Roseberry Care Centres GB Limited

Swiss Cottage Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection visit took place on 21 February 2017 and was unannounced. When we last inspected the service in June to August 2016 we found that the service did not meet the fundamental standards in respect of person centred care, consent to care or treatment, safe care and treatment, good governance and staffing. During this inspection we found that the service was still not meeting these fundamental standards. In addition the service also did not meet the fundamental standard in respect of premises and equipment as the home was poorly maintained and visibly unclean in places.

At the time of our inspection the service provided accommodation for 65 people who need nursing or personal care.

The service did not have a registered manager in post. The previous registered manager had left the service in October 2016, although they had not cancelled their registration. A new manager had been appointed and was in the process of applying to become the 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.

The home had not been cleaned to an acceptable standard to prevent the risk of infection or provide an environment free from unpleasant odours. Procedures intended to reduce the risk of an acquired infection were not always followed by staff.

People did not always receive their medicines as they had been prescribed and medicines administration records were not always correctly completed. Staff did not always ensure that medicines had been taken when they were signed off as having been administered. Stocks of medicines held did not always correspond with the amount recorded. Protocols in place for medicines administration were inadequate.

There were insufficient staff to respond to people's needs in a timely way. Staff had not received appropriate training to identify and support people's needs. Staff performance was not routinely reviewed.

Personalised risk assessments were in place but these were often confusing, contradictory and not updated as people's physical and mental health needs and the associated risks changed. Care plans were not person centred and people were not involved in the review of these. Documentation was often inaccurate, undated and very difficult to read.

People's privacy and dignity was not protected. Doors to people's rooms were routinely left open and people in their beds were exposed to the view of visitors passing their room. People were not always dressed appropriately when they were in communal areas. People had mixed opinions as to the caring attitude of the staff that cared for them.

People also had mixed opinions about the food provided, which did not meet everybody's nutritional requirements. People were not always supported appropriately to eat their food. People were also not supported to maintain their interests and hobbies. People cared for in bed were isolated and lonely.

The quality assurance system was ineffective. The provider had failed to ensure that appropriate action had been taken to address the breaches in regulations that had been identified during the inspection in August 2016 or to identify further areas for improvement.

During this inspection we identified that there were breaches of a number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always given their medicines because at times their medicines had run out of stock. Where there were protocols in place for medicines that had been prescribed 'as required' these were insufficiently detailed for staff to administer in line with the prescriber's intention.

Risk assessments were confusing, contradictory and not always legible. They had not always been updated to reflect the current risks to people.

The premises were neither clean nor well maintained. There were unpleasant odours around the home.

There were insufficient trained staff to meet people's needs in a timely manner.

Staff did not know how to report concerns to the local safeguarding team.

Is the service effective?

Inadequate

The service was not effective.

Lawful consent to care was not always evidenced and documentation showed that staff did not have a full understanding of the requirements of the Mental Capacity Act 2005.

Staff had not received training needed to effectively care for the people who used the service and did not receive regular feedback on their performance, even when in their probationary period.

People were not provided with food that met their dietary requirements. People with diabetes were provided with food that had high sugar content. People who were vegetarian had limited choice available to them. People were not always supported to eat their food in accordance with their care plans.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not always protected. People's doors were open and visitors could see them, in various stages of undress, as they passed by. People were not always appropriately dressed in communal areas.

Not all staff demonstrated a caring attitude toward people who used the service.

People were encouraged to be as independent as possible.

Is the service responsive?

Inadequate

The service was not responsive.

People were not involved in the review of their care plans. The plans were not personalised and contained little detail. Some of the information contained in care plans was not relevant to the objective of the plan. Care plans did not always reflect a person's needs following changes to their physical or mental health.

People were not supported to maintain their hobbies and interests and were bored. People cared for in their rooms had little stimulation.

Is the service well-led?

Inadequate

The service was not well-led.

The service had not had a registered manager in place since October 2016.

The service had failed to send required notifications to CQC.

The breaches of regulations identified in August 2016 had not been rectified and the quality assurance system was ineffective.

Documentation was inconsistent, inaccurate, often undated and sometimes illegible.

Swiss Cottage 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.

An inspection took place on 21 February 2017 and was announced. The visit was carried out by two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of older people in care homes.

Following the last inspection we had asked the provider to send us information as to how they would address the areas for improvement identified at that inspection. Before this inspection, we looked at the actions that they had told us that they would complete. We also reviewed the information available to us, such as notifications and information provided by the public or staff. A notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with eight people who used the service, three relatives of people who used the service, a nurse, two care workers, the chef, the deputy manager and the manager. We reviewed the care records and risk assessments for six people who used the service. We looked at two staff recruitment files and training and supervision records for all staff. We also reviewed information on how the quality of the service was monitored and managed.

Inadequate

Is the service safe?

Our findings

During our inspection in August 2016 we found that people did not always get their medicines as they had been prescribed and there were discrepancies in the stocks of medicines held. During this inspection we checked the medicines administration records (MAR) for all people on two units and found that there were no unexplained gaps. However, staff who had signed the MAR to confirm administration did not always observe that the medicine had been taken in accordance with the provider's medication policy. One person told us, "Some of the girls who go off at eight leave me my sleeping tablet in this little cup and say don't forget to take it when you're ready for bed." There was a risk that the person could have 'stockpiled' the tablets and take an overdose. Also other people may have been able to access the tablets and could have been at risk if they took them.

The MAR also showed that some people did not always get the medicines they had been prescribed as the stocks had run out. A member of staff told us that it was not unusual for people to have to wait for a new supply to arrive from the pharmacy if repeat prescriptions had not been ordered in good time. People told us that they did not always receive their medicines on time. One person told us, "I have complained about waiting for my medication. It gets rectified and then goes back to normal again, (waiting)." Another person said, "I normally get my medication on time but not always. It depends who's on. At night [staff] take a while especially if they are not regular staff."

We checked the stocks of medicines held for four people and found that there were unexplained discrepancies between the number shown to be held in the records and those that were actually held. Poor recording practices when people had been prescribed a variable dose of a medicine, such as one or two tablets, made it difficult for staff to establish how many tablets should be held of some medicines. For one medicine there were eight tablets less than the record suggested. For another medicine there were two tablets more than the records indicated. This showed that not all medicines were accounted for and we could not be assured that people received their medicines as prescribed.

We also found there were a number of medicines records that did not have a photograph of the person to whom medicines should be administered. This put people at risk of receiving the incorrect medicine if the staff failed to identify the correct person to whom they should be given.

A number of people had medicines prescribed on an 'as required' basis. People told us that they often had to wait to be given these medicines after they had asked for them. One person told us, "When I ask for my pain relief it takes ages for someone down stairs to authorise it." There were no satisfactory protocols in place to inform staff as to when people should be offered these medicines. In some cases there were no protocols at all and in others the protocol gave no information as to how much should be administered, the minimum time between doses, the maximum dosage or possible effects of the medicine. This meant that people were at risk of being given too much medicine over too short a period which could lead to physical harm.

People told us that staff did not always follow the correct procedures to prevent the risk of infection when

providing personal care. One person told us, "I do get help sometimes with personal care but they don't always wear gloves." We asked staff about the training they had received on infection control. One member of staff, who had completed their probationary period, told us, "I have not yet done infection control training." We also noted that the overall worn by the kitchen assistant on the morning of our inspection was very stained and dirty. This suggested that the standard of hygiene in the kitchen could be improved.

During our inspection in August 2016 we found that the risks to the health and safety of service users of receiving the care or treatment had not always been identified or assessed. During this inspection we found that the personalised risk assessments were confusing, contradictory and not always legible. They had not always been updated to reflect the current risks to people. One person had risk assessments in place for the risks associated with being on end of life care and nursed in bed. Other risk assessments in their care records however referred to them as being mobile. For example, the mobility assessment stated that they needed full assistance by two care staff, whilst another stated that they needed their food cut up when they were in their wheelchair. Another person had risk assessments in place for behaviour that had a negative effect on others and referred to them wandering around the home. The person's physical health had deteriorated following a period of hospitalisation and they were being nursed in bed on end of life care. They were no longer at risk because of their behaviour. Another risk assessment stated that the person was at risk of uncontrolled or sudden bleeding but did not give staff enough detail as to how this should be managed.

Poor medicines administration, failure to update personalised risk assessments and failure to follow infection control procedures demonstrated a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected the service in August 2016 we found that the level of staffing had been determined using a recognised tool based on people's dependency needs. However, because of the size and layout of the home, the calculation did not ensure that there was an adequate number of staff deployed in all areas to provide care when people needed it.

During this inspection we found that there were still not enough staff to meet people's needs safely. People who lived at the home, relatives and staff all told us that there were insufficient staff to meet people's needs at all times. One person told us, "There is an acute shortage of staff which makes it very difficult then they get stressed and short tempered. I ring my call bell and have to wait ages. Once it took them 50 mins." Another person said, "I don't ring my call bell but I never stop hearing all the others and they go on for ages. It seems like they're ringing all day." A relative told us, "They are understaffed. The carers all seem to be overworked." Another relative told us, "The problem is they are grossly understaffed." A third relative told us, "I think they are short staffed and would probably like to see more regular ones (carers) stay." One member of staff told us, "There are 21 people on this unit and only three can mobilise. Most need two staff to transfer. There are just three care workers and a nurse. The nurse is often doing medicines or dressings and therefore not available to assist with support for personal care. I would prefer to have four care workers on the floor." Following our inspection, the Operations Director informed us there were 19 people living on the unit in question rather than 21. This still meant that three carers and one nurse were supporting a high number of people who were not able to mobilise independently.

The home had two nursing/dementia units on the ground floor and a residential unit on the first floor. The layout of the building was such that there were clusters of rooms in small corridors off a main corridor. This made it difficult for staff to observe people in their rooms and the layout was very confusing both to visitors and people who lived at the home. We encountered a person who was becoming distressed as they could not find their way to the lounge. There were no members of staff visible to guide them.

During our observations of the lunchtime experience on one of the units, we saw there was only one member of staff in the dining room for the first 10 minutes. A second member of staff arrived after 10 minutes and a third member of staff arrived after a further five minutes. One person, who had been seated at the table when we arrived in the dining room, waited over 35 minutes to be offered their meal. Another person waited for 25 minutes, with their dirty plate in front of them, before they were offered dessert. Neither of these people required assistance to eat their food. Two of the three staff were assisting people who needed support to eat their food: the third was plating meals at the hot trolley. In the afternoon we saw that three people were served tea and cakes in one of the lounge areas and then left alone for 20 minutes. The people did not drink and one person could not hold their cake and dropped it on the floor.

Failure to ensure that there were sufficient trained staff to meet people's needs in a timely manner was a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had up to date policies on safeguarding and whistleblowing. Whistleblowing is a way in which staff can report misconduct or concerns within their workplace without fear of the consequences of doing so. Staff told us they had been provided with safeguarding and whistle blowing training. However, some staff were not able to explain what safeguarding was about or how they would recognise and report abuse. One member of staff told us, "I have not experienced it yet and have no idea who deals with safeguarding."

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the arrangements in place for keeping the service clean and hygienic were ineffective. Whilst on our arrival the reception and office areas smelt clean and fresh this was quickly replaced by unpleasant odours in the main corridors. Whilst walking around the building we noted that there were rooms with stained and wrinkled carpets. Bathrooms and shower rooms were dirty and untidy. The bathrooms were often being used as storage areas for hoists and wheelchairs. People's personal items cluttered shelves within the bathrooms. One bathroom had, amongst other things, seven different shaving foams, a razor, talcum powder and two tubes of tooth paste on the shelves. One of the tubes of toothpaste had no lid and had clearly not been used for some time. Some of the bathrooms and toilets had wood panelling on the walls. This had dirt and debris between the panels and could not be cleaned effectively. This put people at increased risk of acquiring an infection. Window frames and sills throughout the building were dusty and the paint on them was chipped in places. Doors to people's rooms had been fitted with brass door knockers. Unfortunately the doors had not been repaired following the removal of previous fittings before being painted. This had left the doors with rough surfaces. The window frames, window sills and doors to people's rooms could not be cleaned effectively and this increased the risk of people acquiring an infection. There was a water cooler in one of the dining rooms which had scale all down the front of it. This could have contaminated the water drawn from it.

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

During our inspection in August 2016 we found that accidents and incidents were not always recorded and the reasons for them analysed to enable the provider to identify ways to reduce the occurrence of such risk. During this inspection we found that the recording of accidents and incidents was being monitored and causes identified.

People and relatives told us that the service was safe. One person told us, "I feel safe here it's like being at

home." Another person said, "Oh yes. I feel safe here because of the girl's and the company." A third person told us, "The reason I feel safe is because I am not on my own I have got people around me who make me happy." A relative told us, "[Name] is not neglected in any way."

We looked at the recruitment documentation for four members of staff who had recently started work at the home. The provider had robust recruitment and selection processes and gaps in an applicant's employment history had been explored during the interview process. We saw that appropriate checks had been carried out which included Disclosure and Barring Service Checks (DBS), written references, and evidence of their identity. This enabled the provider to confirm that staff were suitable to support people who used the service.

We saw that procedures were in place if there was an emergency. There was an up to date emergency contingency plan in place and each person had a personal emergency evacuation plan (PEEP). The PEEP informed staff of the support people needed to move to a place of safety in the event of an emergency.

Inadequate

Is the service effective?

Our findings

When we inspected the service in August 2016 we found that there was no evidence that people had given their consent to the care and treatment provided. Where people lacked capacity to make informed decisions there was no evidence that decisions made on their behalf were in accordance with the Mental Capacity Act 2005 (MCA).The Act 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).

During this inspection we saw that applications had been made and granted for authorisation to deprive people of their liberty for their own safety and the safety of others. In one of the care records we looked at the officer who had authorised the DOLS had appointed a relative to act on behalf of the individual. However, although the relative had visited the person on numerous occasions, the form in the care records which gave consent for the care to be delivered was unsigned. It had been annotated in September 2016 that the relative had given verbal consent to the care provided and would sign the form when they next visited. This had not been done and therefore there was no evidence that they had consented to the care being provided to the individual.

We found that there was confusion by staff about the requirements of MCA. People were routinely assessed for capacity and DoLS when there was no evident need for this. One care record we looked at showed that the person had been assessed as having full capacity to make and understand decisions about their care and their day to day life. However, the consent to care and treatment form stated that consent to care was given by a relative as it was in the person's best interests. This meant that the person may have been receiving treatment that they did not want. In another care record the person had been assessed as lacking capacity, DoLS was in place and a representative had been appointed to act on their behalf. However the care plan later stated that staff should, "Never assume [Name] lacks the capacity to make decisions."

Failure to gain lawful consent to care and treatment was a continuing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were not confident that all the staff had the skills needed to care for them. One person told us, "I don't think they hoist me properly. One day I was hoisted and the sling was nearly round my throat this really frightened me. They don't have a clue. I have also been gripped too harshly on my arms." Another person told us, "Most of the girls I would say are skilled but not all, some grip too hard. The ones that are good I could count on one hand, agency staff are awful."

Staff told us that when they had started at the home they had a period of induction in which they worked with an experienced member of staff, did in house training and read the provider's policies and procedures. There was also a probationary period of six months for staff to demonstrate their suitability for the roles in which they had been employed. One member of staff told us that, although they had completed their six months probationary period, there had been no review of their performance during this period. They also told us that, although they worked on a unit in which people had dementia and exhibited behaviours that had a negative effect on others, they had not received any training on how to deal with this. The manager told us that they had been offered this training during their induction period but had been unable to undertake it due to personal reasons. Another member of staff told us that, although they had been working at the home for a year, they had not undertaken any training on the prevention and control of infection.

We spoke with the in house trainer. They told us that they ran a programme of training modules for new staff and refresher courses for existing staff. They monitored the training matrix to identify staff that were becoming due for their training and planned to run the modules when they were needed. They also ran training modules at night to enable staff that were able only to attend at night to keep their skills up to date.

The in house trainer told us that although they had delivered some training on dementia awareness to a few staff this was not considered mandatory by the provider. The majority of staff who worked in the units for people who lived with dementia had not been provided with dementia awareness training and may not have had the necessary understanding to best support people who were living with a dementia. One member of staff, who primarily worked on these units, told us that they had little knowledge of the different ways in which dementia could affect people or the best ways in which to support them.

Similarly, the in-house trainer told us that it was not mandatory that staff completed training in how to reduce the impact of people who exhibited behaviours that had a negative effect on others. They did, however, provide this training for staff on a regular basis and advised staff of when the modules were to be held. We saw that information about forthcoming scheduled training modules was available in the nurse's office and staff were able to sign up to attend relevant modules. The in-house trainer told us that they had provided training on behaviours that challenge on the day of our inspection.

Staff we spoke with told us that they did not feel well supported and had not received regular supervision from their line manager. Some staff said that they had not had any supervision or discussion about their progress, training or developmental needs since starting work at the home many months previously. One member of staff told us, "I had a supervision last year when [former registered manager] was here."

A lack of appropriate staff training and supervision was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had mixed reactions to the food. Some were unhappy with the choice and quality of the food provided. One person told us, "The food is awful. I am vegetarian, I am constantly asked to pick meat options. I never get asked what I want they just bring me something. Then I have to turn it away if its meat and wait again for them to bring me some food. By the time I get it, it is lukewarm. I even buy my own cereal. Its only [brand] but they never got it for me so my family buy it for me." Another person said, "The food has improved a bit but is very repetitive and it's not always hot. Everything is over cooked. The pasta is atrocious it's stuck together when you get it and puddings are not very good." However another person told us, "The food, I would say, is only satisfactory not brilliant. But I can't complain. I don't like to upset anybody. We get a cup of tea in the morning and afternoon with some biscuits and cake. That's nice. I like a cup of tea." Another person said, "I enjoy the food. There's always plenty of it. I'm never left hungry."

We observed the lunchtime experience on two of the units. In one unit the dining tables had cloths, cutlery, and glassware on them but only one table had salt and pepper. In the second unit there was no salt and pepper on any tables and people were not asked if they wanted any seasoning on their food. People eating in one dining room were given blackcurrant squash with their meal. Although water and orange squash was available they were not offered this. People eating in the other dining room were given orange squash with their meal, without being asked whether this was their drink of choice.

Not all people ate in the dining rooms. Some people had their meals in their rooms and other people ate from trays in one of the lounge areas, although this was not always a pleasant experience for them. One person told us, "I used to go to the lounge to have my meals but I stay in here [their room] most of the time because of some of the residents behaviour and table manners." We observed people in the lounge eating their lunch. One person was seen to be taking food out of their mouth and throwing it on the floor. No member of staff was immediately available to clean the food up

People were assisted to eat their food where this was required and plate guards were used to enable people to eat independently. However, we noted that one person's care plan had stated that they were able to eat finger foods independently but that staff had to supervise them. The care plan also stated that the person needed the assistance of one staff member to eat their main meal with a spoon. As their door was open, we were able to observe that this person was alone in their room with a full meal on their plate which they were attempting to eat with a fork.

We spoke with the chef who had worked at the home for about three months. They told us that they were using the menus that had been devised by the previous chef. They said they had met with a person who required vegetarian food and discussed the menu with them. They had told the chef they would eat fish and the chef had tried to ensure that there was a fish option for them on a daily basis, although this meant that they were not given a choice of meals. The chef told us that they catered for people's special dietary needs and showed us the board in the kitchen where these were listed. The chef said that two people required gluten free food and they made special bread and cakes for them. We asked what special provision was made for the ten people on the board shown to be living with diabetes. The chef told us that they made no provision to supply sugar free food or drink for people who had diabetes. They were given the same foods as everyone else. On the day of our inspection the dessert had been jam sponge and custard. The previous day the dessert had been jam doughnuts. Both of these desserts were high in sugar and not suitable for people who had diabetes. They were also served the same sugary squash with their meals as everybody else. The chef told us that the service no longer used mainly fresh fruit and vegetables. The majority of fruit and vegetables were now tinned or frozen.

Failure to provide a choice of suitable foods for people's dietary requirements and failure to offer the identified support that people needed to eat their meal was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were supported to maintain their health and well-being. One person told us, "I see the chiropodist every six weeks and we get the doctor in every week." Another person said, "We get to see a chiropodist and hairdresser and the GP comes twice a week."

Requires Improvement

Is the service caring?

Our findings

People told us that they were treated with dignity and respect. One person said, "Since I have been here I have been treated with dignity and respect." A relative told us, "We visit regularly and [relative] has always looked clean and smart. They are very personal with him, always call him by his name." However, we found that people's privacy and dignity was not always protected. Whilst we were walking around the home we noted that many people were in their rooms but the doors were open. We saw one person, who was being cared for in bed, had removed their bedding. They had no clothing, other than a pair of knickers, on their bottom half. There were many visitors walking around the home who could have observed the person in this state of undress. We also observed one person sitting in a communal lounge area, shared with people of the opposite gender, eating a meal wearing only their underwear on their bottom half. Whilst they may have been comfortable with this, other people in the room may have been offended.

There was little or no communication with the people when they were being assisted to eat. Staff stood over them and presented food to them. We noted that one of the two members of staff, who was assisting one person to eat their meal, started to assist a second person to eat at the same time. The member of staff stood over them and alternated between offering food to each of them. From their altered body language and facial expressions we could see that the people being assisted to eat appeared to be uncomfortable with this.

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

People and relatives had mixed feelings about the caring attitude of staff. One person told us, "Oh yes they are definitely caring towards me. They always call me by my name and bend down to talk to me." Another person said, "They are very kind to me." However, another person told us, "It depends on certain staff. Some care genuinely and to some it's just a job. On the whole I am looked after." Another person said, ""Some of the regular ones do care but not all, especially agency staff."

We observed staff interaction with people. Staff did show a caring attitude towards people, clearly knew them and called them by their name. In between carrying out tasks they asked people if they were okay or if they need anything.

People were encouraged to be as independent as possible. One person told us, "I sometimes get help with a shower but I can wash myself and they always encourage me to keep my independence." Another person said, "I like to be independent you know, wash myself and that, and they do encourage me." A third person told us, "I am going home soon. [Carer] has really helped me in here. She has spoken with my new psychiatrist who has done some tests with me and believes I am ready to go home."

People were able to be involved in how their care was delivered. One person told us, "I am a bit of a loner, I like my own company but they take the time out to chat to me." Another person said, "I think they know us and what we like and don't like. They ask us that's how they know."

Inadequate

Is the service responsive?

Our findings

During our inspection in August 2016 we found that care plans were lacking in detail, did not address the identified needs of people and the planned care did not meet the aims of the plan. During this inspection we found that care plans were not person-centred. We saw that the care records included a 'This is me' document that was to be completed by the person, or someone on their behalf who knew them well, such as a relative or friend, to build a picture of the individual. This would enable staff caring for them to understand their background and needs. In one care record that we looked at this document had been completed by an activities coordinator, even though the person had relatives who visited them regularly. It contained very little information about the individual and nothing of a personal nature. For example in the section headed 'My Mobility' it stated 'full hoist, 2 carers'.

Care plans contained little detail. The medicines care plan for one person contained no information about the medicines they had been prescribed, any side effects that staff should be aware of or any information as to how the person wished to take their medicines. There was a medicines agreement form but this had not been signed by the person or their appointed representative. We saw that content of some of the care plans, such as maintaining a safe environment and expressing sexuality, had little relevance to the objective of the plan. For example, one entry in a care plan for expressing sexuality stated that the person liked their room to be tidy. In another care plan, in respect of maintaining a safe environment, information about a person's chest infection and diabetes had been included. Staff would have to read the whole of the care record to glean the information that they needed as to how to provide care in specific areas. As there was a high usage of agency staff and permanent staff moved between units, staff on duty at any time would not always know the people on a unit well. This could lead to a significant a delay in the person receiving appropriate care.

People were not involved in the review of their care. We discussed how care plans were reviewed with one of the nurses responsible for doing this. They told us, "For the resident of the day we go through the care plan and evaluate it. We review it independently, just in the office. We know them. Most have dementia and we would get no response." They did, however, mention that if there were concerns they would get the family or GP involved.

Care plans were not always up to date. We noted that one care plan for the management of a person's diabetes stated that this was controlled by the person taking the medicine Metformin. However an evaluation of the care plan that had been completed in February 2017 stated that the Metformin had been stopped. The care plan was therefore inaccurate and the person was at risk of receiving inappropriate care for the management of their illness. One care record we looked at had two care plans for eating and drinking. One had been completed in August 2016 and the second completed in December 2016. As these plans contained different information staff may have provided inappropriate care. Another care record included a document that was untitled but the content identified it as a care plan in respect of managing behaviour that had a negative effect on others. This document had been completed on 8 February 2017 and reviewed on 12 February 2017. It referred to the person exhibiting violent and aggressive behaviour. We saw that at the time of the inspection nine days later, they were receiving end of life care and were unable to move without assistance. The care plan had not been updated again to reflect this.

During our last inspection in August 2016 we found that people's social and emotional needs were not met. People were isolated and bored. During this inspection people told us that there was little for them to do and the activities that were provided were described by people as 'boring'. One person told us, "I don't go to any of the activities. What are they? I don't know. I have been on a couple of trips out with the driver that was good. He took me to Poundland and for a coffee. I spend most of my day in here [their room]. My [relative] has arranged for a newspaper to be delivered to me every day." Another person said, "The activities are not up to much so I don't bother. My [relative] brings me books in and magazines. There used to be a vicar that came but I have not seen him in a long time." A third person told us, "It is boring in here, not much to do. I'm not bothered about going out, that's my choice, but I would like there to be more to do. We just sit and watch TV. I don't know what's on half the time." Another person said, "I don't do any activities. I just sit here all day. There's nothing else to do. It can be very lonely at times."

We noted that although a few people joined in activities, held in one of the dining rooms, on the morning of our inspection, the majority of people had little stimulation. Only six people were taking part in the craft activity being held, with two of the three activities coordinators supporting them. Care records showed that in one month one person, who spent most of their time alone in their room, had been assisted to attend activities on two mornings and had spent one to one time with an activities coordinator on only two occasions. We had previously been told that these one to one sessions usually last no more than 30 minutes. On the day of our inspection the person had been observed as being alone in their room all day. Other than when care staff interacted with them to provide care they had no stimulation. We did not see care staff interacting with people other than when they were required to perform specific care tasks.

We observed people in the lounge on the first floor sat in a row in front of the television. There was no interaction between the people. Nobody appeared to be watching the television. Other than when people were being given food or drink there was no interaction observed between people and staff. One member of staff told us, "They can go downstairs to do activities in the morning. In the afternoon they watch the telly."

Although the provider had increased the number of people employed as activities co-ordinators, there was little evidence that they were effective in keeping people stimulated and engaged. We saw a board on display in the corridor which showed the activities on offer for the coming week. Although there were various crafts and hobby type activities there were also a number of activities such as 'relaxing and watching television.' The new manager told us that they were unhappy with the quality of the activities on offer and were re-instating some that had been cancelled, such as a sewing club, flower arranging and darts.

The failure to provide person-centred care was a continuing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us that the service was responsive to people's changing needs. One relative told us, "I have attended all meetings when asked to. When [relative] got ill they arranged a new bed with rails, pressure mattresses and cushions. Nothing was too much trouble for them."

There was an up to date complaints policy and a system was in place to monitor the response to complaints that had been received. People were not always satisfied with the outcome of complaints they had made. One person told us, "I reported the hoisting incident and they assured me I would not get that carer again. But once again she came to my room [and] this made me very anxious. My [relatives] have been to numerous meetings about different things concerning me like leaving me in a wet pad for hours." However, a relative told us, "Over time I have made a few complaints and requests and they have been dealt with. For example, I requested that someone must assist my [relative] to eat and that was put in place." We looked at the records of complaints that had been received since our last inspection in August 2016. Of the five that

had been received, three had been resolved to the complainant's satisfaction and two were in still in progress but were within the provider's timeframe for response.

Although there was evidence that meetings were held with people who lived at the home, people we spoke with were not all aware of these. One person told us, "I was not aware they had meetings. I have not been to any." Another person said, "Nobody has ever asked me if I would like anything done differently."

Inadequate

Is the service well-led?

Our findings

During our last inspection in August 2016 we found that, although there were systems in place to assess the quality of the service, these were not always effective. Shortcomings in documentation and care provision had not been identified during the quality audits that had been carried out. The registered manager had left the service and the Agency and Recruitment Co-ordinator appeared to be acting as the manager. They were later appointed as deputy manager to the service.

At this inspection we found that the provider had appointed a new manager to the service, although they had not yet completed their application to CQC to become the registered manager. They had taken up the post just three weeks before the inspection. They told us that, although they were a registered nurse and had considerable experience in the field of quality and governance, they had not previously managed a service that provided accommodation for people who required nursing or personal care. The manager was supported by the deputy manager, and the provider's regional and quality managers.

We noted that internal quality audits which would have given the provider the opportunity to identify and address areas that required improvement had not been completed regularly. The last audit of care plans had been undertaken in December 2016. Although there was evidence that an audit had been completed before this the records were undated and therefore it could not be established when the audit had been undertaken. The audits that were undertaken failed to identify the shortcomings in the service. The audit of care plans completed in December 2016 had failed to identify that the plans were not person centred, had not always been updated or that consent to the care provided had not been evidenced. It had therefore failed to identify that people may have been at risk of receiving inappropriate care or care that they did not want and taken steps to prevent this. Similarly infection control audits, completed in October 2016 and started but not completed in November 2016, had failed to identify areas within the home that were dirty, damaged bedrail bumpers and incorrect practices by staff that put people at increased risk of acquiring an infection. By failing to identify these areas the provider missed the opportunity to address them and reduce people's risk of acquiring an infection. Other quality audits had failed to identify the issues with the medicines management. These included the lack of photographs or protocols for the administration of medicines prescribed on an 'as required' basis, annotations to medicines administration records that indicated that medicines may have been missed and incorrect stock balances. Had the audits been completed action could have been taken to reduce the risk of people receiving medicines other than the way in which the prescriber intended..

It was not only the quality documentation that had not been completed to a satisfactory standard. Documentation within people's care records, such as dates that best interest decisions were made and records of accident and falls observations, was frequently undated. Hand written records, such as daily notes, were often not clearly legible. This meant that it was not always possible to identify when an incident or intervention had occurred to enable the provider to monitor patterns and take remedial or preventive steps to reduce the risk of harm to people.

The regional and quality managers of the provider's organisation carried out audits to monitor quality and

compliance with the CQC fundamental standards. They produced a monthly report which was copied to the home manager, the provider's Managing Director and the Chair of the Board. An action plan for improvements was developed following each monthly report and these were followed up during the next monthly visit. However, these audits had also failed to ensure that action had been taken to address the breaches of regulation identified during the last inspection in August 2016 that were again identified as continuing breaches during this inspection.

The deputy manager gave us a copy of the results from a satisfaction survey completed by the home. This was undated and no action plan was provided to evidence how people's views had been used to make improvements to the service. We were not told of any improvements that had been made to the service as a result of this. The provider had failed to show that people's views were considered in the development of the service.

The failure to take appropriate and timely action to address the breaches identified in the previous inspection, to ensure that an effective quality assurance system was in place and documentation was accurate and legible was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the service had failed to notify the Care Quality Commission (CQC) of incidents as they were required to. The manager told us, and records showed, there were Deprivation of Liberty Safeguards authorisations in respect of six people who lived at the home. However, CQC had not been informed of the outcomes of the applications made in respect of them. We found that safeguarding incidents reported to the local authority safeguarding team had not been reported to CQC.

The failure to make required notifications to CQC is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The manager told us that they had already begun to identify the challenges the service presented to them and were reinstating management processes that had been discontinued, such as management oversight of handover on shifts. Staff told us that they attended team meetings on the units where they were able to discuss improvements that needed to be made to the service. However, these were not held on a regular basis due to staff availability. There were no meetings for representatives of the whole staff to discuss issues that affected the service as a whole.