Maria Mallaband 13 Limited

Chaucer House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 9 and 10 January 2019 and was unannounced.

Chaucer House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during the inspection.

Chaucer House is a purpose-built care home, registered to accommodate up to 60 people. At the time of the inspection there were 41 people living at the service.

We last inspected the service on 23 and 24 November 2017. We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and the service was rated Requires Improvement. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions safe, effective, caring, responsive and well led to at least good.

At this inspection we found there had been a deterioration in the quality of service people received: leadership and management was poor, and people had not received safe care. We have rated the service Inadequate overall.

At the time of our inspection, there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There was not sufficient staffing to meet people's needs. The service continued to rely heavily on agency staff, which meant people did not receive care from a consistent staff team. Risks to people had not been assessed and minimised in all cases. For example, one person did not have adequate information to for staff to support them with their catheter care. Medicines were not managed consistently safely. There were issues with medicines ordering, which lead to potential harm for one person. Staff did not always follow best practice around the labelling of opened medicines.

Accidents and incidents were documented by staff, and action had been taken to try to avoid the risk of the incident reoccurring. However, action taken did not always reduce the number of accidents, and no further follow up had been made.

Staff continued to not receive regular supervision to support them to carry out their roles. Staff had received some training, however had not received training in supporting people with behaviours that could challenge. New staff completed the providers induction process. Staff recruitment files showed the provider followed safe recruitment processes.

Some people had recently had DoLS applications authorised by the local authority. We found the conditions on people's DoLS were not consistently being met. People were supported to have choice and control of their lives. Staff supported people in the least restrictive way possible; the policies and systems in the service supported this practice. The principles of the Mental Capacity Act were being complied with and any restrictions were assessed to ensure they were lawful, and the least restrictive option.

Quality monitoring systems had identified the shortfalls but the registered manager and provider failed to make improvements for issues identified during this inspection. This included care planning, risk assessments, staffing and the management of medicines.

Care plans we reviewed lacked person-centred details on how best to support people as individuals. One person had lived at the service for a number of weeks, and yet did not have a detailed care plan in place.

Staff we spoke with understood their responsibilities to safeguard people from potential harm and abuse. People were protected by the prevention and control of infection. The service was clean, well maintained and without odour. The service was purpose built, and since our last inspection there had been some improvements to the dementia friendly signage.

People's needs were mostly assessed before moving into the service and support was given in line with nationally recognised tools to monitor things like people's weight and skin condition. People received enough food and drink to maintain good health and told us that they liked the food. Staff worked in partnership to provide consistent support when people moved to or from the service. Staff worked alongside healthcare professionals when people's needs changed to ensure they received the appropriate care and treatment.

Staff treated people with kindness and compassion and people told us they liked their staff. Permanent staff knew people's needs well and people told us they valued their staff. However, staff did not have sufficient time to spend with people. People and their relatives were consulted around their care and support. People's privacy was respected, and staff encouraged people to be as independent as safely possible.

There was a complaints policy in place and available to people. Complaints were being recorded and acted upon. People received a pain free and dignified death at the end of their lives.

Staff told us they felt supported by the registered manager, and people told us they had confidence in them to make improvements however we found sufficient improvements had not been made since our last inspection.

People who lived in the service and members of staff told us they felt engaged in developing the service due to monthly meetings introduced by the registered manager.

At this inspection four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified.

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.

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.

There were not sufficient staff on duty to meet people's needs.

Potential risks to people's health had not been consistently assessed; there was no detailed guidance for staff to refer to.

Accidents and incidents were logged however action was not always effective in reducing the number of incidents.

People's medicines were not consistently being managed safely.

Staff knew how to recognise and report abuse.

Staff had been recruited safely.

Action had been taken to mitigate risks to people associated with the building. The service was clean.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Some people had Deprivation of Liberty Safeguards (DoLS) authorisations in place. Conditions on these DoLS had not always been met. Staff had an understanding of the Mental Capacity Act and best interests' meetings had been held when people lacked capacity to consent to care and support.

Staff had not received regular training and supervision.

There had been some improvements with dementia friendly signage within the service.

People were supported to maintain a balanced diet.

People were supported to access healthcare services.

People's needs were assessed before they moved into the service.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect as there were not sufficient staff on duty.

Staff were kind and compassionate when they were with people.

People were supported to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not consistently receive person centred care.

Care plans were not always updated to reflect people's changing needs.

People were supported to take part in a range of group activities, however some people were at risk of social isolation.
Complaints were documented, and had been responded to appropriately.

People's end of life wishes had been recorded.

Is the service well-led?

Inadequate

The service was not well-led.

Audits and checks had been completed and shortfalls were identified, however, action was not taken quickly to rectify the shortfalls and improve the service.

The registered manager and provider had failed to implement learning and improvements following the previous inspection.

Staff felt supported by the registered manager, however we found that staff were not receiving formal support to enable them to complete their roles.

The provider displayed their rating and made statutory notifications to the CQC.

The manager understood their regulatory responsibility and had submitted statutory notifications as needed.

Chaucer House

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 9 and 10 January 2019 and was unannounced.

The inspection team consisted of two inspectors, a nurse specialist and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, we reviewed information we held about the provider. This included previous inspection reports and notifications. A notification is information we receive from the service when significant events happen, like serious injury. We reviewed the provider completed 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 our inspection we spoke with 12 people and five relatives. We spoke with the registered manager, the regional director, and nine staff. We looked at care records and associated risk assessments for six people. We looked at management records including three staff recruitment files, training and support records and health and safety checks for the building. We observed the care and support people received in communal areas.

Inadequate

Is the service safe?

Our findings

At the last inspection, potential risks to people's health and welfare had not been consistently assessed. At this inspection, there had been no improvement. Risks to people had not been consistently assessed and there was no detailed guidance for staff to follow to reduce the identified risk. Some people were living with unstable health conditions such as epilepsy. People's care plans did not consistently recognise and minimise these risks. For example, care plans did not have details about what the seizures looked like and what the triggers were. The care plans stated that each seizure should be recorded on the seizure chart. One person experienced two seizures, but these had not been recorded on the chart. The registered manager showed us that the seizures had been recorded in the daily notes, as the epilepsy care plan had not been written until after the seizures had happened.

Some people required a catheter to pass urine, (a catheter is a tube into the bladder). People who have catheters are at risk of infection and from the catheter blocking. People's care plans did not contain detailed guidance for staff on how to manage the catheter, and one person did not have a catheter care plan at all. People required varying levels of support and there was a risk that people would not receive consistent support from staff, and that staff would not recognise when the person was unwell and what action to take. Permanent care staff we spoke with had received training and felt confident to support people with catheters, and informed us if they had any concerns they would always report them to the nurse on duty.

Some people displayed behaviours that challenged and were a risk to themselves and others. One care plan gave staff limited guidance on how to manage the behaviour and distract the person. There was limited information about what triggered the behaviour and when to give medicines that had been prescribed. Staff completed charts giving details about people's behaviour, what had led up to the behaviour and the action taken. Staff had recorded that one person had 15 incidents of behaviour in one month, including verbal and physical aggression towards another person. These incidents had not been analysed to identify any patterns or trends and the care plan had not been updated to give staff guidance to reduce the risk of these incidents happening again to keep people safe.

One person was known to display behaviours that could challenge themselves and others. There was no evidence that known risks has been assessed or mitigated. There was a security guard, in a high visibility jacket with 'security' written on it who provided one to one observations on the person. This was neither dignified for the person, or provided assurances that any risks to the person or others were being appropriately managed by the provider or registered manager. There was little engagement observed throughout out inspection.

Accidents and incidents were recorded, and detail on falls had been analysed to assess if there were patterns or trends and any action taken. However, the action taken had not always been effective in reducing the number of incidents. One person had been falling regularly, a sensor mat had been put in place, so that staff knew when the person was standing, records showed that when the alarm was activated, staff attended and found the person had already fallen. The person was also given a call bell to wear, to call for staff when they wanted to stand, but the person had not used this. The person continued to fall but there

had been no further analysis of the action taken, such as a referral to the falls clinic, or regular monitoring of the person.

The failure to mitigate known risks to people and protect them from avoidable harm is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection there were not sufficient staff to meet people's needs and large amounts of agency staff were employed. Following the inspection, the provider told us that they would be increasing the number of staff on each floor of the service and would reduce the number of agency staff. At this inspection, no improvements had been made in relation to care staff. Staffing numbers were based on a dependency tool, which the registered manager used to assess the number of staff needed. The registered manager informed us the staffing numbers should include three carers on the ground floor, and five on the first floor. On the first day of the inspection, there were two carers on the ground floor and four on the first floor, all the carers were agency staff apart from one. The registered manager told us that two care staff had called in sick that day and they had not been able to cover them. As a result we observed people without staff engagement for long periods of time, and staff busy and rushing. The registered manager had not organised the duty rota to make sure that there were more permanent than agency staff on duty each day. One person told us "We have a lot of agency; whilst some stay on most move on quickly." On the second day of the inspection, all the carers were permanent members of staff, and the registered manager informed us staffing levels were over the assessed levels. However, despite this we found staff were still very busy, and we were unable to speak with them for any length of time, as they were needed to support people. A staff member told us "There's not enough staff, its constant. We don't seem to keep staff. We have had a lot of people leave."

Previously, people had to wait long periods of time for their call bells to be answered, this had not improved. Staff did not have time to answer call bells; we observed a volunteer (whose role was to support with activities and engage with people) answering the call bell, however they were unable to support people with all their needs. Twice during our inspection, we noted that call bells had rung for over 25 minutes without staff being able to respond. One person told us "I have learnt that a minute can mean anything from a minute to 40 minutes." Staff did not have time to spend time in the lounges with people in the morning on the first day of our inspection. One person sat in the lounge and did not interact with anyone for over an hour including staff.

The provider failed to have sufficient numbers of competent, skilled and experienced persons deployed in order to meet people's needs. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Medicines were not always managed safely. Staff told us the ordering of medicines was previously confusing as there was not one allocated person responsible for ordering medicines and ensuring that there was a constant supply of medicines. There was no clear system to follow up if medicines did not arrive at the service when requested. One person's medicine did not arrive when a prescription had been requested, staff had acted but this had not been effective as the medicine supply had run out and the person missed four doses. The day after the medicine doses were missed the person became unwell with the symptoms that the medicine controlled. The registered manager informed us they had appointed a nurse to be responsible for the ordering, disposal and auditing of medicines, and would be using this as learning to try to avoid the error from reoccurring.

Although medicine administration records (MAR) had been completed to show people had received their medicines, we found this was not always the case. For example, one person was prescribed a medicine to

treat iron deficiency. MAR showed the medicine had been given, but the medicine was still in the packaging and had not been administered. Medicines that are given in liquid form, are only effective for a limited amount of time once the bottle is opened. It is best practice for an opening date to be put on the bottle so that staff know when the medicine stops being effective. Staff had not consistently recorded when bottles were opened and there was a risk that people would receive medicine that was no longer effective.

The provider failed to ensure medicines were managed safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people were prescribed medicines on a 'when required' basis such as pain control and medicine for anxiety. There was guidance in place for staff about when to give the medicine and how much. Staff received training in the administration of medicines and their competency was assessed yearly. There were sufficient numbers of nurses on duty to administer medicines. We observed people being given their medicines with patience and kindness.

Some people wished to manage their own medicines, their ability had been assessed. When people were assessed as safe to manage their own medicines, risk assessments and monitoring had been put in place. Medicines that required specific storage and recording, were stored and administered in line with guidance and legislation. The temperature of the fridge and rooms where medicines were stored had been recorded to check that remained within safe limits to ensure medicines remained effective.

Staff were recruited safely. Recruitment checks had been completed to make sure staff were honest and trustworthy. Each person had a Disclosure and Barring service (DBS) criminal records checks were completed before working at the service. There were references and a full employment history to check previous conduct. Checks had been carried out to ensure nurses were registered with their professional body and able to work as registered nurses.

The provider had safeguarding policy and procedures and staff were aware of this. Staff had awareness and understanding of what they needed to do to make sure people were safe from harm and potential abuse. Staff told us they received safeguarding training to ensure they had the skills and ability to recognise when people may be unsafe. Staff told us they knew about the guidelines and contact details for the local safeguarding team, this information was displayed around the service. Staff told us "I know my residents, and I would have no problem whistleblowing if I saw something wrong." The registered manager had made referrals to the local authority safeguarding team appropriately.

We observed the service to be clean, including communal areas and people's rooms. Staff understood their roles and responsibilities around infection control. Staff used protective equipment such as gloves and aprons appropriately. People told us their rooms were cleaned regularly and that the domestic staff were "great." Staff had recently completed external training to become infection prevention 'champions.'

There were systems in place to ensure the safety of people, staff and visitors. Maintenance work was reported and logged promptly after issues being reported. Portable electrical appliances and firefighting equipment were properly maintained and tested. Health and safety audits were completed, and action had been taken to address any issues.

Requires Improvement

Is the service effective?

Our findings

At the last inspection, staff had not received regular formal supervision and appraisal to discuss their performance and development. At this inspection, formal supervision of staff had not improved. Supervision in care settings is a process whereby through regular, structured meetings with a supervisor, care staff can develop their understanding and improve their practice. A supervision matrix had been maintained over the past year. The matrix showed that nursing and care staff had only received one formal supervision in the last year, staff had not received a yearly appraisal. The registered manager informed us they had a plan to focus on supervision appraisals this year. Staff told us they felt supported by the registered manager and were able to go to them if needed, however we could not be sure that the registered manager had a good understanding of staff ability to complete their role.

Previously, staff had not always received training appropriate to their role, such as syringe driver training so that nurses could support people at the end of their lives. Some improvements had been made. Nurses had now received the appropriate training and could support people at the end of their lives. Staff received training appropriate to their roles including specific medical conditions. Training included face to face training and online. The registered manager had organised for specific dementia training for staff, and invited relatives to be a part of the training. However, some people displayed behaviours that could challenge. Staff had not received specific training to support them to be able to de-escalate situations or manage behaviours some may find challenging. Staff told us what they would do in scenarios to diffuse situations, however, incident records confirmed some people repeatedly displayed behaviours that could challenge with no reductions.

When agency staff first worked at the service, the induction they received varied depending on the staff on duty. The process for new agency workers included them having a guided tour of the building, whilst being informed of health and safety process, as well as important information relating to fire alarms. The induction for agency staff did not allow them time to review people's care plans and risk assessments, and therefore agency staff did not always understand people's needs and preferences. Agency staff were supposed to be supported by permanent staff, but we found that due to staffing levels, this was not always the case. People told us regular agency staff were good, however, not all agency staff were of the same calibre and this made people feel nervous when being supported by them. The agency staff had an agency worker placement checklist which detailed that their skills and training were up to date.

The failure to provide appropriate support, training and supervision to enable staff to carry out their duties is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

New staff received an induction when they started including working with experienced staff to learn about people's choices and preferences. Staff attended meetings through their induction with their line manager to discuss their competency before working by themselves. The provider had in place a workbook for care staff and nurses to be completed to check their competencies and skills. Staff had started the booklets, but these had not been completed: the provider had not assured themselves that staff had understood the training and were competent to provide care to people.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

The registered manager had applied for DoLS authorisations when appropriate and these had been authorised. Some authorisations had conditions on them that the service needed to comply with. We reviewed the DoLS authorisations and conditions had not always complied with. For example, one condition stated that the person's communication care plan needed to be updated to include the person's expressive dysphasia. Dysphasia is when people have trouble putting words together to have meaning. The DoLS had been authorised in October 2018, we reviewed the person's care plan, and this had not been updated. The care plan did not mention that the person had any verbal communication needs. This is an area for improvement.

Staff we spoke with showed a good understanding of MCA. We observed staff giving people choices of what they would like to eat and drink, how they would like to spend their time. Staff supported people to make decisions and respected people's decisions when made. When people needed to make more complex decisions and lacked the capacity to do so, staff organised for a meeting to be held to ensure decisions were made in people's best interests.

In most cases, before people moved into the service, a member of the nursing staff met with them to complete an assessment. The assessment covered all elements of their care and support they need including cultural, spiritual needs and expressing sexuality. This assessment was used as the basis to form the person's care plans. People's needs were assessed using recognised tools to assess people's skin integrity, nutrition and pain, these assessments were reviewed regularly. Permanent staff had an in-depth knowledge of people's care and treatment needs and were skilled and confident in their practice. One staff member said: 'We have training updates and champions. I have worked here for a long time. I would not stay if the care was not good'.

People and their relatives had positive feedback about the food. One person told us "The food here is excellent." People told us they had access to sufficient fluids and had positive feedback about the hostesses who regularly offered hot and cold drinks along with snacks. One person told us "I have a jug of water in my room and have plenty of juices and hot drinks" another told us "The hostesses are very good, they always remember how you like your drinks and what you like for breakfast."

Staff worked in partnership with people, other professionals and continually developed their skills. Staff spoke confidently about the care practices they delivered and understood how they contributed to people's health and wellbeing. They were encouraged to reflect, learn and focus on continuously improving their practice at staff handover and team meetings

Staff monitored people's health and wellbeing, acting when any changes were seen. People with complex needs of eating and drinking were protected from risks. For example, one person had difficulties swallowing food being appropriately supported. Staff had arranged for the speech and language therapist to assess the person. Staff had followed guidance following the visit including the kitchen being updated of the person's requirements for a soft diet and an urgent referral to a dietician. People were referred to the GP and other health professionals such as the optician and chiropodist when required.

People were supported to eat and drink sufficient amounts to maintain a balanced diet. There was a choice of meals available to people, the menu board on the ground floor showed the meals available in picture format. People were offered a variety of diets for their specific needs, for example, chopped, pureed, diabetic, low fat, low salt. We observed the lunch time meal, people were treated with respect and courtesy. Staff served the two options on plates and showed them to people to support those living with dementia to make a decision on what they liked to eat. During lunch, people were given support by staff, who were supportive and patient.

Chaucer House is a purpose-built building. The building included specialist equipment to support people's needs. Previously, the signage in the corridors was not appropriate for people living with dementia. At this inspection, some improvement had been made as there were now pictures on the doors for the toilets and bathrooms on the ground floor, where people living with dementia were supported.

Requires Improvement

Is the service caring?

Our findings

There were high levels of agency staff supporting people. People and their relatives raised concerns about the training and knowledge of agency staff, as well as the lack of consistency. Some agency staff had worked at the service for a period of time, however people told us the staffing often changed, and the agency staff did not know them well, and this made them feel vulnerable, especially during the evenings. Staff understood the principles of what it was to be caring, however told us they did not always have the time to practice this. Staff we spoke with told us they found it difficult to provide people with the level of care they wanted, due to the lack of consistent staff. One staff told us they weren't always able to meet people's needs due to staffing. We observed period of time where there were limited interactions between staff and people, however interactions we did observe were positive. People told us the support they received was not always consistent. We found that the registered manager did not always make sure that rotas were completed in a way to ensure people received support from familiar staff.

Some people and relatives told us they were concerned of the risk of social isolation at Chaucer House, due to staffing levels. A relative told us "They may have their quota of staff, but they do not think of the individual needs of people" and "You never see staff in people's rooms, just sitting and talking. People are isolated. Holistic care is hugely lacking." During our inspection, we observed staff to be busy, without the time to spend one on one with those who preferred individual activities or were unable to leave their room due to their healthcare needs. We found that staff did not sit and talk to people for a meaningful length of time.

During our inspection, we observed times where staff were able to offer people emotional support when needed. For example, one person was anxious and pacing. Staff told us this person could forget where their room was located, and when they were reminded they became less anxious. People told us staff were kind, caring and compassionate towards them. When staff interacted with people, we saw them bend to the person's level, and call them by their preferred name. People told us "The staff are very kind and caring to me" and "The staff are kindness itself." A relative told us "The permanent staff are capable, friendly, dedicated and caring." One staff member told us "They are my family, and I treat them as such."

Relatives and people told us they were always welcome at the service, and there were no restrictions on visiting hours. One person told us their family visited them often, and staff knew them well. People had telephones and computers within their rooms to enable them to communicate with their loved ones.

People's care plans and associated risk assessments were stored securely on the electronic system which was password protected.

People's dignity was respected by staff. Staff told us of one person who preferred to have their personal care needs met by a male staff member. Staff told us this person would sometimes have to wait until a male staff member was available, but did have their personal care needs met in their preferred way.
From April 2016 all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability,

impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively. We observed there to be accessible information around the service, including menu boards, and activity posters.

People had access to advocacy services when they needed support to make decisions. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf.

People told us their privacy was respected by staff. We observed staff knock on doors before entering people's rooms. Staff told us how they supported people during personal care, closing curtains to ensure privacy and covering them with towels. Some people needed less support from staff, staff supported these people by prompting them to remind them to complete their personal or oral care routines.

People were encouraged to be independent. Some people left the service independently to go to the local shop, or to visit the nearby town. One person we spoke with told us they knew the codes to leave the building and had a process in place agreed with staff to ensure they were safe when they left the service.

When it was people's birthdays, staff organised parties for them and their relatives. The chef told us they would bake a cake for the person, and staff would purchase an individualised present for each person based on their likes and dislikes.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, care plans had not been completed consistently. The level of detail relating people's choices and preferences was varied and care plans had not always been completed in a timely manner following people's admission to the service. At this inspection, no improvement had been made.

When people came to live at the service, the provider's policy stated that staff used the admission assessment to complete a two-week initial care plan, including initial assessments of risks. However, this policy was not consistently followed. The registered manager told us, that one person's mental health and behaviour needs were being assessed before the full care plan to be written. However, the person had been admitted to the service two and a half weeks prior and at the time of the inspection, did not have a care plan or initial risk assessments in place. Staff did not have any guidance to refer to when supporting the person.

The level of detail in the care plans continued to vary, there were some care plans that included people's choices and preferences and others that did not. For example, one person could not express themselves verbally; the care plan stated that they used body language, but there was no information about what this body language was and what it meant. Staff who did not know the person well, would therefore not be able to communicate with them. There were care plans that did not detail people's needs, such as when people could not put sentences together or what triggers caused people to act in a certain way.

Permanent staff spoke confidently about the way they supported people and met their choices and preferences. However, there was a large amount of agency staff working at the service and there was a risk that people may not be supported in the way they preferred. The provider had an electronic system in place for care planning. Staff we spoke with confirmed suitable arrangements had not been made to ensure all agency staff had access to people's electronic care plans, although regular agency staff did have access. This placed people at risk of not receiving person centred care.

Some people, and their relatives expressed concerns about the activities available to people, and the risk of social isolation. Some people preferred to stay in their rooms, and did not enjoy the group activities organised. Relatives told us they had concerns about people being left alone in their room without social interactions for long periods of time. Documentation we reviewed confirmed that some people regularly declined to take part in activities and we could not establish what action had been taken to ensure the person was provided with meaningful engagement on an individual basis.

The failure to provide person-centred care, designed to meet people's needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Documentation we reviewed as not consistent or up to date. Some people had wounds, these were managed by the nursing staff. We reviewed wound care plans, these had not been consistently completed. Records for one wound had not been completed since 17 December 2018, even though the wound had not healed.

The monitoring of people's diet, fluids and position changes were recorded on the electronic system and in people's rooms on paper, these records did not match. The electronic records were not accurate and did not reflect the care that had been given.

The provider failed to maintain accurate, complete and contemporaneous record in respect of each service user. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an activities team that consisted of two staff members, and two volunteers. Most people we spoke with were positive about the activities team. People told us "I like the singing in the lounge," and "The activities team are very good. They also sit and chat and massage hands." During our inspection, the activities team facilitated chair exercises, a chair yoga class and a discussion session lead by a volunteer which people told us they enjoyed. There was a timetable of activities displayed within the service detail which activities were available on each day. These included visits from the pets as therapy dogs, poetry, music and games. Staff held a winter ball before Christmas which was well attended by people and their relatives. People had been supported to attend their church for services. Staff knew people well, their backgrounds and histories. For example, one person was a keen photographer, and supported staff by taking photographs of events at the service, which they were really proud to share with us.

At our last inspection, we found the provider failed to take necessary and proportionate action when complaints had been made. At this inspection, we found improvements in this area. Complaints were now being documented, and all complaints received had been responded to, and resolved by the registered manager. There was a complaint log the registered manager completed, reviewing the complaints made, and the progress of the complaints. A new complaints form had been introduced. There was a complaints process in place for people and their relatives. People and relative's we spoke with told us they were confident to raise concerns, and that the registered manager would take action. A relative said "I would go and speak to [registered manager]; they are ever so nice."

The registered manager kept a log of compliments received to the service. These included; 'Thanks for the wonderful care their [relative] has received' and 'A heartfelt thank you for all your loving care for [name].'

People and their families had been asked about their end of life wishes and these had been recorded. The service worked with GP's and other health professionals to support people to plan their end of life needs and ensure that their choices and preferences were met. Medicines were available to staff, to keep people comfortable when needed. Staff were able to tell us how they supported relatives following the passing of their loved ones.

Inadequate

Is the service well-led?

Our findings

Leadership at the service was poor. The provider and registered manager had failed to ensure that people's needs were known and met. This had an impact on people's safety, and the quality of care they received. At our last inspection, we found that process in place to monitor, and improve the quality of the service were not sufficient. At this inspection we found no improvements, with widespread and significant shortfalls. Checks and audits had been completed regularly, and audits identified shortfalls. For example, the quality audits completed in October, November, and December 2018 identified issues in relation to medicines raised in this report. For example, the medicine audits for all three months identified the audit had 'failed' due to stock balance checks. When we inspected, three months after stock balance checks had been identified as an issue, we found this to be unresolved, and identified issues with medicines.

We found that information technology systems such as the electronic care planning system were not used effectively to improve the quality of care. Care plan tracking was identified as an issue in the past two audits completed prior to our inspection. The most recent audit stated that there were '155 overdue actions' from the system. However, despite this being identified in the providers audit, we continued to find discrepancies in care plans. Furthermore, these inconstancies were highlighted during our previous inspection, and had not been resolved. During this inspection, we continued to find care plans lacked detailed guidance for staff to follow and were not always reflective of people's current needs.

The provider had an action plan, that detailed the breaches found during the previous inspection, and the progress towards meeting these breaches. The action plan from December 2018 showed the provider was still working to meet four of the five breaches identified during our previous inspection. This demonstrated that governance systems were not effective and that the registered manager and provider failed to learn or drive service improvements.

At our last inspection we raised concerns about staffing levels. Despite this, the providers internal audit, which reviewed the areas highlighted in the previous inspection, did not review or consider staffing levels. At this inspection we found there continued to be a high use of agency staff and staffing levels continued to be insufficient to meet people's needs. Staff we observed were very busy and had little time to engage in meaningful conversations with people. Staff we spoke with told us that the lack of staff impacted their ability to meet the needs of people, and affected staff morale. Staff were not adequately supervised, there continued to be minimal formal staff supervision and competency checks to monitor the quality of the care provided.

People told us they received a quality assurance survey regularly and felt that any issues raised on this were dealt with appropriately by management. However, we found this was not consistently the case. The results of the most recent survey from 2018-2019, which the provider informed us were still in draft format, detailed that 70% of people and relatives did not believe there were sufficient levels of staffing. The provider offered a number of benefits and incentives to work for the organisation, however, we found that the provider was unable to retain staff and address staffing shortfalls.

The provider failed to maintain accurate records in respect of each service user. The provider had failed to fully assess, monitor and improve the quality and safety of the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our last inspection a new registered manager had been employed. The registered manager joined the service in July 2018. People told us there had been a 'succession' of registered managers, and staff told us the management changes were challenging as each new registered manager tried to share their vision for the service. People, relatives and staff were complimentary about the new registered manager. One person told us "[registered manager] is making a good job of addressing weaknesses that were in place before they arrived." A relative told us "The registered manager is engaged with the home and cares about it." However, despite this positive feedback, we found the registered manager and provider failed to make improvements or address concerns following last years inspection.

The registered manager told us they kept their skills up to date by working with other healthcare professionals and sharing best practice within and externally. The registered manager completed regular training and told us they worked alongside staff at the service to ensure their skills remained up to date. However, rotas we reviewed did not confirm this.

Staff and the registered manager were working in partnership with other agencies. The registered manager told us they were working with healthcare professionals on the 'red bag scheme'. The red bag scheme is helping to provide a better care experience for care home residents by improving communication between care homes and hospitals. The registered manager had also been working with the local care homes group to share good practice and for staff to attend specialist training. However, we found staff did not have specific training to help them support people, for example to manage behaviours that could challenge.

Staff completed a survey, the results of the 2018 survey had just been collated by the provider and shared with the registered manager. Staff were asked about their training and development opportunities, the communication within the service, and if they felt valued and received recognition for their roles. 76% of staff said the registered manager was approachable, however 53% of staff stated they were concerned about staff turnover in the service. The registered manager informed us they would review the results of the survey and feedback to staff on actions in the next staff meeting.

People told us there was a positive culture within the service, and that the staff team worked well together. Staff told us they enjoyed working at the service, but the lack of staffing created strain. Staff told us they worked hard to shield their frustrations from people. One staff said "I wouldn't say the morale is fantastic. Staff feel a bit fed up with it all. It's not done in front of the people we support. People wouldn't know."

Staff were able to describe the values of the provider, including 'people being unique' and treated as 'one of a kind.' However, we found due to the lack of staffing people were not consistently treated 'uniquely.'

Staff had regular team meetings, however these were not effective. Accidents and incidents were discussed to try to reduce the likelihood of the event reoccurring, however evidence reviewed confirmed this was not consistently successful. During a senior meeting in November 2018 it was identified that staff did not feel confident on the computerised system and required further training. It was unclear if this had been facilitated by management following the request from staff. Staff we spoke with confirmed they were still unsure of how to use the system, however on the day of our inspection training was being delivered in using the computerised system for care planning. Care records we reviewed were not up to date, and consistent with people's needs.

Regular meetings were held for people and their relatives to give feedback on the service and discuss any improvements that were being made. Meeting notes we reviewed showed people were updated on recruitment progress for new staff for the service, as well as giving details on the training staff, and agency staff receive. The registered manager had introduced meetings to discuss food options, as an action from the previous inspection.

Services that provide health and social care to people are required to inform the Care Quality Commission of important events that happen in the service. This enables us to check that appropriate action had been taken. The registered manager was aware of their responsibilities to inform CQC of significant events that happened in the service, in a timely way and had done so. It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had conspicuously displayed their rating on a notice board in the entrance hall and on their website.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to provide person-centred care, designed to meet people's needs

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 The provider failed to have sufficient numbers of competent, skilled and experienced persons deployed in order to meet people's needs. The provider failed to provide appropriate support, training and supervision to enable staff to carry out their duties.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider failed to mitigate known risks to people and protect them from avoidable harm.

The enforcement action we took:

Served warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider failed to maintain accurate, complete and contemporaneous record in respect of each service user.

The enforcement action we took:

Served warning notice