 2018 where a blister [as a result of skin pressure] had been identified for one person which staff needed to monitor.

During inspection, we observed drag lifts carried out by staff. We informed the manager of this straight away. This is a method of assisting someone to move by placing a hand or arm under their arm pit or by pulling on a person's hand to pull them up. This method increases the risk of injury to both people and staff. The staff

involved in this had received moving and handling training. The manager took immediate action to speak with the staff involved and arranged further training for them.

Health and safety procedures were not robustly followed. Doors which needed to be locked for safety were found open and unlocked. An open bottle of toilet cleaner without a lid had been left in the bathroom next to the sink which was accessible to people. Radiators were not secure on the first day of inspection. We asked the manager to address this straight away which they did. We observed a hole in the ceiling which exposing wiring. Window restrictors were not in place on any of the windows at the service. Staff had not recognised that there was an override feature on the windows to open them further. This posed a risk to service users from falling from a height. We asked the provider to take immediate action to address this. After inspection, the manager contacted us to tell us that window restrictors had been put in place on all windows.

Medicines were stored safely, however further improvements were needed. People had not always received their medicines because they had been missed or because they were not in stock. For example, one person did not receive a medicine for an infection which increased the risk of deterioration to the person's health condition. Topical creams had not been routinely ordered and records in place did not show that people received them as prescribed. Variable doses for medicines were not accurately recorded on medicine administration records. This increased the risk of the wrong dose being given.

The clinical lead told us that they had changed the pharmacy who provided their medicines which had been a positive move for them. They had noticed that the number of medicines issues had reduced.

The risks to infection prevention and control were not managed. Bathrooms were not consistently clean. For example, a shower screen was dirty and tiles had red mould on them. Seals between the flooring and tiles had lifted. Some toilet seats were stained. One toilet contained stained urine bottles and a dirty commode bowl had been left next to the hand washing sink in another bathroom. Walls around sink areas were stained. Malodours were noted throughout the service. Items had not been stored correctly in bathrooms. Disposable gloves were not routinely available in bathrooms and toilets for staff to use.

Relatives voiced their concerns about the cleanliness of the service. One relative told us there were faeces on an en-suite floor for three days. When they raised this issue with staff, action was taken to clean the area. On another occasion, urine had been left on the en-suite floor all day. The relative told us they had complained after the bedroom had not been cleaned for four weeks. Staff had taken action to carry out a deep clean of the room.

The service had been awarded a food hygiene rating of three stars in November 2017. This meant it was satisfactory. We found that improvements to food hygiene needed to be made. We found a packet of ham in the fridge which was out of date. Sandwiches and cooked meats in another fridge had not been appropriately covered and did not contain a sticker to show when the food had been made or opened. A beaker was found in the fridge which contained a fortified drink. The beaker was not clean and did show when the drink had been prepared. Temperature records of foods had been taken for foods for normal diets but not for adapted diets.

The manager told us, "Cleanliness has improved since we opened [new registration in July 2018]. We have reviewed cleaning procedures."

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At times during the inspection, we saw periods of calm. However, we determined that there were insufficient staff on duty overall to provide safe care and support to people. We overheard staff staying, "We are rushed off our feet today." A visitor told us, "Staff are always very busy." A relative told us, "Staff are always saying they are rushed of their feet." We regularly observed people waiting for support and this impacted upon people's dignity. For example, staff regularly told people they needed to wait because they were busy. On one occasion, a person asked to get up and the staff member told them, "You need to wait. You need to sit down and wait. Eat your biscuits." We assisted one person to pull their trousers up because they were walking along the corridor and we were concerned about the risk of falls.

People told us staff did not have time to sit with them. We observed that this was the case. Staff were not visible throughout inspection, particularly on the first floor. We also found staffing levels were reduced when staff left the first floor to collect breakfast for people.

A dependency tool was in place which supported the staffing levels, however we observed periods during the inspection which were chaotic and we observed staff rushing around to provide support to people.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were gaps in care records which related to the safety of people. For example, records of 15 minute observation checks had not been regularly carried out. Some of these records had been falsified; this meant staff had signed to show checks had been completed when they had not carried out the checks of people. At inspection, we observed that the checks could not have been carried out because staff were busy. Staff also told us that they had not carried out checks. Hourly checks of people at night had been completed, however the times of which had been pre-populated. This meant that everyone was checked on the hour, which was not possible. The records did not represent a true reflection of the times which checks were carried out.

Care plans relating to medicines needed further information. For example, bowel medication was placed onto one person's foods, however the care records did not contain information about this medication or why it was given on food. A care plan for covert medicines for another person did not detail which foods were suitable. Medicine rounds were delayed because nurses needed to attend a daily meeting, answer telephone calls and speak with health and social care professionals when they visited the service.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Health and safety certificates were in place and were up to date. Recruitment records were in place and showed that the provider had followed the correct procedures for safely recruiting staff to work at the service.

Requires Improvement

Is the service effective?

Our findings

People at risk of choking were not supported to eat a suitable diet. Staff knowingly prepared and assisted people to eat food which was not suitable for them. One blended meal was prepared for people at risk of choking, regardless of whether they needed a pre-mashed, fork mashable or pureed diet. The blended meals provided did not match the consistency people needed to manage their choking risks. Staff were not aware of national guidance in place to manage choking risks, despite this guidance referred to in letters from health professionals and a copy of this guidance being in place at the service.

Kitchen staff were not aware that people at risk of choking could not be given vegetables with skin, such as peas and sweetcorn. On the day of inspection, we observed a chef preparing blended peas for people who were at risk of choking. These practices put people at serious risk of harm by way of choking. Kitchen staff appeared unconcerned, stating 'This is how we have always done it.' One relative told us "[person using the service] likes rice pudding, but spat the bits out." We noted this person required a pureed diet and therefore food should not contain any bits. Care records did not show if people had been assessed as being able to eat bread. Kitchen and care staff could not provide this information.

A volunteer staff member had been left unsupervised to support people to eat. The volunteer could not tell us the name of the person they had been supporting, when we observed them and could not tell us if the person was at risk of choking. Some care staff could not tell us the difference between a soft and pureed diet. Staff could not tell us what the blended meals were on the day of inspection yet supported people to eat them. When we asked about a pureed option, a member of staff told us, "We don't have pureed options of meals." We asked why staff gave people food which had been blended when they needed a pureed diet and we were told, "This was what the kitchen [staff] provided."

Records showed people were given food which were not suitable to be pureed. This included bread and pasta. We tasted the food which was deemed suitable for people who needed an adapted diet on the second day of inspection. The blended chicken was thick and sticky and contained crusts; we could not eat this without a drink. The blended sweetcorn contained significant amounts of fibrous pieces.

We recommend the provider makes themselves aware of national guidance for choking risks.

We observed one person being given a drink of apple juice which had not been thickened in line with recommendations to manage their swallowing risk. A speech and language therapy assessment referral had been made for this person because staff had noticed that the person coughed each time they had a drink. This demonstrated that staff were not managing the risks to people and their actions put them at increased risk of harm.

Food and fluid balance records were not accurate and did not demonstrate that people were regularly offered fluids. Care plan and risk assessment reviews for people at risk of choking, malnutrition and dehydration had not received regular reviews and the information within these records was not always accurate. For example, no reviews for one person had taken place since 9 April 2018. Weekly checks of the

person's weight to review the risks to this them had not been carried out each week.

People at risk of malnutrition were not regularly weighed or risk assessments updated. For example, mid upper arm circumference checks had been carried out for one person between September 2017 and June 2018, however the nutritional risk assessment had not been completed in line with this information. This meant staff had not reviewed the risk of malnutrition for this person. Staff had allowed people a more generous body mass index score when carrying out nutritional risk assessments which gave an inaccurate overview of the risks to people. Weight records which showed a significant difference in weight from the last weight measurement were not questioned.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives expressed their concerns about the menus at the service. One relative told us, "Food is a big thing for people in here. Once [person using the service] was given dry waffles and a dry burger and bun. They really struggled to eat this. There is no choice at tea time for the meal." On another occasion, the relatives observed people struggling to eat pizza. A relative told us they asked staff to make [person using the service] scrambled egg, however staff refused. One person told us the food was "Rubbish."

Menu's did not included options for people who needed an adapted diet for their choking risks or who needed a vegetarian diet. A choice of meal was not always available for people. Menu options for people with adapted diets were limited. For example, records showed one person had eaten meat, mash and vegetables for 19 days in June 2018.

Meals were not always presented in an appetising way. Sprouts and carrots which had been blended together and appeared a green-brown colour. They had not been blended separately. Gammon in a white sauce was served with brown gravy. Individual items of food were not placed individually on a plate, they were clumped together.

Tables were set on the ground floor which included table cloths and condiments, however cutlery was not provided before the meals arrived. Tables on the first floor were not set at all.

This was a breach of regulation 14 (Meeting nutrition and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were significant gaps in all areas of mandatory training for all staff. This included fire safety, nutrition, equality and diversity, dementia, the management of behaviours which challenge, Parkinson's disease and the Mental Capacity Act 2005. There was no evidence to show that kitchen staff had the necessary food hygiene training. The lack of updated training meant that people were at risk of harm because staff did not have the most up to date knowledge or training to support people safely.

Staff were not supported to carry out their roles safely. Established staff had not received regular supervision and appraisal. A lack of supervision was in place for apprentice staff and volunteers. New staff did not receive regular reviews during their induction to identify whether further support or training was needed. A probationary interview was not carried out with staff to determine whether their probationary period had been successful. Records were not in place to show whether new staff had enrolled onto the Care Certificate. This is a set of standards which sets out the knowledge, skills and behaviours for care staff.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

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 to 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).

Care plans had been written in a style where people had expressed their wishes, however a DoLS was in place which deemed that people could not make their own decisions. For example, in one care plan, the record stated that the person wanted staff to review their risks each month and to use and maintain specific equipment and that they would like their GP informed if their health became at risk. We determined this information was incorrect because the person did not have capacity and had difficulty expressing their needs because of their health condition. A care plan for 'best interest decision making' was in place for another person even though they had capacity to make their own decisions. A care plan audit, dated 6 June 2018 had not identified this omission.

Mental capacity assessments were completed instead of best interest decisions for some people. For other people, best interest decisions had been carried out, but not recorded. Records were in place to show people routinely received an influenza vaccination, yet no best interest decisions had been recorded to show why the decision was in the person's best interests and the people involved in making that decision.

Some people had 'Do not attempt cardiopulmonary resuscitation' (DNACPR) certificates in place. These were not regularly reviewed by staff. We prompted a nurse on duty to review one person's certificate because it was going out of date. We saw this certificate was reviewed by the person's GP. We found another DNACPR certificate was out of date by one month. A tracker was in place on the ground floor to show when which people had a DNACPR certificate in place and when it was due to expire. The information on this tracker was inaccurate because some DNACPR certificates had had been renewed and the information not updated on the tracker and some people were no longer at the service.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Parts of the environment had been updated and repaired, for example, two toilets had been re-tiled on the first floor. A lounge and dining room on the ground floor had been redecorated. A new, second lounge was in place on the first floor which was utilised by people and improvements were noted to the garden area.

Since the provider had taken over the service, some improvements had been carried out. This included a new boiler system and updates to some bedrooms and communal areas. A refurbishment plan was in place. However many areas of the service were still in need of repair or update. There was damage to walls, skirting boards and doors. Flooring had started to lift. Many ceilings had been damaged from a leak. Decorative items on walls were not all secure and held on with a nail. This was not safe practice and increased the risk of harm to people.

There was no ramp from the dining room to the garden. We observed relatives and staff having difficulty lifting people in their wheelchairs over the doorway. We had to intervene and assist a staff member who was unable to do this on their own. One relative told us it was difficult to take [person using the service] outside

because no ramp is in place." The provider told us there was another access to the garden area. We questioned why staff and relatives were not using this.

The dining room on the first floor was too small to cater for people in wheelchairs and for staff to provide assistance. Staff told us people ate their meals in the lounges or bedrooms because they were unable to move around when everyone was in this room.

This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Many aspects of the environment did not reflect best practice in dementia care. For example, contrasting colours on light switches and internal doors were not in place. Blue dementia friendly toilet seats and handrails were not available in all bathrooms and toilets.

Pictorial menus were not in place people living with a dementia and for people who had a visual impairment. Staff had not recognised that these were needed. There were no visual prompts to navigate people around the service. Dementia friendly crockery was not in use.

We recommend that the provider considers how the environment meets the needs of people living with dementia and sensory impairments during their refurbishment.

People had regular access to health and social care professionals. We observed staff contacting professionals and completing referrals in relation to medicines, falls, nutrition and behaviours which challenge. We also saw professionals visiting the service and letters of recommendations were found in people's records. However as demonstrated above, staff were not always aware of or were following those recommendations.

Requires Improvement

Is the service caring?

Our findings

People's dignity was compromised at times and went unnoticed by staff because they were not visible in communal areas. One person had pulled their trousers down in the corridor exposing their underwear and incontinence pad. We saw three people in stained clothing. A relative was concerned that one person had worn the same clothes for two days. This person bathed every day at home, but now was only able to bathe on a Monday and Thursday. Another relative expressed their concerns that when visiting [person using the service], they regularly found they had been incontinent and needed assistance from staff, however staff were busy and assistance took time.

This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives had expressed concerns about the timeliness of care, however, we received positive comments from people and relatives about the care which they received from staff. Comments included, "The staff look after me," "The staff know me well," and, "I have a view, I like it here. My family live around here." Relatives comments were, "The staff are lovely," and, "The staff are friendly." Staff told us they enjoyed working at the service. One staff member told us, I love the residents, they give me a good day."

We carried out SOFI observations at mealtimes and in lounges during the day. We observed that care was task led, however, when staff provided care and support to people, the interactions from staff were kind and caring. Staff maintained eye contact with people and positioned themselves at the same level as people. Staff offered appropriate touch when people needed support. Positive interactions were observed between people and staff. Staff talked to people about their families, food and the weather. We saw that staff were concerned that one person appeared to be sleepy during lunch, this was shared with the nurse on duty who monitored the person's temperature and observed their swallowing

Not all staff were aware of people's needs or the risks to them. Staff could not always tell us if people were subject to deprivation of liberty safeguards. We intervened on one occasion because a staff member was going to cut one person's toe nails. We directed them to the nurse of duty who said they could not do this because of the person's health condition. Some relatives disclosed their concerns that staff did not know people well. For example, one relative told us [person using the service] had been given a blended meal despite being able to eat a normal diet. Another relative told us that signs of agitation were missed.

Care records did not demonstrate that people were involved in planning and reviewing their own care. There were no comments from people in care plan reviews. When we asked people, no-one confirmed that they were involved in reviews of their care. Advocacy services had been sought for people when needed. This is a means of accessing independent advice and support to assist people to make decisions.

People had access to a small range of assistive technologies. These are products and services that empower disabled people to become more independent. Under the Equality Act 2010, assistive technology is recognised as a 'reasonable adjustment' which should be made available to prevent discrimination in a

wide variety of contexts. These assistive technologies included walking aids and wheelchairs. A tablet and Wi-Fi was available but not used. The manager did not know if staff were competent to use this device. Information was not routinely available for people in other formats, such as large font. However, the manager did say that records would be made available in languages other than English if needed.

Visitors were given privacy by staff when they came to see friends and relatives. We saw many visitors enjoyed sitting with people in communal areas, however staff kept interruptions to a minimum when people wanted to spend time in their bedrooms with their visitors.

Requires Improvement

Is the service responsive?

Our findings

Care records were in place for people which covered key areas of needs. However, we identified that further improvements were needed to care records. Information contained in care plans was not always accurate or up to date. Care plans had not been reviewed when incidents took place or when they had been changes in people's healthcare needs. There were gaps in care records because records had not been fully completed. Some care records had been handwritten and the handwriting was not always legible.

Staff were not familiar with care plans and did not use the information in them to manage or for see people's needs. This also reflected the lack of up to date training and poor practices in place to minimise the risk of harm to people. Aggression was noted in some admission assessments, yet this information had not been used to determine triggers, create a person-centred care plan which included triggers and de-escalation techniques. Staff had not considered that several people who displayed behaviours which challenge lived together in the same area and decide how to manage this. Bedrooms had not been allocated in a way which gave people space from one another in order to minimise the risks for people.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some improvements had been identified with regards to activities. Care staff and relatives worked together to deliver activities. The manager told us they would be implementing 'Sunshine trolley's' for staff to facilitate activities for people who were nursed in bed. They also told us they would be supporting people to deliver 30 second and five-minute activities for people living with dementia. Some people and relatives provided mixed review about the quality and variety of activities at the service. Relatives told us that more activities needed to take place on the first floor. One relative told us, "Activities and entertainment normally take place downstairs. It would be good to have more going on up here."

The manager told us further work was needed to improve activities overall, however we could see that work was being carried out in this area. One person's care record said they needed to use their fiddle muff all of the time because it provided stimulation when laid on their bed or sat in their chair. We did not observe this being used during the inspection.

At the time of inspection, planned dates were in place for relatives to deliver a ukulele session for people. A summer fayre and dance group had also been planned. At inspection, people had congregated together to watch the World Cup, details of all matches were on display for people to read. Some people did go out into the community and were able to access a local pub and shops. Activities records showed people had been involved in hand massage, watching a movie and a tea dance.

At a meeting for residents, where the garden was discussed, relatives had expressed their interest in helping people to paint the garden furniture. The manager had contacted an allotment association to ask for their involvement with the service and was awaiting a response.

Complaints had been made and records were in place to show that they had been addressed. People and relatives told us that they knew how to make a complaint if they needed to.

Some people were receiving end of life care at the time of inspection. Care records included information about people's wishes. We discussed one person with a nurse and they told us that anticipatory medicines were available for them. Training in end of life care was not up to date.

Requires Improvement

Is the service well-led?

Our findings

The provider had an auditing system in place which was designed to improve the overall quality of the service. This system was not effective because it had not highlighted all areas for improvement. Where actions had been identified they had not been addressed.

Audits had failed to identify some of the issues we found at inspection. Catering audits had not highlighted that people at risk of choking had been given foods which were not in line with their dietary needs or in the consistency which they required. This practice increased people's risk of choking. The audits had not included any tasting of foods provided to people, which would have highlighted that some foods were unsafe. The audit did not include a knowledge check of staff and did not seek to include feedback from people and their relatives. Care plans were not matched with the food provided to people to make sure people received the consistency of food they required. The catering audits showed that training was out of date for all kitchen staff, yet no action had been taken to address this.

Infection prevention and control audits had not identified the same level of concerns as we had identified during this inspection. For example, the audits did not reflect that the service was not clean Two audits highlighted that a lead staff member was needed for this area. This remained unaddressed at inspection.

Operational audits demonstrated the provider was already aware of concerns in relation to record keeping, training, supervision and menu's yet timely action had not been taken to address these concerns prior to inspection. Where audits had been carried out, actions had been put in place and tasks allocated to staff with dates for completion, however these had not been carried out.

The practices in place at the service did not support the security of confidential information. Throughout each day of inspection, office doors were open and unlocked. This meant care records in cupboards and filing cabinets were accessible, care records left open on desks and information displayed on white boards were accessible to anyone. In the ground floor office, keys hung on the wall of the office were accessible. Signage from the previous provider remained on display. Staff wore badges which displayed the previous provider's logo.

The manager told us that work had been carried out to address low morale in the staff team. This had resulted in some staff leaving the service and new staff employed. A relative told us, "Lots of staff have left. Morale is low. I often hear staff complaining." However, the inspection demonstrated that staff were not working together to ensure the safety of people using the service. For example, the maintenance team had regularly checked windows, yet no window restrictors were in place; the service is not clean despite domestic staff in place. Kitchen and care staff have been preparing and assisting people to eat food which increases their risk harm by choking. Staff practices have also increased the risk of abuse to people, by way of physical abuse, neglect and organisational abuse.

Action plans were put in place following reviews by South Tees Clinical Commissioning Group and South Tees infection control team, yet they have not been addressed.

During the inspection process, we have requested information which included policies and procedures, staff rotas and training records. We experienced significant delays in receiving this information. We also asked the manager to provide information in relation to a specific incident which has not been provided.

Services that provide health and social care to people are required to inform the CQC of deaths and other important events that happen in the service in the form of a 'notification. Systems were not in place for staff to complete and submit notifications in the manager's absence. Staff did not have access to a computer and did not have access to paper records to be able to fax the notification.

After inspection we sent a letter of concern to the provider and asked them to send us an action plan which demonstrated the improvements which they intended to make including timeframes. We have asked for an updated action plan to be sent each month

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Notifications had not always been submitted when needed or had not been submitted without delay. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We will take action outside of this inspection to address this. We will report on any actions once they have been completed.

A registered manager had not been in place since September 2017. It is a statutory requirement to have a registered manager in place at service to deliver the regulated activities at the service. The manager started in November 2017 and submitted an application to become a registered manager four days prior to the inspection.

Staff told us support was in place from the management team and all felt able to approach them. Comments included, "[Clinical lead] makes it good to be here. They are a good lead." And, "The home is a lot better now. The management are so much better. [Manager] is nice but firm, And, "The manager is strict. I like the boundaries they have out in place."

The manager told us they were supported by the provider. After inspection, the provider contacted us and we could see they were committed to making improvements at the service.

The service had links with the local community. People were known in their community because they used local amenities. We saw that local school visited the service. The service worked alongside health and social care professionals, attended safeguarding meetings and shared information with them.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect (1) service users were not treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs (1) The nutritional and hydration needs of service users were not being met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment (1) The premises were not suitable for the purpose which they were being used and they were not properly maintained.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment (1) people did not receive safe care and treatment.

The enforcement action we took:

We imposed a notice of decision to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance (1) Systems and processes were not operated effectively..

The enforcement action we took:

We imposed a notice of decision to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not on duty. (2) Staff had not received appropriate support, training, supervision and appraisal to enable them to carry out the duties they are employed to perform.

The enforcement action we took:

We imposed a notice of decision to restrict admissions.