Ilford Homes Limited

Sweetcroft Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This comprehensive inspection took place on 24 and 25 April 2018 and was unannounced.

The last comprehensive inspection took place in September 2017. The service was rated 'Inadequate' in the key question 'Is the service Well Led?' and 'Requires Improvement' in the key questions 'Is the service Safe, Effective and Responsive?' and overall. We found seven breaches of Regulations relating to staffing, fit and proper persons employed, safe care and treatment, person-centred care, requirement as to display of performance assessments, good governance and notifications of other incidents. After the inspection we served a warning notice on the provider for a breach of regulation in relation to good governance because they were not maintaining accurate, complete and contemporaneous records in respect of people using the service and staff. We asked the provider to meet the requirement of the regulations by December 2017. We also served Fixed Penalty Notices on the provider for a failure to send statutory notifications to the Care Quality Commission and also for a failure to display the rating of Sweetcroft Residential Care Home on their website.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of 'Is the service Safe, Effective, Responsive and Well Led?' to at least good. At this inspection we found the provider had made some improvements but not enough to fully meet the Regulations.

Sweetcroft Residential Care Home is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Sweetcroft accommodates a maximum of 20 people. At the time of the inspection, 16 people were using the service.

The service had a registered manager. 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.

During the inspection we found that risk management plans were not always robust enough to minimise risks. In addition, we saw poor moving and handling techniques used by care workers that could put people using the service at risk of poor care.

Some care workers had not had medicines training since 2015 and there were no written records of medicines competency testing to confirm care workers were assessed as competent to administer medicines safely. We recommended that the provider seek and implement national guidance in assessing staff competencies including those relating to the management of medicines.

We had mixed feedback regarding the home having enough staff on duty to meet people's needs. They were

dependent on agency staff but had hired new care staff which would reduce the need for agency staff.

We saw individual acts of kindness from staff, but people were not always treated in a person-centred manner. Lunchtime in particular was task orientated instead of meeting people's individual needs. We also found that activity provision was not person centred to meet people's individual interests.

The provider had procedures in place to protect people from abuse. Staff we spoke with knew how to respond to safeguarding concerns.

Care workers had relevant training, supervision and annual appraisals to develop the necessary skills to support people using the service. Safe recruitment procedures were followed to ensure staff were suitable to work with people.

The principles of the Mental Capacity Act (2005) were generally followed, but not all care workers we spoke with understood about people consenting to their care.

Staff had completed training in infection control and wore appropriate protective equipment to reduce the risk of the spread of infection.

People's dietary and health needs had been assessed and recorded so any dietary or nutritional needs could be met.

The service worked well with other professionals and we saw evidence that people were supported to access healthcare services appropriately.

People were involved in planning their care and care plans contained information to give staff guidelines to care for people in their preferred manner.

There was a complaints procedure in place, however the service had not had any complaints in the last year.

People using the service and staff told us the registered manager was available and listened to them.

The service had a number of systems in place to monitor, manage and improve service delivery to improve the care and support provided to people. However, these were not always effective in identifying the quality of the data.

We found three breaches of regulations in relation to safe care and treatment, person-centred care and good governance. We are taking action against the provider for failing to meet regulations. Full information about CQC's regulatory responses to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People had risk assessments but the risk management plans were not always detailed enough to provide clear guidance about how to minimise the risk of harm.

We saw unsafe moving and handling practices that could put people at risk of harm.

There was no written record of medicines competency testing to demonstrate that staff were appropriately trained to manage medicines.

Safeguarding and whistle blowing policies were up to date. Staff followed these and knew how to respond to safeguarding concerns.

Incidents and accidents were recorded appropriately so trends and patterns could be identified to support learning and prevent reoccurrence.

Safe recruitment procedures were followed to ensure staff were suitable to work with people using the service.

The provider had infection control procedures in place which were followed by staff.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider generally acted in accordance with the requirements of the Mental Capacity Act (2005) to promote people's rights. However not all care workers we spoke with understood the principles of the Act.

People's physical, mental health and social needs were assessed prior to their move to the home which helped to ensure the provider only supported people whose needs they could meet.

Care workers were supported to develop professionally through,

training, supervision and appraisals.

People's dietary and health needs had been assessed and recorded and were monitored.

Is the service caring?

Requires Improvement

The service was not always caring.

Although individual care workers treated people with kindness, we saw that the provider did not always operate the service in a person centred manner, particularly in the way meal times were organised.

Care plans identified people's needs and preferences to provide staff with guidelines to care for people.

Family members were welcomed to the home and had regular contact with people using the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Activities for people were not always person centred or meaningful and did not always reflect their interests and preferences.

People were involved in planning their care. Care plans included people's preferences and guidance on how to support them. Reviews were held monthly.

The service had a complaints procedure and people knew how to make a complaint if they wished to.

People had their advanced wishes for end of life care recorded so staff were aware of these and were prepared to meet these if they developed.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had a number of data management and audit systems in place to monitor the quality of the care provided. However these appeared to only check, there was a document in place, and not check the quality and content of the document, for example, risk management plans.

People and staff were able to approach the registered manager to discuss any aspects of their work and felt supported. People using the service and staff had the opportunity to provide feedback to improve service delivery.	

Sweetcroft 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 24 and 25 April 2018 and was unannounced. The inspection was carried out by one inspector 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.

Prior to the inspection we looked at the information we held on the service including notifications of significant events and safeguarding. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also contacted the local authority's safeguarding and quality assurance teams to gather information about their views of the service.

During the inspection we spoke with five people using the service, nine relatives, six care workers, one catering worker, two healthcare professionals, the deputy manager and the registered manager. We viewed the care records of six people using the service and six care workers files that included recruitment, supervision and appraisal records. We looked at training records for all care workers. We also looked at medicines management for six people who used the service and records relating to the management of the service including service checks and audits.

Requires Improvement

Is the service safe?

Our findings

At the inspection on 13 and 14 September 2017, we identified a breach of regulation relating to fit and proper persons employed. This was because we found safe recruitment was not always followed. Following the inspection, the provider sent us an action plan indicating how they would address the identified breach by December 2017.

During the inspection on 24 and 25 April 2018, care workers' records showed that the provider had systems in place to ensure support workers were suitable to work with people using the service. The files contained checks and records including probation reviews, two references, identification documents with proof of permission to work in the UK if required and criminal record checks. For agency staff working at the home, the provider received a profile of each agency member of staff they used which included information such as training and criminal record checks. Training recorded either 'full mandatory training' or 'health care assistant training' which meant there was no indication of what the actual training was or when it was completed. The registered a manger agreed to contact the agency to request more detailed information.

At the inspection on 13 and 14 September 2017, we identified a breach of regulation relating to staffing. This was because we found the provider did not deploy enough skilled and experienced staff to care for people. We also observed that care workers completed care tasks rather than provided person centred care because there were not enough of them. Following the inspection, the provider sent us an action plan indicating how they would address the identified breach by December 2017.

During the inspection on 24 and 25 April 2018, we asked people using the service and their families if they thought there were enough staff. They told us, "No, they are short staffed. Breakfast, evening and night. They are rushed off their feet", "I think so. It's quite good", "There are agency staff at evenings and weekends", "Yes, for [person]", "The odd time [I am] trying to find someone but I think there is enough staff." A healthcare professional said, "There is always plenty of staff around. Some can provide information. Most just look for the seniors."

Care workers said, "Sometimes there is not enough staff and they get agency. The same people come. Lately have agency most days and nights", "I think because they have been using agency, they have enough staff but not all the agency have worked in this environment" and "I think there could be more staff. For example if someone is doing medicines, it takes them off the floor." Some care workers told us work could be a struggle, as in their opinion, not all care workers were doing their job as required and that created extra work for those who were.

Since the last inspection the provider had hired two more care workers. The registered manager told us they now had a full staff team and planned to recruit bank care workers so they always had available cover. At present agency staff were being used mainly at night but it was anticipated one of the new recruits would become night staff.

The registered manager was no longer working on the floor and was able to spend more time managing

their own role. The deputy manager was covering the kitchen at the weekend but the registered manager planned to employ kitchen staff so the deputy could continue to provide management support and be on the floor when needed. As not all permanent care workers were in place and they were still using agency staff, we found that the provider was in the process of improving the staffing situation in the home. We will check whether all the improvements have been made at our next inspection.

At the inspection on 13 and 14 September 2017, we identified a breach of regulation relating to safe care and treatment. This was because we found people's risk assessments were not always robust enough. In addition, the accident forms did not comply with the accident procedure that stated 'learns from adverse events'. The registered manager completed a monthly audit but there was no specific analysis of incidents and accidents to identify trends and patterns to support learning and to prevent reoccurrence.

During the inspection on 24 and 25 April 2018, we saw people had risk assessments but the risk management plans were not always robust enough. One person's general risk plan recorded that the person could be aggressive when being moved. It noted the person had seen the GP and speech and language therapist but did not provide guidelines for how to manage the behaviour. Furthermore, the moving and handling action plan for how to support the person when helping them to mobilise did not contain guidance for using a moving belt or what to do if the person became verbally aggressive.

A second person's risk assessment stated they were at a high risk of falling but the action plan was not robust enough to prevent and minimise risk. The action in the falls risk assessment tool was, "To continue to observe [person] for when they try to mobilise and to assist them at all times when they are mobilising." The falls risk plan of care indicated, "to assist [person] at all times when they are mobilising." We discussed with the registered manager and deputy manager the fact that there were three separate falls documents with vague directions instead of a single document that undertook a risk assessment and provided a risk management plan with clear step by step guidance on how to manage the risk. They agreed to look at how they could clearly format relevant information in one place.

In addition we saw poor moving and handling practice when two care workers were transferring a person from a wheelchair to a lounge chair. The person had on a moving and handling belt and one member of staff used the belt but the other hooked their arm under the person's arm which meant the person was being moved from two different angles. We also saw the brakes on the wheelchair were only on, on one side. When we asked about the move, both members of staff thought they had individually moved the person correctly. We spoke with the registered manager who agreed to address it with the care worker who had not supported the transfer correctly.

The above paragraphs are a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that some people had falls risk assessments and action plans that met their needs. For example, we saw one person's assessment rated them at high risk of falls and the action plan noted the GP had visited and would refer them to the falls clinic. However we did not see any record to confirm the person had attended the falls clinic.

The provider was putting in measures to reduce risk and the home had a falls champion whose role it was to share good practice to minimise the occurrence of falls. Additionally the local authority had recently provided the service with a falls and prevention management pack to help reduce falls. This was in the process of being implemented.

The registered manager completed a monthly accident audit that included falls which noted any further action to be taken. This was sent to the local authority monthly and helped to provide an overview of the service.

During the inspection, we looked at medicines management for six people including two who were administered controlled drugs. The provider had a medicines policy which included PRN (as required medicines) guidelines. Medicines were kept in a locked trolley and controlled drugs were kept in a separate locked cabinet. We completed a medicines stock take and found the stocks tallied with the quantity recorded on the medicines administration records (MAR). MAR charts were filled out correctly and included a photograph and allergy information. The 'medicines received' record had photos of people's medicines and directions for administration. Medicines were audited weekly.

Only care workers administering medicines attended medicines training. We saw training had been completed between 2015 to 2018, which meant some care workers administering medicines last completed their training three years ago. Furthermore, although the registered manager was undertaking general observational competency testing, and told us they observed medicines administration, the record did not indicate staff had been specifically observed managing medicines, therefore we could not be confident that care workers were appropriately skilled to administer medicines safely.

We recommend that the provider seek and implement national guidance in assessing staff competencies including those relating to the management of medicines.

People using the service and their relatives told us they felt safe. One person said, "Yes I do feel safe. I feel safe in my room" and relatives told us, "They're very good. They don't ever leave her standing. I feel secure knowing that [person] is here" and "I think [person] is safe. There is always two [staff] with them." When we asked care workers how they kept people safe, they told us, "Never let them walk on their own", and "Use the right equipment. Always use a frame and make sure someone is with them walking."

There were systems in place to help safeguard people from abuse including safeguarding and whistle blowing procedures, and safeguarding adults training. Most care workers we spoke with could identify the types of abuse and knew how to respond appropriately. Comments included, "I would go straight to [registered manager] or a senior" and "I would report to [registered manager] straight away and if she didn't do anything to report to the Care Quality Commission (CQC)." However, one long standing care worker could not name the types of abuse and did not know what external agency they could report safeguarding concerns to which we advised the registered manager of. They told us they would look into this matter.

The provider had checks in place to ensure the environment was safe. These included health and safety checks of the building, a weekly fire alarm test and the checking of fire equipment. Fire drills were undertaken twice a year and the last one was in November 2017. Maintenance checks were also up to date, such as for lifts, hoists and gas safety.

The provider had an infection control policy dated October 2017 to help protect people from the risk of the spread of infection. Support workers undertook the appropriate training in infection control and used appropriate protective equipment as required. Care workers told us they "wear gloves and aprons and put waste in the right bag" and "Wear gloves all the time, dispose and wash hands with sanitising gel and sometimes wear aprons." One relative said, "I do think the home is kept clean."

Requires Improvement

Is the service effective?

Our findings

People and their families were involved in planning people's care. Prior to people moving to the home, the registered manager undertook initial assessments that addressed people's physical and mental health needs including nutrition, falls, social background and religious needs and their likes and dislikes. A pre-admission falls questionnaire was also completed and some people's care records contained the local authority's care plan. The person's profile page included their preferred name, contact details, financial arrangements and a photo and description of the person.

Care workers told us they had received an induction and shadowed a more experienced care worker and were then on probation. The supervision policy and procedure said, 'All care staff should have at least one formal supervision session of at least one hour's duration every two months.' Supervision was not being held that often but we did see evidence of care workers receiving supervision in the last year. Care workers said, "I get one to one with [deputy manager] every two months. It helps me to see how I'm progressing. I'm more confident now", "[Registered manager] can tell me where I'm going wrong" and "If I don't understand something they [managers] will explain it to me." Appraisals were undertaken annually.

A relative said, "They [care workers] appear to have the right skills to care for people. They seem to do an amazing job." The staff training database indicated all staff had training in areas the provider considered mandatory including safeguarding adults, health and safety and infection control in 2017. The registered manager also told us they had arranged for a nurse to come to the service over several weeks to provide training for pressure area care.

The provider recorded observational records for care workers as a means of testing people's professional competencies but this did not include medicines. The registered manager said they would add this in to the form. Separate competency testing for hoists had been put in place. Due to our observations of a handling belt being used incorrectly, the registered manager said they would include observations of the hoist and handling belt as part of a manual handling competency assessment of staff.

People's care plans recorded information around diet and nutrition such as, 'prefers soft food', 'likes water and juice', doesn't drink enough so needs encouragement', '[Person] would prefer to stay in their room at mealtimes'. Relatives told us, "The food is okay" and "The food here is proper cooked meals."

A weekly menu was created on a monthly basis. As it was a small home, the cook said they regularly spoke with people about their meal preferences. A book in the kitchen recorded people's likes and dislikes and the kitchen had a list of people's allergies, who was diabetic and who was on certain medicines that could interact with certain foods. We saw one person was not on the list and it was therefore out of date, but when we raised this it was updated on the day of the inspection.

The service had daily handovers so care workers knew what had happened on the previous shift and what was required of them each day. We saw evidence of input from other healthcare professionals including the dietician, speech and language therapist, chiropodist, district nurse, falls clinic, optician and GP. Comments

from healthcare professionals included, "I am impressed by the care staff. They know the patients really well. They flag stuff up and communicate with families. [I have] seen improvements. There is continuity" and "In general good at following instructions. Proactive in terms of liaising with the district nurses and diabetic nurses."

We saw evidence that people's day-to-day health needs were being met. People told us if they were feeling unwell, "You tell them and they will ring for the doctor" and "They help me. The doctor comes round." One relative said, They're very attentive to his medical needs and the doctor has been in to see him today. They're very good with observing for his pain." Another told us, "They make sure [person] takes [medicines] and check their mouth afterwards." The GP attended the service every Wednesday and every person who required a district nurse visit had an individual file with the nurse's notes for example regarding wound care. People's weight and blood pressure were recorded monthly. We saw some significant changes in weight for the last month, but the registered manger said they needed a new weigh scale and the weights were not correct.

Sweetcroft was talking part in a pilot commissioned by the clinical commissioning group (CCG) to promote health and wellbeing. As part of the pilot, a GP who was an elderly care specialist visited Seeetcroft once a week, although people remained registered with their own GPs.

The GP completed a holistic 'Medical Care Plan' with the person and their families. It recorded if relatives had Lasting Power of Attorney (LPA) for both property and affairs and health and wellbeing and if the person had an advanced directive. Other areas assessed included health issues, for example, diabetes and falls, medicines required and allergies. There was a summary of the discussion with the person and their family and the GP conducted a baseline examination of the person. The care plan contained goals and decisions regarding medical optimisation and advanced care planning and there was an action plan for the GP. This meant the GP had a clear overview of peoples' current health needs, their future wishes and who was involved in decision making for the person.

The GP told us that care workers were good at raising changes in peoples' mobility and asking for a review. They also noted that the registered manager recognised when people had needs the service could not care for and would request a medical opinion early on to expediate the moving on process.

People's rooms were personalised to their tastes and were clean. However in one person's bedroom we saw three wheelchairs. As soon as we pointed this out, they were removed. The room was also missing a call bell as were two other rooms we viewed. The deputy manager thought the call bell might have been removed from two of the rooms because the people could not use them. Consequently we were told staff checked on the people regularly and this was recorded in the daily logs. We discussed with the managers having a single log dedicated to recording when people were checked on as the checks were not obvious in the daily notes.

Since the last inspection we saw the provider had replaced chairs and cabinets and laid new flooring in some areas. New dining room chairs were on order and the registered manager had requested estimates for a new dining room floor and upstairs flooring. New hoists had also been purchased. At this inspection we saw one toilet was missing a lid and a new one had been ordered. We noted the pull cords for the call bells in the toilets were tied up too high for people to reach if they had fallen on the floor. When we told the deputy manager this, they untied them all to lower them.

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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA

Not all care workers had undertaken MCA training and those who had, last completed it in 2016. The local authority told us they had offered sessions on MCA and DoLS but this had been cancelled. The registered manager said they would reschedule the training. Three care workers told us they did not remember their MCA training and could not explain to us what consent to care, best interests decisions or DoLS meant. For example, when we asked about consent to care, one care worker told us one person was "wobbly on their feet, so we try to encourage her to sit." There was no indication that they thought the person should have a choice about whether or not they wanted to sit. Another care worker told us, "I think it's around some can and some can't go out. It's understanding needs are different. You listen to them to understand what they're saying." The registered manager said they would reschedule training with the local authority and arrange for inhouse training to address the gaps in knowledge.

Most files contained MCA day to day decision forms for washing / showering, feeding / nutrition, changing incontinence pads, dressing and medicines. The record was activity specific and had a mental capacity assessment with actions taken and why they were in the person's best interests.

People's consent to care forms were divided into personal care, finances, agreeing to staff managing correspondence, administering medicines and information to be stored and shared. Some consent forms were out of date and needed to be updated. People had signed each section appropriately but we saw 'I agree / disagree' had not always been crossed out to confirm they had or had not given consent. The deputy manager said they would update old consent forms and ensure 'agree' or 'disagree' was crossed out on everybody's records as part of their file audits. In addition, we saw one file where the person who signed to consent was not always consistent. The person had signed their medical consent form but their day to day consent form was signed by a relative but it was not clear if the relative had legal authorisation to do so on the person's behalf.

We saw for one person using bed rails there was a best interests decision made with their family as the person was assessed as not having capacity to make this decision. People also had Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms in the front of their files which were signed by the GP and the summary information at the beginning of the file indicated if people had DNACPR, DoLS and the capacity to make decisions regarding for example, day to day decisions. We saw DoLS authorisations were appropriately requested and if a person did not require a DoLS authorisation, this was also recorded. As part of the Medical Care Plan we saw records of advanced care planning. The process around resuscitation should a person become very ill was discussed with the person and their family and where required a DNACPR put in place.

Requires Improvement

Is the service caring?

Our findings

When we asked people if they liked living at the home, they told us, "On the whole it is generally good. [Care worker] I give ten out of ten to", "I do exercises. The food is very good. People are very good and very caring", "I am quite happy here" and "It's alright."

Relatives comments included, "[Person] is really happy being here and they like everyone", "They're all very accommodating which I love.", "The staff are lovely with [person]. They have so much patience.", "[Person] recognises and responds to people here" and "It's a really pleasant place for [person] to be. [Person] is getting the care and attention she needs." However, one relative told us, "It's homely but we haven't built up a rapport [with staff]. All [staff] seem nice but a bit disengaged. More functional than attentive." They explained that they did not have any reason to think their relative was not being taken care of physically, but the staff were not always attentive.

A healthcare professional said, "They [staff] interact with the clients well. They always seem happy" and a social care professional told us, "I've had a lot of positive feedback on Sweetcroft from family members and residents."

While the feedback from people and their relatives indicated care workers were individually caring, our findings during the inspection showed that the service as a whole was not always caring because we saw examples, particularly at lunchtimes, of people not being supported to receive care and support that took into consideration their wishes and needs. This meant that people's right to make choices was not always respected and their independence was not always promoted.

During lunchtime on the first day of the inspection, people started moving into the dining room at 1pm. Serving started at 1.25pm and lunch finished at 2.20pm. We observed that when one person was given pork chops to eat, they asked the care worker how they could eat it with no teeth. The care worker then brought the person a sandwich. However, the fact that they brought food that the person had not chosen in the first instance indicated they were not giving people choices of what to have to eat. Another person was also having sandwiches which were served to all people eating sandwiches from a single plate. The care workers did not ask if people wanted any more when they finished what they had, and a member of the inspection team had to ask for more for one person. We also observed that care workers were doing tasks for people instead of sitting down at the tables with people and providing encouragement with the task and eating.

Our observations of lunch on day two were similar, in that lunch took over an hour and a half for the 16 people using the service, and care workers were task orientated rather than person centred. For example, we saw three people who were sat in the dining room at 1pm waiting for half an hour before they were offered sandwiches for lunch and by 1.50pm, having eaten their sandwiches, they were still sitting alone at their table staring passively. For people who were having a hot lunch, we saw a care worker offering them gravy at 1.30pm after they had started eating their meal. One person who clearly did not want to sit down at the table was brought into the dining room at 1pm and while care workers were trying to do other things such as set the tables they encouraged the person to sit down. The person did not begin eating until half an

hour later. Additionally, as there were no care workers sitting at the table to support and encourage people with eating, the person began putting their food on the table and into another person's mug but care workers were unaware of this. When we discussed this with the registered manager they told us, they had already made a request for a continuing care assessment because the home was finding it difficult to support the person. However, adjustments had not been made for the person in the interim to make lunch a more positive experience for them and others. We discussed with the registered manager possibly having more than one sitting for a shorter period of time with care workers supporting people.

While we were sitting in the dining room, we could hear both a television and radio which made it difficult to hear either one clearly. On both days in different communal rooms there was competing noises from televisions and radios. In the afternoon of the first day, we noted the television was on a daily topical programme and later a reality show that no one in the room was watching. Care workers did not ask people what they wanted to watch or have alternative choices such as DVDs that people may have been interested in. In one lounge, we saw a care worker come in and turn on the television without asking people in the room what they wanted to watch. One person told a member of the inspection team, they didn't want the television on.

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

After lunch one the first day, we heard three care workers in the lounge talking about a person's medical condition loudly enough for other people to hear the conversation. A healthcare professional also said, "I have observed staff talking to each other inappropriately in front of service users." When we discussed this with the registered manager they said they had spoken with staff in the past about keeping people's information confidential and being respectful in how they discuss information, but they would raise it again with staff and possibly look at doing a small workshop within the team meeting to help highlight how to manage information appropriately.

We also observed other occasions when care workers treated people with kindness and respect. For example, we saw one care worker walking with a person who wanted to go outside through the front door. The care worker was very patient in explaining they needed to go out the back door to the garden. At lunchtime we saw that whilst staff did not always demonstrate they offered people's choices about their main meals, they did offer choices about drinks and puddings

When we asked care workers how they supported people to have choice, they told us, "We give them a choice of what they want to wear, eat, drink, join in the daily activity, go to the toilet. Day to day things really" and "You ask them what they prefer and their care plans say what they like, for example, what time they go to bed, shower, bath, what they want to eat."

The staff welcomed relatives and we observed a number of relatives visiting. One relative said, "I can pop in whenever [family member] wants. I know most of the girls and they all refer to me by name. Very homely."

Requires Improvement

Is the service responsive?

Our findings

At the inspection on 13 and 14 September 2017, we identified a breach of regulation relating to person-centred care. This was because we found the service was not person centred regarding activity provision and the activities on offer were not very meaningful for most of the people using the service. During the inspection on 24 and 25 April 2018, we saw the provider had made some improvements to activity provision.

The provider had an activity co-ordinator who had one to two dedicated days per week to plan and carry out activities with people using the service. Two members of staff were completing booklets with people called 'All about me' which provided a life history and people's interests, which in the future could be used to provide more meaningful activities for people. The home had an activity planner but it was too high up for people to see with small font and pictures. Therefore information about the activities that were being planned for people was not always easily accessible to them.

People had a 'social care and activities plan of care' which included an assessment of needs, aim of care and key working instructions. However, the plans did not provide guidelines on how to engage people in their interests. For example, one person's plan recorded their need as: 'used to like gardening, now likes to sit in the garden, likes quiz shows, likes to talk about the war, doesn't like to participate in activities'. The aim was 'allow [person] to do things he likes. Encourage to interact' and the key working instructions were to 'ensure [person] aware of activities. Encourage chair activities'. We did not see any evidence the person was engaging in the activities he liked such as sitting in the garden or talking about the war. Also the plan said the person did not like to participate in activities but the instructions were to ensure he was aware of them and to encourage him in the activities available rather than the activities he enjoyed.

Another person's care plan stated they did not have a preferred activity but they looked at magazines and were assisted outside to smoke. There was no indication of what magazines they liked or if they required help to purchase them. Nor was there any indication how often they smoked or where the person's cigarettes were kept. None of the care records we viewed indicated people had an activity preference even though they did list some likes. This meant people's social and recreational needs were not always assessed and plans were not developed or implemented to ensure these needs were being met.

We saw the service user guide stated, 'therapeutic activities take into account service user interests, skills experience, personality and medical condition. The home offers a wide range of activities designed to encourage the client to keep mobile and take an interest in life.' We did not see many 'therapeutic' activities during our inspection or planned, except on the first day of our inspection when we observed people in the lounge doing chair exercises in the morning. The care workers in the room were chatty and encouraged people to exercise and people were chatting back. In the afternoon people played snakes and ladders.

One relative said when they visit the home, people are "just sitting in the lounge." Other relatives thought it would be better if the service had "more activities during the day. Feasible ones that [person] can access. When they have singalongs, residents love it. It needs to be every week. A singalong every other afternoon

would be good" and it would be better "perhaps if they brought an entertainer in more often."

The paragraphs above show that overall the service was not person centred regarding activity provision and the activities on offer did not fully meet the needs of the people using the service.

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

Whilst there was room for improvement, some people enjoyed taking part in the activities offered at the service. People we spoke with said, "I sit and watch TV. I play darts", "They have activities where they ask questions" and "They play board games with us and do noughts and crosses." A care worker told us, "We do a lot of painting for celebration days, for example St Patrick's Day. We throw little birthday parties and racing parties. Bingo and quiz games are about and [we talk with] people about their past." The home also planned to get flowers for the garden for people who were interested in planting them.

People had care plans which gave guidelines for people's routines such as when people liked to get ready for bed and when they liked to get up, how they liked their personal care and if they required support with things such as hearing aids, glasses or mobility aids. Care plans recorded people's activities but some said 'no preference' which meant staff did not have any guidelines for how to support people with an activity that was meaningful to them.

People had summary care plans for both day and night routines. The day plan included when the person wished to get up, washed, dressed, if they would like a shower or bath and what time they would like lunch, tea and supper at. It also noted if people required medicines administration, help with repositioning or help with their mobility.

The general risk plan of care provided a page of background and the current situation regarding people's heath and routines. It included an 'aim of care', for example, 'To allow independence. To get [person] to interact more' and key worker instructions, for example 'Assist [person] with personal care and daily tasks. Encourage to participate. Monitor for signs of infection.' Some people had ABC (action, behaviour, consequence) charts. One person had a behavioural support plan that said to, 'approach slowly, calmly, explain to them. Encourage and support. Complete behavioural charts.'

We saw reviews were completed monthly and care plans had an attached record that indicated the review date and if the care plan required modifying.

The service had a complaints procedure but had not had any complaints. They also had an easy read complaints policy. People and relatives we spoke with confirmed they knew how to make a complaint if they wanted to. One relative said they had not made a complaint, but if it was a little issue like laundry, they spoke with the registered manager who dealt with it. The complaints procedure was not displayed prominently but the registered manager said they would arrange for it to be displayed by the front door.

The service user guide did not say who to complain to in the care home or provide contact details. It also stated, 'If a complaint cannot be resolved to the satisfaction of the complainants, they will be advised to contact CQC or alternatively both residents and their families can contact CQC directly at any time' and gave CQC's contact details. The Statement of Purpose also gave CQC's phone number, email and address regarding complaints. This information was incorrect as it is not a function of CQC to resolve complaints by people or relatives about the quality of service they received.

The training data base indicated some care workers had completed end of life care training in 2016. The 'Medical Care Plan' completed by the GP with the person and their families, if appropriate, contained goals and decisions regarding medical optimisation and advanced care planning so there was a record of how people wished to be cared for at the end of their life.

Requires Improvement

Is the service well-led?

Our findings

At the inspection on 13 and 14 September 2017, we identified a breach of regulation relating to the Registration Regulations 2009 of not notifying the Commission of the outcomes of applications made under DoLS to deprive people of their liberty. We took enforcement action and served the provider a Fixed Penalty Notice that they have since addressed. During the inspection on 24 and 25 April 2018, we saw the provider was correctly notifying the Commission of events and incidents that happened at the service, as required by law.

At the inspection on 13 and 14 September 2017, we identified a breach of regulation relating to the requirement to display performance assessments. This was because we found the provider did not display their ratings on their website and they were not visibly displayed in the home. We served a Fixed Penalty Notice on the provider that they duly addressed. During the inspection on 24 and 25 April 2018, we saw the provider had displayed their rating both on their website and prominently in the home.

At the inspection on 13 and 14 September 2017, we identified a breach of regulation relating to good governance. This was because there was a lack of effective monitoring, analysis, documented outcomes and actions required to improve the service to meet the needs of the people using it. Record keeping was not always complete and contemporaneous and there was no analysis of information to develop and improve service delivery as demonstrated by the incident and accident forms and feedback surveys. As this was a repeated breach we took enforcement action and served the provider a warning notice.

During the inspection on 24 and 25 April 2018, we saw the provider had increased and improved their auditing and monitoring but the quality of their records was not always good enough. For example the audits had not identified that robust risk management plans were not in place to manage risks people faced.

There were a number of monthly checks which included health and safety, care records, staff records, infection control and fire safety reviewed monthly. There was a further overall check list to confirm all the checks for the month had been completed. In addition to the general infection control check, one person's bedroom and one communal room had a more detailed infection control inspection once a month. An accident audit was completed monthly and emailed to the local authority and the registered manager undertook monthly medicines audits and expense audits. This provided them with an overview of the service so they could respond to issues, minimise risk and improve service delivery. However, the file audits needed to look at the content of the records to ensure they were effective and not just that they were in place.

The above were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that all policies and procedures had been reviewed in 2017, however the legislation and guidance was not all up to date. For example, the policies were quoting from the Health and Social Care Act 2008

Regulations from 2010 instead of 2014. The registered manager contacted the provider to address the issue and bring the policies and procedures in line with current legislation and guidance.

The registered manager told us that after the last inspection, they had liaised with the registered manager of another home to share best practice and had implemented more audits and competency testing to improve overall service delivery.

People using the service, relatives and care workers all confirmed they could speak to the registered manager or deputy manager if they had concerns. Relatives said, "[The deputy manager] is very good and has always done whatever she can to help", "They [managers] are all very approachable which I like", "As soon as I walk through the door, they update me. It's a real family feel. All of the girls, not just management will phone me. I'm comfortable coming here. They're lovely", "If they have any queries they phone me or keep me informed" and "Every time I phone, they're always helpful."

Care workers said, "I ask [registered manager] for help. She does respond", "[Registered manager] manages the service well. She's approachable and listens", "[Deputy manager] is good at listening and will act on it straight away", "I think the [registered manager] and [the deputy manager] are a good team together. I've never had an issue where they haven't responded to" and "I've had concerns and spoken to [the registered manager] and they have listened."

The provider received feedback and shared information through team meetings and residents' meetings. Care workers said, "We have team meetings, especially if something has gone wrong." The last staff meeting was held on 26 July 2017 and the next one was due 08 May 2018. No one we spoke with who used the service had attended a residents' meeting but a relative said, "They do have family meetings and minutes are sent out." The last resident and relatives meeting was held in December 2017.

The provider had undertaken service user satisfaction surveys in 2017. Only three people responded. They all said they were 'quite' to 'very satisfied' with the service. They planned to do another survey in 2018 to gather people's views about the service.

We saw evidence the provider worked with a number of other professionals including, the hospital, optician, Speech and Language Therapist, the GP and the local authority. We received feedback from the local authority's quality assurance officer who inspected the service annually. They told us, "There are no current concerns or safeguarding alerts that we are aware of at Sweetcroft." The registered manager told us they were speaking to their contact person in the local authority regularly and were attending provider forums so they received up to date information about the adults social care sector.

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 The registered person did not ensure the care and treatment of service users was appropriate, met their needs and reflected their preferences. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not always have effective arrangements to assess, monitor and improve the quality of services provided. The registered person did not maintain accurate, complete and contemporaneous records in respect of each service user, in the carrying on of the regulated activity or the management of the regulated activity. Regulation 17 (1) (2) (c)