Weldglobe Limited

St Georges Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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 13 and 21 July 2016, and was unannounced.

St Georges Care Home provides accommodation, care and support for up to 35 older people, some living with dementia. At the time of our inspection there were 29 people using the service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

At our last inspection 30 April 2015, we found that the registered manager had not sent us information that we expect them to send us routinely in the form of statutory notifications. This is information about important events they are required to send us by law. During this inspection we found that they had addressed this issue.

At the last inspection we found a breach of Regulation 17 HSCA (RA) Good governance. Shortfalls identified the provider was failing to seek and act on feedback from people for the purpose of continually evaluating and improving the service. In addition systems were not in place to monitor the quality of the service and keep records of the outcome.

During this inspection we found there were still problems with the systems in place to assess and monitor the safety and quality of service provision. Leading to a lack of governance and oversight in line with current regulations. Existing quality assurance systems were failing to protect people from the risks of receiving inappropriate or unsafe care and treatment. Appropriate action to independently identify, assess and manage risks relating to the health, welfare and safety of people and others who may be at risk had not been established.

We also found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to staffing, person- centred care, respect and dignity, safe care treatment and good governance. You can see what action we told the provider to take at the back of the full version of the report.

The provider was failing to ensure that the service was operating effectively to ensure that people were receiving safe and effective care. There were gaps in how the service assessed and monitored the quality of its provision. While there were some quality assurance mechanisms in place, these had proved ineffective at identifying areas for improvement, and not all aspects of the service were being effectively monitored. The provider did not have robust oversight of the service's operations and this was impacting on the quality of the care delivered.

People were not consistently supported by sufficient numbers of staff who were effectively deployed to

meet people's needs. There were occasions, for example at meal times where staffing levels were not appropriately deployed to ensure people had a good mealtime experience. At times care was task focussed and hurried with staff unable to respond to people promptly.

Risk assessments did not consistently provide staff with guidance on how risks to people were minimised. Improvements were needed to ensure people consistently received care and support that was personalised to them and met their individual needs and wishes. Staff did not always respect people's privacy and dignity and interact with them in a caring, compassionate and professional manner.

People's experience of how they spend their days was inconsistent. Whilst there were some areas of good practice with regards to group activities and social stimulation there were also several instances where people were left for periods of time with little or no interaction. Improvements were needed to ensure people especially those living with dementia spent their time in meaningful and fulfilled ways.

There were areas in the service where equipment was not always stored safely and where people's individual needs were not safely met by the adaptation design and decoration of the service.

Robust systems were not in place to ensure care and support was based on the assessed needs of each person and reflected in their care records. Care plans for people were not effectively reviewed or reflective of people's up to date needs. Risk assessments in relation to people's personal care, moving and handling and medicines had been completed to keep people safe. However, we found that the information held was not consistent across the service, and this meant that staff did not always have accurate and clear guidance to help them support people safely at the service.

Improvements were needed to ensure appropriate arrangements were in place to ensure people's medicines were administered and recorded safely.

Safe recruitment checks on staff were carried out. Staff were trained to meet people's needs. However improvements were needed to ensure staff received regular supervision to feel confident in their role and care for people safely.

People and relatives were complimentary about the care and support provided.

Procedures were in place which safeguarded the people who used the service from the potential risk of abuse. Staff understood the various types of abuse and knew who to report any concerns to.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLs). Appropriate mental capacity assessments and best interest decisions had been undertaken by relevant professionals. This ensured that the decision was taken in accordance with the Mental Capacity Act (MCA) 2005, DoLS and associated Codes of Practice

People and relatives said if they needed to make a complaint they would know how to. There was a complaints procedure in place for people to access if they needed to. However complaints and feedback received could be used more routinely as an opportunity to learn and improve the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Deployment of staff did not always ensure there were sufficient staff to meet people's care and welfare needs.

Risk assessments did not consistently provide staff with guidance on how risks to people were minimised.

Improvements were needed in the service's management of medicines.

There were areas in the service where equipment was not always stored safely and where people's individual needs were not safely met by the adaptation design and decoration of the service.

Staff were knowledgeable about how to recognise abuse or potential abuse and how to respond and report these concerns appropriately.

Is the service effective?

Requires Improvement

The service was not always effective.

Robust supervision arrangements were not in place to support staff in their role to effectively meet people's needs.

The Deprivation of Liberty Safeguards (DoLS) were sufficiently implemented. Referrals had been made where required.

People's nutritional needs were assessed and professional advice and support was obtained for people when needed. However people were not consistently supported to have a positive meal time experience.

People had access to appropriate services which ensured they received ongoing healthcare support.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff approach was inconsistent and at times task focussed and hurried. Staff did not always undertake meaningful interactions with people.

Peoples' privacy and dignity was not always respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's experience of how they spend their days was inconsistent. Whilst there were some areas of good practice with regards to activities and social stimulation there were also several instances where people were left for periods of time with little or no interaction. Improvements were needed to ensure people including those living with dementia spent their time in meaningful and fulfilled ways

People's care was assessed and reviewed and changes to their needs and preferences were identified and acted upon. However improvements were needed to ensure care records provided staff with the guidance to consistently provide personalised care and support to people.

People knew how to make a complaint and felt that their choices were respected.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not ensured that the service was operating effectively to ensure that people were receiving safe and effective care at all times.

Systems and processes to effectively assess, monitor and improve the quality and safety of the service were not in place. This meant the service was unable to independently identify where quality and safety were being compromised and respond without delay.

St Georges Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 13 and 21 July 2016 and was unannounced. The inspection team consisted of an inspector and a specialist advisor who had knowledge and experience in dementia care.

Before the inspection the provider completed a Provider Information Return [PIR]. This is a form which asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not speak with us, for example, people living with dementia.

During the inspection we spoke with eight people living at the service, seven people's relatives, and one health professional. We spoke with the registered manager and nine members of care, catering and domestic staff. We also observed the interactions between staff and people.

To help us assess how people's care needs were being met, we reviewed five people's care records and other information, including risk assessments and medicines records. We also looked at records relating to the management of the service, recruitment, training, and systems for monitoring the quality of the service.

Requires Improvement

Is the service safe?

Our findings

We found inconsistencies with levels and deployment of staff. On the first day of the inspection we observed several instances when there were insufficient numbers of staff to keep people safe and to meet their needs. This included one person repeatedly calling out, "Nurse," and, "Help," trying to attract a staff member's attention. Their requests went unanswered as staff were busy attending to other people's needs. We also saw that some people became anxious and upset when left alone. Staff were unable to provide the level of one to one support needed in these situations because they had to attend to other people's needs.

In addition the lack of staff effectively deployed at the lunch time meal meant that not everyone had a positive meal time experience. For example we saw a member of staff supporting two people to eat their meal at the same time. They were unable to focus on both people enough to ensure that they were not rushed and were able to use the time to positively engage and enjoy that time. In the smaller lounge the staffing arrangements and layout of the room did not factor in the risk of choking. There was one member of staff for a period of 20 minutes to meet the needs of 10 people. Two people needed regular reassurance as they were unsettled and kept getting up to walk around. The wall in the middle of the room restricted the view of being able to see that people on both sides were safe and risks could be promptly addressed, for example if a person was choking or fell. When another member of staff came to assist, both members of staff stayed on the same side of the room unable to see the people on the other side and be assured they were safe and not at risk.

Staff on duty reflected the levels reported on the rota, however, we found that there was no system in place to ensure that staffing levels and skill mix were being reviewed continuously, and adapted to respond to the changing needs and circumstances of people. The registered manager was unable to demonstrate how they had considered the different routines of the day against the existing staffing levels and how this affected people's care.

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

Following the first day of the inspection the registered manager contacted us to advise they had taken immediate action to address the shortfalls found surrounding meal times. Our second day of the inspection found the tables had been moved and positioned in the two dining areas to enable staff supervising and assisting with mealtimes the ability to see all the people in the rooms.

Improvements were needed in the service's management of medicines. We found inconsistencies with the systems in place to ensure people were administered their medicines in a safe manner. Two members of staff operated a 'tag team' method. On the first day of the inspection the medicines trolley and all necessary equipment was taken into a small snug area in the service and the medicines dispensed from there. When one member of staff left the room to administer a person's medicines they informed their colleague and vice versa. This system worked well to ensure the trolleys were monitored at all times. However, the system failed when the member of staff who was monitoring the unlocked trolley moved to another area in the snug, out

of sight of the medicine. This was unsafe as it potentially allowed the other people, staff and one person's relative in the room access to medicines which may cause harm if swallowed.

We saw a staff member administer eye drops to one person. There were two separate records in place that the staff member was required to sign to show that these were provided. They had signed one but not the other, we prompted this staff member to ensure that both were signed to give a clear audit trail. This is potentially unsafe as having two records running for the same medicines risks the person being overdosed. In addition some medicines were dispensed without checking the person was available and ready to receive their tablets. This meant that unnamed dispensed drugs were left in the trolley during the medicine round, ready to be given when the person returned to the lounge. This could lead to the medicines being given to the wrong person. It would be safer to only dispense people's medicines when they were available to take them.

Bottles of medicines and the trolleys were sticky in places; this is unsafe as it allows dust to adhere to bottles and potentially contaminate the product.

Although medicines audits noted the occasional missing signatures from the MAR charts they did not reflect the actions taken to address the issue. This meant that the records did not clearly show that people had received their medicines as prescribed.

The registered manager assured us they would review their medicines processes and systems in response to our feedback.

Risk assessments were in place which provided staff with guidance on how risks to people were minimised. This included risks associated with mobility, nutrition and medicines. However improvements were needed to ensure people's care records were accurate, particularly in relation to moving and handling plans. Some plans provided staff with clear guidance on how to move people, but others did not provide adequate instruction to staff which would ensure that people were moved safely and comfortably. For example one person's record stated they were able to walk with the assistance of two members of staff. However in another part of their care plan it was noted that they should be hoisted for all transfers. This meant that people may not be receiving safe care in line with their current needs. We brought this to the attention of the registered manager, who said they would take prompt action to update people's risk assessments including their moving and handling plans.

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

Improvements were needed to ensure equipment was always stored safely. During the day of the first inspection there were a number of wheelchairs used for assisting people to mobilise left in the main lounge. This impeded people's movement around the room and posed a potential trip hazard. The lounge space was overcrowded when people were seated in their chairs. Staff were seen repeatedly moving wheelchairs, people's footstalls and side tables to be able to walk about the room. However on the second day of the inspection the registered manager showed us the wheelchairs had been moved to another area of the service whilst appropriate storage was being arranged.

People's individual needs were not safely met by the adaptation design and decoration of the service. The newly carpeted areas had fine multi coloured stripes on a green background. This was particularly disorientating for people with visual spatial problems especially those living with dementia. Whilst the home had a range of good reminiscence resources stored in a corridor space decorated as a 1960's kitchen, there

was no natural light and the doors to the communal bathroom and main corridor were disguised by highly patterned decoration. This is potentially unsafe and disorientating as someone leaving their bedroom would not be able to find a safe exit. In addition there was highly patterned wall paper in this poorly lit area which could be distressing for people with spatial problems resulting from Parkinson's or dementia.

We recommend that the service explores current guidance from a reputable source on improving the design and decoration of accommodation for people living with dementia (For example Alzheimer's Society's website).

Despite what we had found people told us that they were safe living in the service. One person said, "I feel very safe and settled here." A relative described how they felt that their relative was safe and how the staff were alert to the risk of them falling and carried out regular checks specifically at night to ensure they were safe. They said, "I feel better knowing the staff are close by and pop in to make sure [person] is safe and secure."

On the second day of the inspection we found the registered manager has taken action to address the inconsistencies with staffing and the safe management of medicines. There was effective deployment of staff and leadership during the shift. They also advised they were developing a formal process for determining staffing levels in line with people's needs and busy times of a shift. In addition we saw that people received their medicines in a safe manner and medicines were administered, stored and recorded safely. One person said, "I get my tablets on time and when I need them. Always with a drink so I can swallow them properly." Staff were seen to discreetly provide reassurance and an explanation to people about what there medicines were for. These measures need to be sustained and embedded into practice to ensure people's needs are safely met.

Systems were in place to reduce the risk of harm and potential abuse. Staff had received up to date safeguarding training. They were aware of the provider's safeguarding adults and whistleblowing (the reporting of poor practice) procedures and their responsibilities to ensure that people were protected from abuse. Staff knew how to recognise and report any suspicions of abuse to the appropriate professionals who were responsible for investigating concerns.

Appropriate recruitment checks had been carried out on new staff, to ensure they were of good character and suitable to work with people living in the service.

Requires Improvement

Is the service effective?

Our findings

People's lunch time meal on the first day of the inspection was not positive. There was inconsistent leadership during the shift; staff were not organised and well-co-ordinated to consistently meet people's needs effectively and safely.

Not all staff told people what food was being served to them. In the main lounge drinks were placed out of people's reach resulting in one person spilling their juice on their clothes and the floor. People who were physically able were taken and seated at the tables first which meant they had a long waiting time while others were assisted. Some people became restless and got up from the table, when this occurred they were told by staff to, "Sit down, lunch is coming," and "You stay there." One person who had spent all morning in their wheelchair was seated at the table 45 minutes ahead of the meal and was unable to reach their plate or cup effectively because their seating was too low, they were not offered the choice to sit on a dining room chair. People who had slept in their chairs all morning were woken last after everyone had been seated; this gave them, very little time to wake up and adjust before their food was served. Their meal time experience was affected because they were too drowsy.

People who required assistance with their meal were not always supported by staff appropriately and in a sensitive manner. We saw one member of staff supporting a person to eat their meal with a fork when a spoon would have been more effective. The food kept slipping through the fork delaying the person getting a mouthful of food and at the appropriate temperature the meal was served.

In the smaller lounge one person was observed to be given their meal without the appropriate equipment to maintain their independence; a plate guard and their own beaker as referenced in their care records. We had to intervene to a member of staff who was unaware the person was becoming frustrated in their efforts to eat their meal without the necessary equipment they required.

Following the first day of the inspection the registered manager contacted us to advise they had taken immediate action to address the shortfalls surrounding meal times. We found on the second day of the inspection that the meal time experience was positive; staff were well organised and communicated with each other to ensure people's needs were met.

These improvements need to be fully embedded into practice to ensure people are consistently provided with a positive meal time experience that supports and promotes their independence.

We recommend that the service explores current guidance from a reputable source to ensure that mealtime experiences are an opportunity to support and promote independence, in addition to creating a positive mealtime experience, particularly for those with specialist needs including dementia and Parkinson's.

Systems were in place to ensure that staff received training including refresher updates and achieved qualifications in care. People told us that staff were well trained and competent in meeting their needs. One person said, "[Member of staff] is very capable and knows how I like things done. Doesn't need to be told

twice. Others you sometimes have to remind them." A relative commented that, "Staff are good at what they do. I have never seen anything to give me cause for concern."

However processes for staff supervision were not robust. Staff reported infrequent supervision sessions. Records indicated slippage with planned supervisions but provided no explanation or alternative date when they would take place. Improvements were needed to ensure staff were regularly supervised to develop their day to day practice and enable them to undertake their roles and responsibilities properly.

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

Improvements were needed to ensure staff consistently asked for consent before they supported people with their care needs, for example to mobilise or when providing assistance with eating or with personal care. On the first day of the inspection the majority of staff did seek consent but we observed instances where staff moved people's wheelchairs, footstalls or tables without asking for people's consent and did not explain when supporting someone with their meal what was happening. This caused people to be startled and disorientated. We reported this to the registered manager who advised they would take immediate action. On the second day of the inspection we saw that staff were seeking consent and were able to demonstrate to us how they involved people as fully as possible in decisions about their care and support.

Discussions and records confirmed that staff had received MCA training. Guidance on best interest decisions in line with MCA was available to staff in the office.

MCA assessments and best interest decisions were in place for people. The registered manager told us that relevant applications had been made under DoLS to the relevant supervisory body, where people living in the service did not have capacity to make their own decisions. They told us about examples of this and the actions that they had taken to make sure that people's choices were listened to and respected. They understood when applications should be made and the requirements relating to MCA and DoLS.

People were complimentary about the food in the service. One person said, "The food is nice. Good old fashioned food. Very tasty." Another person commented, "I don't mind the food here. Plenty to eat. Portions are a good size."

People's records showed that, where required, people were supported to reduce the risks of them not eating or drinking enough. Where concerns were identified, including weight loss, action had been taken, for example informing relatives or making referrals to health professionals. Guidance was acted on where people were required to have fortified drinks to boost their calorie intake. Where people were at risk of not drinking or eating enough there were records in place to monitor this. However improvements could be made in the recording of people's food and fluid charts. Although the charts were updated regularly where required there was no target fluid intake on the form for staff to be aware if this had been reached. Without

this information staff could not be assured that people were provided with enough to drink in line with their assessed needs.

People had access to health care services and received ongoing health care support where required. We saw that referrals to relevant professionals were done so in a timely manner. One person told us, "I see the doctor whenever I need to. I have had my feet done and think it is my eye check today". Another said, "If something is not right I just tell [registered manager] or one of the others [staff] and they make me an appointment for a doctor". A visiting health professional said, "I find the staff at the home are very accommodating. They know the residents well and will contact us if they need advice or have any concerns."

Requires Improvement

Is the service caring?

Our findings

On the first day of the inspection there were inconsistencies in the staff approach leading to several instances where people's needs were not being met and their dignity compromised. This included staff ignoring people's comments and speaking to each other over people. Language used by staff did not always value people. One person tried to make conversation with a member of staff and tell them some information but the staff member raised their voice and re-directed the person to focus on the task they wanted them to do which was to, "Sit down."

People were given misinformation such as, "I will be with you in two minutes," "Give me 30 seconds," and, "Be with you in a second." Despite telling people that they would return in a set time, they did not. This led to people becoming frustrated.

Staff did not consistently or effectively respond to the attempts of people to communicate. Their interactions did not always value people. People were repeatedly told by staff to, "Sit down," or "Sit down and wait." One person who tried to leave the lounge was told by a member of staff, "You must stay here where I can keep an eye on you." This restricted their choice and independence. One person with limited verbal speech was given a drink which they drunk quickly. They called out to a member of staff to attract their attention. They were acknowledged but staff did not approach the person. The person continued to try and express themselves through non – verbal techniques that they wanted more to drink; putting the beaker to their mouth and banging the beaker on the table. This went on for over 10 minutes until the person eventually dropped the beaker to the floor, put their head in their hands and made no further attempts to communicate. This did not value the person nor did staff respond to their requests for attention.

Three staff members involved in the transfer of a person from their armchair to their wheelchair all spoke to the person at the same time. The person was living with dementia and was unable to follow what they were being asked to do because of the confusing instructions. Before the person was settled two of the staff moved away, leaving the third staff member struggling to seat the person comfortably.

People who tried to leave the lounge were told to return to their seats and physically prevented from leaving by a member of staff blocking the doorway. One person became upset as they wanted to go to the toilet. This was disregarded by the member of staff who said, "You must stay here where I can keep an eye on you." Staff did not consistently respond to people's requests if they fell out of the service's usual routine. For example one person asked for a drink and was told it would be lunch time soon and there would be drinks then.

We saw that when people did engage with visiting relatives or staff, they responded in a positive way, smiling and talking. However in between these times people sat for long periods with limited stimulation, showed signs of being withdrawn and disengaged with their surroundings.

Whilst the majority of staff respected people's privacy and dignity there were inconsistencies. This included some staff observed to discuss people's personal care needs over their head in full hearing of the other

people in the lounge.

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

The registered manager contacted us after the first day of the inspection to advise us of the immediate actions they had taken following the inconsistencies seen in the staff approach. This included speaking with staff and reviewing the staff deployment arrangements including leadership to ensure staff were supported in their role to meet people's needs. They acknowledged that in future they would make themselves more visible to ensure staff felt reassured by their presence as some staff had expressed they were nervous during the inspection. On the second day of the inspection we found that the staff approach was in keeping with the positive feedback we had received from people and their relatives. The atmosphere in the service was calmer and staff were less task focused. We saw staff and the registered manager engaging with people in a warm and friendly manner and people were responding by laughing and smiling. Several people were talking about the boat trip they had been on the day before with the staff saying how much they enjoyed it.

Despite the inconsistencies we had seen during our inspection people told us that the staff were caring and treated them with respect. One person said, "I like it here, it is very nice and the staff treat me well." Another person commented, "Staff are very helpful most of the time; none are unkind to me." A third person shared their experience of using the service with us they said, "Staff are all very nice. I have had no troubles settling in and feel well looked after."

Relatives told us that they were always made to feel welcome when they visited and that they could 'turn up' at any time. This meant that people were able to socialise with family and friends as they chose and reduced the risk of social isolation. Feedback from relatives about the staff approach was positive. One relative commented, "Generally all in all it is very good, staff are very kind and know [person] really well and have developed a good friendship." Another said, "I come here all the time and am made most welcome. People seem happy and content here."

We received mixed views about how people were involved in their ongoing care arrangements. One person said, "They [staff] have got a big folder with stuff in about me but I not sure what is in it." Another person said, "I have seen my care plan with my [relative] and [member of staff] recently." We brought this to the attention of the registered manager who told us that they were intending to implement a more robust system where people and their families were encouraged to take part in developing their care plans. This would include care records being consistently signed by people or their representatives.

Requires Improvement

Is the service responsive?

Our findings

Improvements were needed to ensure people's care records were current, accurate and detailed in respect of their plan of care and support. There was no formal plan for reviewing people's care records. We could not be assured that information was relevant and reflected people's needs due to inconsistencies found. This included one person's charts for documenting their bowel movements recorded on the chiropody treatment form. There were missing entries on the bowel chart which may have been recorded elsewhere but this had not been independently picked up. This meant the monitoring in place for the person was ineffective and not an accurate record.

There were discrepancies found in the observations of people's health; monthly weights were being recorded but for two people there were no entries since May 2016 with no explanation for the gaps. Therefore staff could not identify changes in people's condition and respond accordingly. People's daily records were task led reflecting the care provided without reference to interactions and observations of wellbeing; including mood and mental state. In addition documentation in people's care records did not consistently include the person's name or other identifier and some did not have a signature and or dates to show when the record had been completed and by whom. We could not be assured the information was up to date, accurate and relevant in meeting their needs.

Care plans should contain comprehensive information to ensure staff understood the individual needs of the people they are caring for. Care plans did not always provide up to date and complete information, which meant that opportunities were being missed to tailor care for the individual needs of people. It also demonstrated that the services' approach to regular reviews of people's care was inconsistent. The registered manager told us would act on the feedback we provided and review and update all care plans.

This was a breach of Regulation 9 Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Improvements were needed to ensure people who were more dependent including those living with dementia consistently had their social and cognitive needs met. People received limited social attention and were at risk of isolation as staff interactions especially on the first day of the inspection were task focused and fixed on routines. Systems were not in place to accurately document the activities undertaken by staff other than the activities coordinator.

There was one activity coordinator on shift responsible for providing activities and engagement for all 29 people and whilst we observed that there were some areas of good practice with regards to wider group activities and social stimulation, such as a current affairs group and a mini putting game, we found inconsistences. This included where some people were left for long periods of time with little or no stimulation outside of the activity coordinator's hours. The first day of the inspection staff were task orientated and only interacted with people when completing a care task or following set routines. It was left to the activities coordinator to engage and provide social stimulation to people. On the second day of the inspection the activities coordinator and staff were engaging and interacting with people providing one to

one and wider group activities and stimulation.

Staff told us that regular safety checks were in place for people who spent their time alone and they tried to spend quality time with people but acknowledged that records did not reflect the individual engagement and activity provided. Whilst tea and cakes was arranged for two people in the bedroom of one of the people who by choice preferred to remain in their bedroom, we were not assured that an effective system was in place to ensure everyone received quality interaction to reduce the risk of isolation.

Despite the inconsistencies we had seen people told us that there were social events and a range of activities that they could participate in. This included games, quizzes and entertainers. People were complementary about the recent river boat trip. One person said, "We certainly had the weather for it. Was lovely bobbing about on the boat." Another person said, "We do lots of different things with [activities coordinator], [they] keep us busy."

People were supported to maintain their diverse needs for example their chosen faith. On the first day of the inspection we saw that people were taking part in Christian worship. One person said, "I enjoy the service and appreciate they come to do the service no matter what the weather."

People could have visitors when they wanted them. Three people's relatives said that they were always made to feel welcome in the service. This meant that people were supported to maintain relationships with the people who were important to them and to minimise isolation.

People told us they knew how to complain or raise a concern. One person who had raised concerns previously told us, "I didn't like something and I told them [registered manager], after speaking with my [relative]. [Registered manager] was very good and dealt with it there and then. I wouldn't hesitate to speak up again." A relative said, "I know the manager and all the staff here. If I had a problem I would raise it but to be honest there has been no need. [Person] is happy here." There was a formal complaints process available in the service. The log of complaints showed there had been none received in the last 12 months.

Discussions with people, relatives, staff and the registered manager told us that the service responded to people's comments and concerns. For example incorporating changes to the menu, the planning and provision of activities and events as well as individual changes to care arrangements. However information in this area was minimal and did not always reflect the actions taken in response to people's feedback. This was a missed opportunity for the service to demonstrate how they valued and took into account people's feedback to improve the quality of the service. The registered manager advised us they would look into how people's comments, concerns and compliments could be effectively recorded to demonstrate continual improvement of the service.

Inadequate

Is the service well-led?

Our findings

At our last inspection 30 April 2015, we found a lack of formal arrangements in place to seek and act on people's feedback for the purpose of continually evaluating and improving the service. In addition the provider did not have effective systems in place to monitor the safety and quality of the service and keep records of the outcome.

During this inspection we found there were still problems with the systems in place to assess and monitor the safety and quality of service provision. Leading to a lack of governance and oversight in line with current regulations. Existing quality assurance systems were failing to protect people from the risks of receiving inappropriate or unsafe care and treatment. The shortfalls we had identified had not been identified through the provider's internal quality monitoring arrangements. This included medicines audits which identified there were missing signatures in the Medicine Administration Records (MARs) but did not reflect actions taken to address this to improve practice and ensure people received their medicines as prescribed. Fire safety records were not completed to show that checks in relation to fire safety equipment, alarms and emergency lighting had been undertaken every month in accordance with the provider's policy and procedures and ensure they were fit for purpose. Infection control processes were not consistent. Records for cleaning and turning mattresses were completed on the same form and therefore the frequency of checking was not clear. We found a stained mattress in use which was a potential source of infection and had not been identified in the daily checks to ensure appropriate action was taken. Quality assurance systems were not robust in that not all aspects of the service, including spot checks of staff and audits of care plans, were being assessed and monitored effectively.

Effective systems were not in place to identify where the quality of the service was compromised, including the experience of people receiving the service. We found discrepancies in the staff approach and leadership during shifts which did not promote a positive culture that was person centred, open, inclusive and empowering. Staff practice was inconsistent; opportunities were not taken to improve the experience of people through person-centred care in line with best practice.

An effective and consistent approach to the staff supervision process was not in place. This is required to support staff, help them to develop in their day to day practice in caring for people and enable them to carry out their roles and responsibilities properly.

There was a lack of consultation with best practice guidance in relation to promoting an environment that was enabling, safe and promoted wellbeing. People's needs had not effectively been considered in relation to dementia and how this affects their cognitive ability, impacting on their day to day living.

Although improvements had been made to formally seek and act on feedback from people and relevant persons about their experience of the service by carrying out a satisfaction survey. There was no analysis and evaluation of the survey to drive improvement of the service. Informal feedback from people and the actions taken in response to comments and concerns was not effectively recorded. This was a missed opportunity to show how the service valued and acted on people's feedback.

The shortfalls we had identified had not been picked up through the provider's internal quality monitoring arrangements. This included inconsistencies with records and staff behaviours that did not consistently ensure that people received person-centred care in line with best practice. We noted that the service had begun working with an external consultant to develop their quality assurance systems but at the time of the inspection it was too early to see the impact of this.

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

When we brought our concerns to the attention of the registered manager, they acted promptly to ensure that improvements were made without delay. They submitted to us an initial improvement plan that took account of the shortfalls we had found and immediate actions to mitigate the risk. These improvements will need to be sustained to ensure people receive a safe quality service.

People and relatives knew who the registered manager was as they had been working in the service for a long period of time and were complimentary about their hands on approach. One person said, "[Registered manager] is lovely always checks in on me and makes sure I am alright." A relative said, "If I have any problems I speak to [registered manager] and they sort it out straight away."

Staff told us they felt able to raise issues with the registered manager, and spoke positively of them. One member of staff said, "[Registered manager] is supportive and approachable. Always available if you need them." The registered manager advised us they were developing the staff meeting minutes to improve communication to ensure all staff were kept informed of changes in the service and knew their roles and responsibilities and what was expected of them and others in the organisation. They added that future meeting minutes would include follow up to any actions arising as they had identified this as an area for improvement.

At our last inspection 30 April 2015, we found that the registered manager had not sent us information that we expect them to send us routinely in the form of statutory notifications. This is information about important events they are required to send us by law. During this inspection we found that they had addressed this issue.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Robust systems were not in place to ensure people's care records were current, accurate and detailed in respect of their plan of care and support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff approach was inconsistent and at times task focussed and hurried. Staff did not always undertake meaningful and respectful interactions with people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Robust systems were not in place to ensure safe and effective management of medicines. Risk assessments did not consistently provide staff with guidance on how risks to people were minimised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Deployment of staff did not always ensure there were sufficient staff to meet people's care and welfare needs.

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 17 HSCA RA Regulations 2014 Good governance Robust systems were not in place to effectively monitor and evaluate the safety and quality of the service to drive continual improvement. The provider has not ensured that the service was operating effectively to ensure that people were receiving safe and effective care at all times.

The enforcement action we took:

Warning notice served