Shannon Court Care Home Limited

Shannon Court Care Centre

Inspection report

112-114 Radcliffe Road
Bolton
Lancashire
BL2 1NY

Tel: 01204396641
Website: www.shannoncourt.co.uk

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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

The inspection took place on 2 October 2018 and was unannounced. The inspection was brought forward due to concerns raised by professional visitors to the service around issues such as falls and medicines errors. There had been some recent changes in the management of the home and the new manager had only been in place for a matter of weeks. The home had an improvement plan in place and were working closely with the local authority and the clinical commissioning group (CCG) to implement improvements. The home had put a voluntary suspension of placements in place whilst improvements were being made.

The last inspection was undertaken under the previous provider registration on 6 December 2016 when the service was rated good in all domains and overall. At this inspection we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to safe care and treatment, nutrition, dignity, person-centred care and good governance. We also made recommendations with relation to implementing overviews of safeguarding concerns and falls and ensuring activities were person-centred.

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

Shannon Court Care Centre accommodates up to 78 people in one adapted building. The service provides nursing and personal care in three separate units over three floors. One of the units specialises in providing care to people living with dementia. At the time of the inspection there were three vacancies and two people were in hospital.

There was an acting manager in place at the home who was in the process of registering with the Care Quality Commission. 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.

Leadership at the service had been inconsistent for a period of time. Documentation was poor and there was a culture of ineffective responses to people's basic needs and dignity. There was a lack of guidance for the staff around the importance of providing person-centred, respectful care for all the people who used the service.

Systems were not always effective in ensuring medicines were administered, recorded and stored safely. There were appropriate safeguarding and whistle blowing policies in place and staff had a good awareness and understanding of them. There were enough staff on duty and recruitment systems were satisfactory.

Risk assessments were completed but individual risk assessments were not always effective. Health and safety measures were in place and accidents and incidents were recorded.

Staff completed an induction on commencing work at the service. However, we noted that some sections of the induction booklet were incomplete. Staff had completed essential training and refresher training was ongoing. Staff would benefit from more in-depth dementia training. The premises were not as dementia friendly as they could be.

The food choices were limited and there was a lack of fruit and vegetables on the menu. Pureed food was unappetising, and the lunchtime experienced could have been improved with more attention to detail.

The home was working within the legal requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Staff were hard working, cheerful and caring. They worked as a team and were friendly and respectful. Communication between relatives and the home was good. Independence was encouraged and there was evidence within care plans of the involvement of the person and their relatives with care planning and reviews of care.

We saw an instance where a person's dignity was compromised which was unacceptable. Although oral hygiene care plans were in place, there was a lack of oral hygiene in practice for a significant number of people.

There was a service user guide with information for people who sued the service and their relatives.

Some care files were disorganized, and things were out of place. Documentation within care plans was person-centred but this did not always translate into actions. There were some activities within the home but there was a lack of one to one or small group activities. Some staff had undertaken training in end of life care and some care files had people's wishes documented. However, others did not, nor were any reasons for this recorded.

An appropriate complaints policy was in place and people were aware of how to raise a concern. We saw a number of compliments received by the service.

People described the manager as approachable. There were regular supervisions, appraisals and staff meetings in place.

Handover documentation between staff shifts was poor. None of the sheets had been checked or signed by the manager as was the procedure. There were a number of audits in place, but not all of these were completed appropriately. Audits had not been checked by the manager or provider as required.

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 consistently safe.

Systems were not always effective in ensuring medicines were administered, recorded and stored safely.

There were appropriate safeguarding and whistle blowing policies in place and staff had a good awareness of them. There were enough staff on duty and recruitment systems were satisfactory.

Risk assessments were completed but were not always effective. Health and safety measures were in place and accidents and incidents were recorded.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff induction was in place and further training was completed as required, though staff would benefit from more in-depth dementia training. The premises were not as dementia friendly as they could be.

Food choices were limited and were lacking in nutritional value. There was a lack of fruit and vegetables on the menu and pureed food was unappetising. The lunchtime experienced could have been improved with more attention to detail.

The home was working within the legal requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were hard working, cheerful and caring. They worked as a team and were friendly and respectful, but we saw a person's dignity being compromised. Although oral hygiene care plans

were in place, there was a lack of oral hygiene in practice for a significant number of people.

Communication between relatives and the home was good.

Independence was encouraged and there was evidence within care plans of the involvement of the person and their relatives with care planning and reviews of care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Documentation within care plans was person-centred but this did not always translate into actions. Some staff had undertaken training in end of life care but not all care files had people's wishes documented. There were some activities within the home but there was a lack of one to one or small group activities.

An appropriate complaints policy was in place and people were aware of how to raise a concern. We saw a number of compliments received by the service.

Is the service well-led?

Inadequate

The service was not consistently well-led.

People described the manager as approachable. There were regular supervisions, appraisals and staff meetings in place.

Documentation was poor and there was a culture of ineffective responses to people's basic needs and dignity. There was a lack of guidance for staff around the importance of providing person-centred, respectful care for all the people who used the service.

There were a number of audits in place, but not all of these were completed appropriately. Audits had not been checked by the manager or provider as required. There was a lack of oversight by the management.

Shannon Court Care Centre

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 was prompted in part by concerns raised by professional agencies who visit the service on a regular basis. These were being dealt with via an improvement plan devised jointly between the professional agencies and Shannon Court Care Centre.

The inspection took place on 2 October 2018 and was unannounced. The inspection team comprised of two adult social care inspectors, a medicines inspector, a specialist advisor (SPA) who was a nurse and two experts by experience. An expert by experience is a person who has had personal experience of using or caring for someone who used this type of service. Both experts by experience had personal experience with older people and people living with dementia.

Prior to the inspection we looked at information we had received about the service. This included notifications, safeguarding concerns and whistle blowing information. Due to the concerns raised we brought forward the inspection therefore due to time constraints we did not request a provider information record (PIR). This is a form that asks the provider to give us some key information about what the service does well and what improvements they plan to make.

We also contacted the local authority, the Clinical Commission Group (CCG), the local authority safeguarding team, the Community Infection Prevention and Control team and Healthwatch Bolton. Healthwatch is an independent consumer champion for health and social care. This helped to gain an overview of what people experienced when accessing the service.

During the inspection we spoke with the manager, the deputy, a senior carer, four nurses nine care staff, the dementia champion, an activities coordinator, an enhanced care coordinator, 12 people who used the service and nine relatives. We looked at seven staff personnel records, seven care files, training records, meeting minutes, supervision notes, audits and other records. We looked around all areas of the home

including some bedrooms and bathrooms, communal lounges, dining rooms and corridors.

Requires Improvement

Is the service safe?

Our findings

We asked people who used the service how they took their medicines. One person said, "Yes I do (take medicines), I take them myself, the staff remind me to take them". Relatives said, "We've no issues with [relative's] medication"; "[Relative] is the best they have ever been. They're very good with [relative's] medication and it's working well. There's no problems at all".

We observed the morning medicines round. The service used the Biodose system, which is where medicines are contained in a 'pod'. Each pod can contain tablets or liquid medication. We found that most medicines administration record (MAR) sheets were completed and signed, some handwritten MAR sheets were double signed as required, but some signatures were missing.

The Registered General Nurse (RGN) on duty, who was a bank nurse, noticed that a medicine listed on one of the pods had not been recorded on the MAR sheet. This medicine had been given for over three weeks, as it was in the pod with other medicines and had not been questioned. However, it had not been signed for by the nurse on duty during this period. The RGN took the correct action and called the GP and the pharmacy to ensure this medicine was supposed to be taken and requested a new MAR from the pharmacy. The RGN made a hand-written entry on the current MAR to confirm the administration that day. For another person we found two doses of medicine had been missed. Both of these issues were raised with the manager on the day of the inspection and the manager reported them to safeguarding and contacted both GPs. There was no impact on either person with regard to the medicines errors. All other medicines in the Biodose were correctly taken and recorded.

The medicines room was a small space where the medicines trolley was permanently fixed. The room and fridge temperatures were not being taken correctly (minimum and maximum temps) and the policy had no version number, date of issue or review date. There was no integral thermometer in the fridge, some insulin was stored there, but there was no guarantee that this would still be effective. There was stock in the fridge that did not need to/or should not be in the fridge. An audit of temperatures needed to be done regularly to ensure these issues were captured and addressed. This was discussed with the manager on the day of the inspection and the provider later. They agreed to add actions from the inspection to their already on-going improvement plan, to be addressed immediately.

There were some out of date medicines and boxed stocks required running balances and a weekly audit to ensure any issues were identified and addressed. A diary system for ordering was required as there was no evidence that medicines had been ordered. The protocol for covert medicines, that is medication given without the person's knowledge when they are unable to make an informed decision and the medication is given in their best interests, needed to be with the MARs. Similarly protocols for medicines given as and when required (PRN) were inconsistent.

We looked at the controlled drugs (CD) cabinet. There was a medicine with no instruction to staff about how this medicine should be prepared, that is, as an oral liquid or injection. The balance check was correct, but the recording very poor. We found it was impossible to confirm whether all medicines had been given

correctly, but evidence seen meant that one liquid medicine must have been wasted or given in excess to have used the quantity that had been used. Poor documentation had been identified within the existing improvement plan. The manager and the provider agreed to ensure that documentation with specific regard to medicines would be addressed immediately.

On another unit we saw a letter to a GP requesting authorisation to administer 'homely remedies'. However, there was no detail as to why the homely remedies would be given and for how long. The wrong dose of one medicine had been recorded as given on one day.

The above examples demonstrate a breach of Regulation 12 (2) (g) of The Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

Staff had undertaken training in infection control and used appropriate personal protective equipment (PPE) such as plastic aprons and gloves when administering personal care. One relative told us, "[Relative's] room is lovely, and the cleaners are pretty good, her room's spotless".

We asked if people felt safe at Shannon Court Care Centre. One relative told us, "One hundred percent". Another said, "Oh yes, I have no problems whatsoever with [relative's] safety". One relative stated, "Excellent, for instance they are doing work on the steps outside". Another commented, "[Relative's] definitely safer here [than in their own home]".

One person told us they had once had an issue with someone coming into their room and taking something. We spoke with staff and management about this and, as there was no evidence of this happening, they felt the comment may have been a consequence of the person's dementia condition. However, we observed that the home's new café was a public area and was situated close to some bedrooms, creating a potential safety risk. We spoke with the manager about this and she agreed to look into locking the bedroom doors in that area with the agreement of the people whose bedrooms they were.

There was an appropriate safeguarding policy and procedure and a safeguarding file. All safeguarding incidents had been logged and followed up with appropriate actions. Staff had undertaken safeguarding training and those we spoke with had a good understanding of the issues. We recommend the service implements an overview of safeguarding concerns to be audited regularly. This would help ensure any patterns or trends could be highlighted and actions then taken to address these. There was a whistle blowing policy and staff were aware of how to report any poor practice they may witness.

People who used the service and relatives told us there were usually enough staff around. One told us, "Yes, there are plenty of staff here. We get on well with them". Another said, "During the day, yes. I don't know about night time". One person said, "There's never enough staff when something happens but in general, yes there is enough staff".

Care files included a dependency tool to calculate the level of assistance each individual required. This was then fed into staffing levels. We saw that the rotas were consistent and evidenced flexibility to help ensure staff could meet people's changing needs, though some agency staff were being used at present.

Staffing levels on the day were sufficient in most of the units to ensure people's needs were met. However, one unit housed people who, according to care plans, displayed behaviour that challenged the service. Some staff on this unit were agency staff, who were less familiar with the individuals. This could potentially make it more difficult for them to address the needs appropriately. The manager explained that via performance management and recruitment, potential staffing issues were being addressed to help ensure

more permanent staff members would be in place very soon, minimising the need to use agency staff.

We looked at seven staff files and saw that essential recruitment information, such as application forms, references and proof of identity were included. However, in some files other information was incomplete, for example, some induction sections had not been signed off, or new starter fire check forms and handwashing assessments were incomplete and not all files contained terms and conditions or job descriptions. All staff had been subject to a Disclosure and Barring Service (DBS) check. These checks help ensure potential staff are suitable to work with vulnerable people. We saw that all clinical staff had personal identification (PIN) numbers recorded and these were checked on a monthly basis and were all up to date. Some staff had two files which made finding information difficult. All the files needed attention and streamlining, which we discussed with the manager on the day of the inspection. This had already been commenced as part of an action plan that the home had implemented in conjunction with the local authority and the Clinical Commissioning Group (CCG) in response to concerns raised.

Personal emergency evacuation plans (PEEPs), were kept in a file in the reception area where they would be easy to locate in the event of an emergency. These files contained information about the level of assistance each individual would require to safely evacuate from the building.

There was a business continuity plan in place. There was an up to date fire risk assessment in place. Staff had undertaken fire training theory, but no practical training had been completed. Not all staff knew how they would evacuate people to a safe compartment of the home in the event of a fire, so further training was required. We saw the required health and safety certificates relating to gas and electrical safety, legionella checking, portable appliance testing (PAT) and lift maintenance. All were up to date.

General and individual risk assessments were in place, but some of the individual ones were ineffective. For example, one support plan included the need to support the individual with smoking to ensure this was done safely. However, there was no indication of the frequency the person required to do this. One care file, where the person displayed behaviours that challenged, did not efficiently identify and manage risks of harm to others which was identified on behavioural charts. This person had been identified as requiring a more specialist placement and was awaiting a move. Risk assessments we saw indicated that information about risks and safety was not always comprehensive or up to date, which could place people at risk of harm.

Accidents and incidents were recorded on forms within people's files and regular safety/falls prevention meetings were held with the local Clinical Commissioning Group (CCG), and actions recorded. However, in some cases falls diaries were not completed with every fall. People who had suffered an accident were to be observed for the next 24 hours and charts were in place for this. These were not all completed as required. We recommend an overview of falls be implemented to enable any patterns or trends to be highlighted. The overview should be audited on a regular basis to ensure all relevant information is included.

Requires Improvement

Is the service effective?

Our findings

One person who used the service said, "I think they [staff] are lovely and they are well trained to the work which is very hard". Another told us, "I would say yes most of them [are well trained], they are run off their feet and some are more caring than others".

Staff told us the induction consisted of orientation to the building and all relevant mandatory training. There were regular evaluations of the new employee's progress to ensure they had sufficient support and assistance in place. There was a training matrix in place which showed a comprehensive programme of mandatory and refresher training had been completed by staff. There was also supplementary training in place which some staff had undertaken, such as end of life training and dealing with challenging behaviour.

Some care files were disorganized, with documents filed in the wrong place, which could lead to mistakes being made in care delivery. The manager told us they were currently re-writing care plans and risk assessments to help ensure these were easier to follow. This was evidenced via an on-going improvement plan that the service was working through with other professional agencies. A succinct summary of care at the front of each file would assist new or agency staff to carry out care interventions correctly.

The home used the red bag scheme for transfers to hospital. The Red Bag should contain the person's care information, medication records, their medication. The Red Bag Initiative was rolled out to all nursing homes across Bolton NHS Foundation Trust with the aim of improving the experience of people on admission to hospital and reducing their length of stay by speeding up the discharge process and improving communication between hospitals and nursing homes. The red bag scheme helped ensure information sent with people was consistent and gave staff clear guidance about what information to send and how to send it.

People's nutrition and hydration needs were recorded within care plans and some people had food and fluid charts to record the amounts taken and follow up with actions when required. These actions were followed up appropriately. Referrals were made to other agencies and professionals, for example, Speech and Language Therapy (SALT) team. Advice and guidance was recorded and followed up as required. Food and fluid charts were the responsibility of the enhanced care coordinators and were completed correctly.

One person told us, "When [relative] has health concerns they send him to the doctor". Another said, "They have put him with the doctor they use here, I have a podiatrist that comes in to see [relative] but you have to pay for it".

We asked people about the food. One person told us, "The food is lovely, very good, we get enough to eat". Another person said, "You get two or three choices of what to eat, and if you don't like it they will make you something else". Further comments included; "I can have breakfast whenever I want"; "They feed me well and it is quite nice food. There's a lot of baked beans which gets a bit monotonous".

We asked about pureed food. One person said, "I like my food when it's not mushy". We observed them

being served their [pureed] lunch, their facial expression portrayed horror when it was placed in front of them. Their comment was "It's awful". A relative said, "[Relative] doesn't like the pureed food, it's not appetising at all. They always come around with an afternoon snack so [relative] usually gets a yoghurt and a piece of fruit. There's also biscuits and cakes".

Breakfast consisted of cereals and continental style breakfast and people confirmed this was nice. The lunchtime meal was often breakfast type food, for example, cheesy scrambled egg or beans on toast. There were a lot of sandwiches and we saw that on one day the choices were assorted sandwiches or soup and sandwiches, not offering real choice. There was a lack of fruit and vegetables offered or planned in menus. There were no finger foods, for example cereal bars and healthy snacks, which are often easier for people living with dementia who walk around a lot and burn a lot of energy, to eat.

We spoke with the manager and provider about the lack of nutritious food and monotony of certain aspects of the menu. They agreed to re-evaluate the menus and ensure a more nutritious and varied diet was implemented. We also discussed the need to make the pureed food more appetising and appealing, which the manager and provider agreed to look into immediately.

The above issues constitute a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to a lack of nutritious food.

We observed the lunchtime experience in two units. Choices were limited, and the main dish was more appropriate for breakfast. There was an absence of vegetables and the pureed food was an unappetising mush. People were not encouraged to use the dining rooms in all areas of the home. On one unit the menu was displayed in the dining room, three tables had tablecloths on them and one also had a flower vase. However, nobody sat in the dining room, 12 people remained in the lounge for their lunch and ate off little tables placed in front of them. All the staff wore protective aprons as required. Two people were supported by staff to have their lunch. Drinks were served with dessert, in coloured plastic cups. The other dining room we observed was clean and tidy with a cheerful mural of an American diner on the wall. Menus were not displayed on tables, but there was a menu board with pictorial representations of the food. The pictures were poor quality and it was difficult to say what the meals actually were.

This service specialised in dementia care, but improvements could be made within the home to make it more dementia friendly, which we discussed with the manager on the day of the inspection. The building was difficult to navigate, and areas of the home had names of colours, for example, red corridor, but no recognisable colour theme. There was some signage and bedroom doors had names and numbers, and some had memory boxes outside, to help people recognise their room. However, many of these boxes were empty. The lights on the corridors were sensor lights which come on as people approach and go off after they leave the area. This could be unnerving for someone living with dementia, and older people with sensory impairments. There was a lack of relevant reminiscence type pictures on the walls and some bedrooms were quite bare and uninviting, with a lack of personal possessions to make them homely. Some of the bathrooms had contrasting toilet seats, which help people living with dementia to see them better, but others did not.

There was only one Registered Mental Nurse (RMN) at the home who preferred to work on the general unit. The Registered General Nurses (RGN)s, who worked on the dementia unit, had an understanding and some training in dementia, but it would be preferable to have an RMN consistently working with people living with dementia.

Some of the communal areas had bright cheerful murals. The cafe on the ground floor had the potential to

be a nice area to enable residents and visitors to sit in a quiet place. The therapy room was very popular and well used. It had relaxing lights and mood music and was run by a qualified therapist who demonstrated a very practical and caring attitude. They cared for the people who used the services and their relatives, offering hand and foot massages and using this opportunity to check on foot health, particularly with diabetics. They worked closely with people and relatives who were new to the home to help them with the settling in period.

Staff had undertaken basic dementia care training and a few had gone on to complete Dementia Jewels training, which helps explain the different stages of dementia. However, no advanced dementia training had been accessed. Staff we spoke with were enthusiastic to widen their knowledge and understanding.

Care files showed that consent was sought for issues such as agreement to the care plan. These were signed by the person who used the service or their representative, as appropriate. We saw that staff asked for people's consent before offering personal care. One person who used the service said, "They help me to have a shower, they always ask me first".

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 so that they can 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. There were a number of DoLS authorisations in place and these were appropriate. Systems were in place to ensure these were reviewed and renewed as required. DoLS care plans were in place to ensure staff were given guidance with regard to this issue. Not all staff had MCA and DoLS training but this was arranged for the near future. The staff we spoke with had some basic understanding about what DoLS meant in practical terms but were unable to say if conditions were included in DoLS. authorisations.

Relatives we spoke with were aware if their loved one was subject to a DoLS authorisation and what this meant. There was a lack of reference to MCA principles in some documentation, however in practice we witnessed people being given choices on daily aspects of their lives.

Requires Improvement

Is the service caring?

Our findings

People who used the service told us the staff were kind and caring. One person said, "We all know one another". Another told us, "It's alright here. I can't say I really enjoy it, its community living so it is what it is". Other comments included; "They look after me very well, I've no complaints at all"; "The staff are very friendly"; "The girls are very good, and they do sit and talk if they have time"; "The staff are very nice". A relative said, "[Relative] has a lovely room with pictures of the family".

Nurses we spoke with told us they felt the care staff had good knowledge of how to approach people with dementia and manage their needs. There was a dementia champion amongst the care staff, and we spoke with them at length and they demonstrated a caring attitude. We witnessed this person giving a hand and leg massage to a person being nursed in bed, although they were unaware of our observation. We saw them interacting in a caring way, stroking the person's head and talking to them softly.

We observed interventions by carers which were done in a caring and empathic manner, with the person who used the service being informed of the process and being reassured if they were anxious. Throughout the day staff were hard working, cheerful and caring. They worked as a team, sharing caring and practical duties and were friendly and respectful.

Staff called people by their first names or preferred names. During informal conversations, staff spoke about individuals with knowledge of their backgrounds, likes and dislikes, as well as their current individual needs and behaviours. Throughout the day, we did not observe a lot of individual interaction between staff and people who used the service apart from interaction linked to personal care.

Relatives we spoke with felt dignity was generally respected. They told us, "[Staff] close the curtains [to maintain dignity]"; "[Relative] has an en-suite room"; "Of course they are [respectful of dignity]. [Relative] would be the first one to tell you any different".

We checked people's toothbrushes and, although there were care plans in place for oral hygiene, we found that toothbrushes we checked were completely dry which led us to conclude that they had not been used that day. We saw dirty dentures left in the sink in one bedroom and some rooms had no hand towels in them.

The dementia nursing area, unlike the other units, was quite noisy and chaotic and people on this unit were less well groomed. There was a person who used the service asleep in a bed in the communal lounge area. The manager told us they needed to observe this person as they were prone to falls. However, being in the lounge in this way presented a dignity issue for the person as this did not demonstrate respectful care and appeared to be more for the benefit of the staff. We discussed this with the manager who agreed better management of this person's needs would be implemented.

These issues constituted a breach of Regulation 10 of The Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

People told us communication with the home was good. One relative told us, "[Relative] can't communicate very well verbally. They observe his body language to see if he is happy or needs any help". We asked if relatives were contacted when anything changed with their loved one. One relative said, "Yes, 100%; they have dealt with [relative] and helped me if I have any problems".

We asked if independence was encouraged. One relative told us, "They encourage [relative] to walk on their own, with guidance. They move [relative's] seats around in the dining room so [relative] can meet different people". People who used the service told us they would be supported to contact advocates if they required them.

There was evidence within the care plans of the involvement of the person and their relatives with care planning and reviews of care. We asked people if they had been involved with their or their relative's care plan. One relative said, "Oh yes, they go through it all". Another told us, "[Other relative] helped [relative] write their care plan". A third commented, "I was made aware of what they were going to do".

The service had a service user guide with information for people who used the service and their relatives. This will need to be updated once the new manager is registered with CQC.

Requires Improvement

Is the service responsive?

Our findings

Documentation within care plans we looked at was person-centred and included a personal profile with information about people's backgrounds, beliefs, preferences and choices. We asked people if they were supported to make choices. One person said, "[If I am unwell] I have an extra sleep in bed. If I wasn't well they [staff] would call the doctor". Those we spoke with told us they could go to bed and get up when they wanted to. We asked what the best thing about the home was. A relative told us, "For me the care [relative] has been shown since she has been here, she is not like someone off the peg, she is an individual". Another said, "Friendly staff towards residents and visitors", and a third commented, "I would think the friendliness of the staff. I think they are all on a mission to do their best".

Although documentation was person-centred, this did not always translate into actions. For example, one person's religious beliefs and visits to their chosen place of worship were described as being very important to the person. When we spoke with staff they had not put anything in place to support the person with this aspect of their life. This was discussed at length with the manager who agreed to address person-centred care within their improvement plan.

Examples of where care was not person-centred included some people having no toiletries. People were unable to access their own rooms during the day unless accompanied by a member of staff, as most bedrooms were on a different floor to communal areas, the building was difficult to navigate and there were key pad locks, with different numbers, throughout the home.

We asked about activities at the home. One person who used the service told us, "We do crafts, we have singers here, very much so. Very rarely we go out on trips. I go to the Irish centre". Another said, "They are having singers this afternoon. They did the royal wedding and two staff dressed up as Harry and Meghan. They hold religious services". Other comments included; "[Relative] likes to see photos of the family"; [Relative] would like trips out but it is the staff needed and the cost"; "They could do with more staff, two have been upgraded [promoted] and they try to get them [people who used the service] out in the garden"; "Relative has her hair done every two weeks and a massage every week. There used to be jigsaws and things for them to do but that seems to have stopped. I bring her a newspaper and then the others read it too. We also bring books in for one of the other residents, he really likes his books and he's an avid reader now. There should be at least newspapers for them, they don't mind if it's a day late, it's just something for them to read".

There were some activities within the home but there was a lack of one to one or small group activities on the day of the inspection. There was a singer in the afternoon for those who wished to participate, but this was not everyone's choice and the signing was quite loud and some people were unable to get away from the noise.

Some staff had undertaken training in end of life care and some care files had people's wishes for when they were nearing the end of life documented. However, others did not have any wishes recorded or any reasons why this was so, for example, if the person did not wish to discuss this at the time.

The above examples demonstrate a breach of Regulation 9 of The Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

An appropriate complaints policy was in place and people we spoke with were aware of how to raise a concern. One relative told us, "The majority of staff are great, some are brilliant, and a couple are very poor. I've lodged a couple of complaints". We saw the complaints log, which was completed appropriately, and complaints were responded to as required. The complaints and concerns were evaluated on a monthly basis to look at any patterns or trends and address them.

We saw that the service issued a satisfaction feedback form to people who used the service and relatives, on a regular basis. We saw the results of the last survey which were positive, showing a high level of satisfaction with all personal care, food, décor and staff. There were also relatives' forums for people to attend and put forward their views and suggestions and raise any concerns they may have.

We saw a number of compliments received by the service. Comments included; "You all did a wonderful job in making our day (wedding anniversary) so very special"; "Thanks for looking after [name], a job well done; "Thank you for all the care and respect you gave [relative]".

Inadequate

Is the service well-led?

Our findings

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was an acting manager in place at the home who was in the process of registering with the Care Quality Commission.

Staff we spoke with told us they were well supported by the management team and care staff felt they could go to the management team with any issues. However, nurses reported needing to depend quite a lot on the senior carers for information about people who used the service as care plans were not readily accessible when they were time pressured on a shift. This was reflected by the care staff we spoke with.

We found that systems for identifying, capturing and managing organisational risks and issues were ineffective. Leadership at the service had been inconsistent for a period of time. Documentation was poor and there was a culture of ineffective responses to people's basic needs and dignity. There was a lack of guidance for staff around the importance of providing person-centred, respectful care for all the people who used the service.

Handover documentation between staff shifts was poor. There was a 24-hour handover sheet which should be handed in to the manager daily and signed, but there were days when no information was recorded. On other days the information was very basic. None of the sheets had been checked by the manager. One unit had a communication book, which contained better information, but was still not checked by the manager. Staff, especially agency staff, require detailed information about the people they are providing care for. This was not available and could potentially place people who used the service at risk of harm or inadequate care. This was discussed with the manager and the provider. Care files were already being improved and updated as part of the on-going improvement plan.

There were a number of health and safety audits in place including equipment checks. There was a home maintenance plan but some of the daily and weekly maintenance checks had not been completed for the last few months. Fire checks were all dated and signed but there was a lack of indication of what had been checked. Some audit sheets were blank or incomplete. None of the audits had been checked by the manager to ensure they were completed appropriately. Although the provider visited the home on a regular basis there was a lack of oversight from the provider in relation to audits and checks. Care plans lacked detail, some recruitment files lacked information, individual risk assessments were not comprehensive, there was incomplete documentation around falls and medicines audits were poor

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

People who used the service and their relatives were aware of who the manager was. One relative told us, "In the short time she [manager] has been here I can't fault her". A relative said, "We would definitely

recommend this place". Another commented, "They would listen if we had anything to say or complain about".

A new post of enhanced care coordinator had been created and three staff had been promoted to this role a matter of weeks before the inspection. They were supernumerary and were able to check care charts, spend time with people who used the service and assist with activities. Other duties included, doing resident of the day audits, checking for missing signatures on medicines charts, checking daily care charts, re-writing care plans, medication audits, assisting in the initial assessment process with management and performing spot checks during the night. The staff member we spoke with had done one of these checks the previous night. Because of the post being new it was difficult to identify its effects, but the expectation was that it would benefit the daily care process. One enhanced care coordinator told us "I like the new role. There is more one to one time to take people out".

There were regular supervisions and staff meetings. Some of the staff files had supervision notes in place and other staff had supervision sessions booked in. The manager provided a supervision matrix which evidenced regular one to one meetings. Annual appraisals had been completed by the previous manager and the new manager had noted the dates when they were due to be undertaken again.

We saw minutes of staff meetings, where discussions included staffing issues, diet and fluid charts, safeguarding, health and safety, nail care, mouth care and shaving, handover and new posts. These meetings provided an opportunity for staff to raise issues or concerns or make suggestions.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care was not provided with regard to people's preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users were not being treated with dignity and respect

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided safely with regard to the proper and safe management of medicines

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Suitable and nutritious food was not being provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes did not effectively assess, monitor and improve the quality and

Treatment of disease, disorder or injury

safety of the services provided