The Oak Residential Homes Limited

Glendale Residential Care Home

Inspection report

14 Station Road
Felstead
Essex
CM6 3HB

Tel: 01371820453
Website: www.theoaksresidential.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 1 March 2017 and was unannounced.

Glendale Residential Care Home provides accommodation and personal care support for up to 20 older people who require 24 hour care and support including people living with dementia. On the day of our inspection there were 15 people living at the service.

The service had employed a manager and who had been registered since 2010. 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.

Visits from environmental health inspectors and a fire officer highlighted a number of areas where action was required by the provider to improve the safety of the environment and protect people from the risk of harm. Fire doors were wedged open. Food and hygiene safe practices were not followed to safeguard people from the risk of harm.

People's medicines were not managed safely and effectively. We were not assured that people received their medicines as prescribed. Improvements were needed in the way that people were supported with their medicines and how this was recorded and monitored.

We found a lack of sufficient measures in place to ensure the safety of people during procedures where staff were required to support people with their moving and handling transfers.

The provider did not operate a safe and robust system when recruiting staff. Checks on the suitability of staff including Disclosure and Barring (DBS) checks had not been carried out on all staff prior to their starting employment.

Staff were not to be provided with the full range of training required, relevant to their roles which would provide them with the skills and knowledge to keep people safe. This failure to consider, plan and provide for the range of skills required put people at risk of their health, welfare and safety needs not being met.

There was a lack of nationally recognised assessment tools in place to monitor people at risk of malnutrition. People's weight was not always effectively monitored and where people had lost significant amounts of weight, referrals to a GP or dietician for specialist advice and support had not been actioned. This placed people at risk.

The majority of interactions we saw were respectful and supported people's dignity; however improvements were required to provide privacy and dignity for people when using the upstairs shower. People were not

always involved in making decisions about their care.

People were being put at risk of not having their welfare and safety needs met as there was a failure to ensure that people were protected from the risks associated with improper operation of the premises. The provider had failed to respond fully to improve the safety of the environment to protect people from the risk of harm in response to fire officer visits.

The quality of the internal assurance systems in place were not robust enough to identify the shortfalls that we identified at this inspection. The provider failed to identify and mitigate the potential risks to people's health, welfare and safety.

The provider had a system in place to respond to complaints. However, complaints had been logged but the provider did not provide an audit trail of any response with a record of the steps taken to resolve complaints in a timely manner to the complainant's satisfaction.

During this inspection we identified a number of breaches of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People are at risk because there were not insufficient numbers of suitably trained, competent, skilled and experienced persons deployed in the service to meet people's needs.

People had been placed at risk as the provider did not operate an effective system for management of the premises. Not all areas of the service had been adequately maintained. The provider had failed to respond to improve the safety of the environment to protect people from the risk of harm.

People at risk of frequent falls were not well managed which meant that people continued to be at risk

Improvements were needed in the way that people were supported with their medicines and how this was recorded and monitored

The provider did not operate a safe and robust system when recruiting staff. Checks on the suitability of staff including Disclosure and Barring (DBS) checks had not been carried out on all staff prior to the start of their employment.

Is the service effective?

Requires Improvement

The service was not effective.

People's views on the quality of the food were in the main positive. However, the provider did effectively monitor those at risk of malnourishment.

Staff were not provided with the full range training required, relevant to their roles and provide them with the skills and knowledge to keep people safe.

People said that their health needs were met and where they required the support of healthcare professionals, this was provided such as visits from GP's and opticians. However, further work was needed to ensure people had access to regular dental check-ups and support when required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were kind and compassionate. However improvements were needed to ensure people had access to lockable spaces for their possessions and promote their independence.

The majority of interactions we saw were respectful and supported people's dignity; however improvements were required to provide privacy and dignity for people when using the upstairs shower.

People were not always involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not responsive.

Improvements were needed in how people's care was planned and provided. Care plans did not always provide staff with the guidance they needed to provide safe care and treatment that met people's needs.

The provider had a system in place to respond to complaints. However, complaints had been logged but the provider did not provide an audit trail of any response with a record of the steps taken to resolve complaints in a timely manner to the complainant's satisfaction.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The quality of the internal assurance systems in place were not robust enough to identify the shortfalls that we identified at this inspection. The provider failed to identify and mitigate the potential risks to people's health, welfare and safety.

Glendale Residential Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 1 March 2017 and was unannounced.

This inspection was carried out by one three inspectors 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 care service. The Expert by Experience had experience of providing care and support for an older person.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that 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 other information that we held about the service such as statutory notifications. This is information providers are required to send us by law to inform us of significant events. We also made contact with the local safeguarding authority and reviewed information sent to us from stakeholders.

We spoke with nine people who were able to verbally express their views about the quality of the service they received and five people's relatives. Some people were not able to verbally communicate their views of the service to us and therefore, we observed interactions and how care and support was provided to these people throughout our inspection.

We looked at records in relation to four people's care. We spoke with the manager, deputy manager, the cook and four care staff. During our inspection we spoke with one healthcare professional and stakeholders prior to our inspection.

We looked at records relating to the management of medicines, four recently employed staff recruitment records, staff training, risk assessments and systems for monitoring the quality and safety of the service.

Inadequate

Is the service safe?

Our findings

Staff told us they received safeguarding training through reading workbooks which included a question and answer assessment which was sent away to be assessed by a training provider. However, we determined that this safeguarding training was not at a suitable level for their role. All of the staff we spoke with said they would report bad practice to the manager if they witnessed it. However, they were unable to demonstrate any knowledge or awareness of local safeguarding protocols and how to refer matters of concern to the local safeguarding authority and others. Staff were not aware of any written safeguarding policies or whistleblowing procedures in place with guidance to prevent abuse. The manager told us she had not herself received any up to date training in this area for some time.

People were not always assisted to move in a safe way. There was for some people a lack of moving and handling risk assessments in place which would include a plan for managing risks in relation to the use of lifting hoists and wheelchairs.

We found that risks to people were not always assessed and minimised. We observed one person sat in a wheelchair being mobilised by staff to and from the dining room without foot plates in place. Foot plates attached to wheelchairs are designed to protect people from the risk of injury to their feet and legs when being transported. We pointed out this evident risk with the member of staff and also the manager. However, throughout the day of our inspection no action was taken to in response to our concerns to locate and place on the wheelchair the foot plates to mitigate the risk of harm to this person, staff continued to transport this person using the wheelchair without foot plates in place. We discussed this again with the manager who told us that this person did not like the footplates on the wheelchair. We looked at this person's care plan and found that no assessment of risk had been carried out which would assess the risk associated with the wheelchair being used without foot plates in place and no control measures in place to provide guidance for staff in the steps they should take to mitigate the risks to this person's safety.

We asked the manager and staff what arrangements there were in place to ensure staff were sufficiently trained in safe moving and handling techniques including the management of risk. The manager told us that they had previously been trained as a trainer to enable them to be accredited to provide staff with a demonstration of safe techniques and competency assessment of staff. However, they also told us their accreditation to provide this training had lapsed in 2016. This meant that we could not be assured that staff had been trained by a competent person.

We looked at the provider's accident and incident reporting. We saw that one person had experienced four falls within the last month. Although these incidents had been recorded, there was no record within this person's care plan including no assessment of risk with any falls prevention guidance for staff. This meant that there were no prevention measures put in place to mitigate further risks of harm from falls. We therefore believed this person to be at risk and discussed this with the deputy manager who told us they were not aware that referrals could be made to the local falls prevention team for specialist advice and support.

This demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Staffing levels at night did not meet people's needs. One person told us, "When I use the call bell staff come within five to fifteen minutes. I ring for assistance during the night." Another told us, "I am not overly worried when they are delayed as I know there is only one member of staff on at night."

Staff and the manager told us that there had been recent changes to the staffing structure and the allocation of staff. The post of activities organiser had been removed and we were informed that care staff now took responsibility for providing this support. The manager told us that the previously vacant posts of administrator and activities coordinator would not be filled and the administration tasks had now been cascaded to the manager who in addition to the day to day management of the service told us they frequently covered vacant care shifts.

The staff rota was not clear as to arrangements in place to support newly employed staff on their induction. We noted that one newly employed member of staff who had not been trained in safe moving and handling techniques was placed on the rota. We were not assured that they were working in a supernumerary capacity and were concerned that they would be expected to provide care for which they had not yet been trained and assessed as competent.

Staff and the manager confirmed that the staffing levels were set as three care staff during the period of 8am to 2pm, two from 2pm to 6pm and three care staff from, 6pm to 10pm. Care staff told us their role included laundry, serving meals and providing social activities alongside their care duties. At night, one waking carer, supported by a sleeping in carer who could provide support if needed. We noted that one sleeping in carer had been on call within the last month for 14 days without a break. With one waking night staff, there was not enough staff on duty to ensure people's safety and welfare. Records showed that people needed care during the night including those, living with dementia, who routinely woke up early and were supported with their personal care. This included people who were at high risk of falls. Staff who had worked nights told us there was insufficient staff to meet people's needs at night when two or more people required support at the same time. There was no effective system in place to demonstrate how the leadership calculated the staffing levels to ensure it was safe.

We found one member of care staff lived within the building where the service was provided, in a room on the top floor with meals provided from the communal kitchen. This member of staff as well as working shifts throughout the day was also designated to provide sleep in duties which meant they were required on call on a nightly basis. There was no employment contract in place which would specify the conditions of their employment and describe how the current arrangements would be safely managed and people living in the service safeguarded.

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

We reviewed the recruitment records for four most recently employed staff. We found that two staff had been employed to work at the service before adequate safety checks had been carried out. This included the provider not having carried out disclosure and barring checks (DBS) and obtaining references from the most recent employer. We were therefore not satisfied that the provider had established and operated recruitment procedures effectively to ensure that staff employed were competent, assessed as safe to work with people who may be vulnerable prior to the start of their employment and had the skills necessary for the work they were employed to perform. This demonstrated a lack of action taken by the provider to safeguard people.

This demonstrated a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were needed in the way that people were supported with their medicines and how this was recorded and monitored. Alongside the manager we carried out an audit of stock against medicines administration records (MAR) in relation to six people's stock of medicines. This included a review of stock and records for the administration of pain relief medicines and antibiotics. Four of the six people had not consistently received their medicines as prescribed. This included pain relief medicines and antibiotics. Staff had recorded on the MAR record a daily running total of medicines in stock which did not tally with the actual amount of stock in place. This meant that this daily audit of medicines was ineffective in identifying the shortfalls we identified.

Where people were prescribed transdermal pain relieving skin patches, there was no records of where the skin patch had been placed on the body which would have evidenced that care had been taken to place the patch on alternative sites at each administration in accordance with NICE guidance This meant that we were unable to determine if staff had administered patches in accordance with the prescriber's instructions to ensure people's safety and effectiveness of the medicines.

Not all medicines were stored safely and securely. The metal medicines cabinet did not have sufficient storage and we saw that two people's medicines had been stored in plastic boxes within a locked cupboard. This meant that medicines were not stored as required to ensure compliance with the Medicines Act 1968.

We found in the main kitchen food storage cupboard seven containers of thickening powder prescribed for people assessed as at risk of choking. We noted these items were up to four months out of date. We spoke to the manager who told us these items were waiting to be returned to the pharmacist but could not give an explanation as to why these were stored alongside food products.

We saw that where people had been prescribed medicines to be administered on an 'as and when required' basis known as (PRN) there were no up to date care plans with PRN protocols in place which would described what these medicines were prescribed for, what symptoms for staff to look out for and why these had been administered.

The medication record MAR was not an accurate or contemporaneous record. Staff, including the manager were signing for medicines such as prescribed creams and lotions when they had not personally administered them . This meant that the records may not reflect practice and we were not assured that people were consistently receiving their creams and lotions as prescribed.

The provider's medicines policy failed to provide guidance to the level of detail required in line with current legislation and National Institute for Clinical Excellence (NICE) guidance for managing medicines in care homes. We reviewed the report produced following a recent external medicines management audit which had been carried out by a Clinical Commissioning Group (CCG), pharmacy inspector on 6 February 2017. Shortfalls identified within this report which still required action by the provider included; the provider's medicines management policy should be updated to include information as to the management of homely remedies, a list of staff who are authorised to administer homely remedies, the need to implement PRN protocols with care plans updated, the recently misplaced controlled drugs register to be found and a clear record of controlled drugs being entered into the controlled drugs record book upon receipt and where errors had been made in these records, not to be crossed out but recorded in line with national guidance.

Some staff told us they had received medicines management training through workbooks. However, they were not regularly competency assessed to check their understanding of what they had learnt.

The manager showed us weekly and monthly audits. These had been sporadic with the last audit carried out in December 2016. Audits had been ineffective at identifying the discrepancies we found.

These shortfalls demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The premises were not fit for purpose in line with statutory requirements. This included insufficient bathrooms available for the number of people suing the service.

Recent building works had been carried out to provide for an increase in the number of beds from 16 to 20.

We walked around the service and saw some safety mechanisms in place such as window restrictors and radiator covers to protect people from the risk of falls out of windows and scalding from hot surfaces. However, we found a number of areas which presented a risk of harm for people. We found a fire door wedged open in one person's room. When we tested the hot water temperature where people had access, we found this quickly became too hot to comfortably keep our hands under the water. Whilst the recommended water temp should not exceed 43c, we noted from the provider's record of water temperature testing that there had been several months reports which identified these same water outlets with temperatures registered in excess of 70c. These records did not evidence any action taken in response to these identified risks and to rectify them. We were not assured that prompt, effective action had been taken to mitigate the risks to people from the risk of scalds. In contrast we found when testing the temperature of water from other outlets that the temperature remained cold. People and staff told us the downstairs shower room water temperature had been cold in the hand basin and the shower temperature lukewarm for some time. This was confirmed from our testing of the water temperature from these outlets. We also found in the downstairs shower room there was no heating provided. We discussed this with the manager who told us this room had been without heating for several months and they were waiting on a plumber to rectify this.

We noted from a review of actions from a fire officer's visit which took place in July 2016 that there was still outstanding work to be completed. For example, outstanding actions included the fire door to the staff room should be replaced with a recommended fire resistant door and an independent fire risk assessment should be carried out when the new building works had been completed by a person accredited to do so. The manager told us that an external company had been commissioned to complete this work and it was anticipated this would be completed within the next month.

We reviewed the provider's environmental risk assessments. These had not been reviewed and updated since 2015. We noted that there were two staircases within the service where people living with dementia had access. We asked the manager if these areas of the service had been risk assessed. The manager told us that they had not but would following our inspection take action to rectify this.

We reviewed the report from a recent visit to the service from environmental health staff carried out on the 27 February 2017. A number of areas had been identified where the provider was required to take action to mitigate the risks to people's health, welfare and safety. Areas of concern identified included ineffective hand washing and cleaning regimes, kitchen staff unaware of the correct use for sanitizer, items in fridges were not safely stored according to the provider's own policy and hand contact surfaces such as fridge's and

microwaves were found not to be clean. The provider was also found to have displayed for public viewing a five star rating when they had previously been rated only three stars.

We observed throughout the day of our inspection care staff wore disposable aprons whilst serving lunch. However, throughout the rest of the day staff consistently entered the kitchen to make drinks without wearing any protective clothing. This presented a cross infection risk as staff would provide personal care to people and then enter the kitchen without wearing the plastic aprons provided which presented a risk of bacterial cross contamination. We found a review of staff files and discussions with staff did not demonstrate that newly employed staff had received training in basic food hygiene.

This demonstrated a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

The provider told us in their provider information return document submitted prior to our inspection that, 'Staff are encouraged and supported in undertaking training from completing the Care Certificate to in house training, assessor led training and external training'. However, staff told us that all of their training was provided through the reading of workbooks, provided by an external organisation whereby staff were required to read the workbook and then answer written questions to assess their competency. Staff and the manager confirmed that there was no face to face training provided and neither were staff competency assessed in relation to the administration of people's medicines and in safe moving and handling techniques.

We looked at the files of four staff recently employed. We found for two staff the care certificate; a set of inductions standards that health and social care workers adhere to and evidence their competency had been commenced. However, for other staff we found there was a lack of induction programme and training profiles used to plan for training and record when completed, were found to be blank.

The manager confirmed that two newly employed staff, identified on the rota as working had not received training in moving and handling techniques. The manager who had previously been trained as a moving and handling trainer and designated to provide this training for staff and assess their skills and knowledge to ensure people were supported safely, their certificate of competency had expired in 2016.

For three staff employed in the last year we found supervision records contained little information which would evidence training that had been completed and lacked evidence of any planning for their personal development. Staff had not signed or could evidence that supervision had taken place. We were therefore not assured that people received care from staff who had been supported to undertake training, learning and development to enable them to fulfil the requirements of their role.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). 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.

Although staff and the manager told us they had received training in MCA through the reading of workbooks and submission of questions and answers assessments, it was evident from our discussions with them that they lacked adequate understanding of their roles and responsibilities with regards to the Mental Capacity Act 2005 and related Deprivation of Liberty Safeguards (DoLS). We were not assured that the training provided was relevant and effective in equipping staff to understand their roles and responsibilities in

promoting and protecting people's human rights.

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

People's views on the quality of the food were in the main positive. One person said that, "The food is nice, some not so nice, it depends whose cooking." Whilst another said, "The food here always smells lovely." And, "The food is hotel standard, very good and well presented."

We observed the food to be attractively presented. People were provided with a choice of two meals from a six week rolling menu.

People at risk of poor nutrition and dehydration were not always sufficiently monitored. The manager and staff confirmed that they had not received any training in Malnutrition Screening Tools (MUST). We found there were no assessment screening tools in operation which would identify individuals at risk of inadequate nutrition. Not everyone was regularly weighed and care plans did not contain any reason for this. We noted one person where staff had recorded this person had lost 10 kg since January 2017; a two month period. The manager confirmed that there had been no referral to a GP or dietician to access specialist advice in response to this significant weight loss and neither any guidance for staff in the event of unplanned weight loss to commence more regular weight monitoring. One person who was cared for in bed had not been weighed for a significant period of time. If staff had received MUST training this would have provided them with the knowledge they required to monitor this person's weight by measuring the circumference of their arm. This lack of monitoring put people's health and welfare at risk.

We noted comments recorded in staff communication books reminding staff to offer regular fluids to keep people hydrated. We also observed staff asking people what their choice of meal was for the following day. However, our observations and records reviewed showed that nutritious snacks were not being routinely offered between meals, to boost calorific intake. Improvements were needed to support people in having access to suitable snacks to promote weight gain and wellbeing. Staff demonstrated a lack of understanding in how to fortify foods to increase the calorific content of foods for people who may be at risk of losing weight. We recommend that the service explores current guidance and seeks advice from a reputable source relating to how to support people in meeting their individual nutritional needs, particularly those with specialist needs including dementia. For example Social Care Institute for Excellence (SCIE) guidance on, Eating well with dementia and Nutrition for older people in care homes.

This demonstrated a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said that their health needs were met and where they required the support of healthcare professionals, this was provided such as visits from GP's and opticians. One person told us that they had, "No problem, I see a doctor when I need to." We noted from staff communication books that people had access to a chiropodist who was visiting regularly. However, we also noted that people had requested a dentist due to experiencing problems with their teeth. One relative told us that their relative had needed dental treatment and that as the service did not have access to a dental service to provide regular check-up visits, they personally were in the process of supporting the service to find a dentist to meet people's needs.

Relatives told us that staff were good at keeping them updated as to any changes that affected their relative's health.

Requires Improvement

Is the service caring?

Our findings

When we asked people if they were treated with kindness and compassion the majority of comments we received were positive. One person told us, "They are all kind to me." And I don't have any problems with the staff they are kind and helpful when you need help." However, one person said, "The majority of staff are very nice but some are rather off hand. They are not nasty or cruel, just off hand when they are helping you."

We saw people's relatives being welcomed, and that they knew staff's names and that they felt comfortable to let staff know that they would take over a care task. A relative described staff as, "Considerate and caring." They provided us with examples linked to their relative's care. For example, One relative told us, "I can leave my [relative] here after visiting and not think twice about it. Staff are simply fabulous and more like friends than carers." One relative told us that the staff were friendly and this would be one of the reasons they would recommend the service to others. Another described staff as, "Kind and caring," this they told us they had always observed during their regular visits.

Improvements were needed as not everyone was being supported to keep their possessions safe. People told us they did not have keys to their bedrooms. Not everyone had access to a lockable space to keep valuables and possessions important to them safe and secure. Some of the furniture supplied by the service had no lockable compartments. Two people recently admitted to the service had purchased their own lockable safe. They said it was important to them to have a place of safety for their possessions. The manager made a note of our feedback and said that they would look into the situation where rooms did not have this provision.

The majority of interactions we saw were respectful and supported people's dignity; however improvements were required. The upstairs shower room contained a shower which was located directly in front of a frosted glass window. This window did not have a blind or window covering in place. There was a note on the shower room door requesting staff turn off the light. When asked why this was in place the manager told us neighbours had complained about the light being on and so it was evident that neighbours could see into the shower room window. The lack of window covering meant that the protection of people's privacy and dignity had not been considered.

The service had one bathroom and two shower rooms. The bathroom was out of action. The downstairs shower room did not have any heating and lacked hot water. This meant that there was only one shower room available to meet the needs of all the people living at the service, registered to provide care and accommodation for 20 people. This lack of provision impacted on people's right to choice as to whether they would prefer a bath or shower. Care plans we reviewed did not evidence that people's choices, preferences and needs had been considered with this regard.

Requires Improvement

Is the service responsive?

Our findings

Care plans did not always provide staff with the guidance they needed to provide safe care that met people's needs. The provider had implemented an electronic, care planning system for all their care records including care plans and risk assessments. Care staff carried around mobile tablet devices to record any care input. The management team demonstrated this system to us but when we requested information, we observed staff struggling to gain access to the system due to issues with intermittent internet access. The manager told us this was an ongoing problem with the system in use. The manager also told us there was no back up system such as paper copies of care plans.

We found one person's care plan contained little information which would reflect their current complex care needs. The manager told us this was because they were admitted initially for respite care two months ago, but now that they had been agreed for permanent residency the care plan would be updated. We considered that given this person's complex care needs, this lack of information and guidance for staff placed this person at risk of not having their health, welfare and safety needs met regardless of whether they were living at the service short term of permanently.

Care plans did not provide information as to how people's level of dementia impacted on their ability to take part in activities, and what action staff could take to support them to join in. Where people were not supported to access mental stimulation, this put them at risk of social isolation.
People's care plans held basic, task focused guidance for staff on supporting people's individual needs in a safe manner. However, further improvements were needed. There was a lack of information to demonstrate that people, and their relatives and or advocate had been involved in developing the care plan. A relative told us that they were not aware of having seen one.

Prior to our inspection we received information of concern whereby people told us they were required to purchase their own rise and fall beds after they had been living at the service for a significant period of time and this equipment had been required to support their changing healthcare needs. Relatives told us this expectation had not been identified prior to admission to the service. We reviewed the care home contract which had been recently updated to include; 'We do provide some specialist equipment' but did not state what equipment was being referred to. However, not all contracts we reviewed and signed by people who currently lived at the service referred to any requirement for them to be responsible for the purchase of specialist equipment. Personal inventories did not contain all of the items which people had purchased including items of furniture they had brought with them into the service.

Whilst we observed some, one to one interaction with people such as painting nails. We observed people who spent the day looking into space with little interaction and some only when relatives visited. There was a lack of planning in place to assess individual needs for social stimulation whilst considering personal interests and hobbies.

There was no group activities taking place and planning for this provision. The majority of people we observed sitting in the lounge or their bedroom with no meaningful activity other than the TV and some one

to one nail painting. One relative had commented in a recent survey carried out by the provider, "Sometimes the TV on has little relevance to people living here."

We were told by staff that the activities coordinator was no longer in post and that the provider would not commit a budget for activities. They told us that they had provided many of the activities themselves when they could. They also told us there were occasional visits from outside entertainers but to fund this staff needed to raise funds to support these activities. People living with dementia had no sensory objects to stimulate their senses.

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

We reviewed the provider's process for responding to complaints. Records showed that complaints had been logged but the provider did not provide an audit trail of response with a record of the steps taken to resolve complaints promptly to the complainant's satisfaction.

Requires Improvement

Is the service well-led?

Our findings

The quality of the internal assurance systems in place were not robust enough to identify the shortfalls that we identified at this inspection. The provider failed to identify and mitigate the potential risks to people's health, welfare and safety.

Prior to our inspection the provider completed as required a 'provider information return' where they documented their response to the question we asked, 'What do you do to ensure the service you provide is well-led?' They told us, 'The manager has an open door policy and encourages residents, staff and other professionals to raise any concerns or suggestions they may have as soon as they occur to prevent a build up of tension or anxiety and to improve the service we provide.'

We found the quality and safety monitoring of the service was sporadic and ineffective in identifying where quality and safety of the service was being compromised. The provider did not provide effective oversight of the service.

The manager told us the provider visited the service regularly, carried out a tour of the premises but did not document any quality and safety monitoring such as health and safety audits, reviewing the quality of care plans, audits of medicines management and checks on staff recruitment files. The manager told us that following the provider visits to the service the manager typed up notes. We reviewed the last two provider visit reports produced by the manager and noted that these were a recorded minutes of a meeting between the manager and the provider where they discussed the ongoing building works with one minor reference to; 'She checked rotas and communication book and spoke to staff and residents'.

The audit and monitoring systems in place were not robust enough to independently identify and address shortfalls to drive improvement. This included the lack of effective systems to identify and respond to the shortfalls we identified at this inspection. For example, in the management of people's medicines, the lack of effective induction and training of staff , in supporting people with safe moving and handling and how the numbers of staff were determined and reviewed. In addition there was no analysis or consideration of the impact on the quality of care linked to the reduction in numbers and the deployment of staff in the service.

There was a lack of action taken by the provider to assess environmental risks to people and others. The lack of action by the provider to assess risk with action plans implemented to mitigate risks to people's health, welfare and safety put people at risk of harm. We discussed this with the management team but the potential risk had not been picked up prior to our visit.

Staff practice was task based and there was scope to improve the quality of care people experienced. Best practice was not being explored to influence how care was being delivered. For example effective engagement with people living with dementia, providing mental stimulation and activity and ensuring that risks linked to poor nutritional intake were addressed proactively.
Because of this this we were not assured that the service had a consistent approach to governance that ensured the quality of the care people received.

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

People and their relatives told us they knew the management team well, that management had a visible presence in the service and staff encouraged open communication with them. When visitors arrived we heard staff greet and where required update relatives on a people's welfare.

People and their relatives had been invited to share their views in a recent survey. The majority of comments received were positive such as, '[relative] gets great care which gives me peace of mind.' And 'Staff are always very caring'.

There were minutes of regular meetings for people and their /relatives and staff. One relative told us, "I know these meetings are held, but I don't often go to them, but then I know them all here and the manager and I will often chat about things, so I know what's going on."

Staff told us that they felt supported in their role and had regular access to discuss any concerns and seek advice and feedback from their manager. Staff were complimentary about the manager. They told us, "We support the manager and she supports us. I have known her for a long time", "This manager asks you to do something and she lets you get on with it. This is a nice place to work", and "I feel supported by the manager. We have regular staff meetings. Staff morale is quite relaxed."

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 People are at risk of their emotional and social needs not being met through lack of mental stimulation. Regulation 9 (1) (3) (b)(c)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines had not always been administered accurately, in accordance with the prescriber's instructions to make sure that people who used the service were not put at risk. The provider did not assess and protect people against the risks by way of doing all that is practicable to mitigate any such risks in the management of their medicines. The provider's medicines policy failed to provide guidance to the level of detail required in line with current legislation and National Institute for Clinical Excellence (NICE) guidance for managing medicines in care homes.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People at risk of poor nutrition and dehydration were not always sufficiently monitored. Staff were not provided with training in the use of Malnutrition Screening Tools. There were no

assessment screening tools in operation which would identify individuals at risk of inadequate nutrition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who used the service and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15 (1) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality and safety monitoring of the service was sporadic and ineffective in identifying where quality and safety of the service was being compromised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not taken reasonable steps to ensure that staff were safe to work in the service prior to the start of their employment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People are at risk because there are not sufficient numbers of suitably trained, competent, skilled and experienced persons deployed in the service to meet people's needs. Regulation 18 (1) (2) (a)