Sunnycroft Care Home Limited

Sunnycroft 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

The inspection took place on 11 December 2017 and was unannounced. Sunnycroft is a 'care home' for up to 59 people. The service supports older people, many of whom are living with dementia. The accommodation comprised of a purpose built property connected to a bungalow and a house. When we inspected, the bungalow was not in use as there were repairs and refurbishment on-going. There were 36 people living at Sunnycroft when we inspected on 11 December 2017.

At our last inspection carried out on 26 and 27 October 2016, we found three breaches of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014 in relation to person centred care, assessment of risk and governance.

During this inspection on 11 December 2017, although some improvements had been made, we found the service to be in continued breach of the same three regulations. You can see what action we took at the back of the full version of the report.

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.

The registered manager at the service had been registered with CQC since 26 October 2016. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

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 question of safe, responsive and well-led to at least good. They provided this to us, and whilst we noted some areas had improved since our last inspection, we found some areas had not improved sufficiently, and we found new concerns such as environmental risks.

People's health, safety and well-being were at risk because the registered manager and provider had failed to identify where safety was being compromised. Infection prevention and control procedures were ineffective and we found that hygiene in the service was poor.

Quality assurance and auditing mechanisms were not sufficiently robust to identify the concerns we found during the inspection.

The provider needed to develop their approach to ensure that it was consistent in delivering care in a way that supported a positive and person centred culture. People did not always receive the time and attention they needed to fully meet their needs, and some practices in the service did not take account of people's

individual needs. This had an impact on providing care which was consistently dignified and respectful.

Staffing levels met people's physical needs, but did not always allow staff to take time to support people's emotional needs.

We observed some interactions between staff and people were poor, and in some cases was lacking. Staff received relevant training to care for people living in the service, but were not applying the learning in an effective way. The registered manager had identified this as an area requiring improvement. However, where some staff had been identified as needing to improve, action plans were not in place to ensure improvement was made in a timely manner.

The provision of activity was not meeting the individual or specialist needs of all people using the service. We observed people sat for periods of time, disengaged with their environment.

Improvements were needed in people's mealtime experience, and we have made a recommendation about this.

People were not always fully supported by their environment. The provider had not considered how to maximise the suitability of the premises for the benefit of people living with dementia, and we have made a recommendation about this.

Appropriate arrangements were in place to ensure people's medicines were obtained, stored and administered safely.

People were referred to other health care professionals to maintain their health and well-being.

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

Safe recruitment procedures were in place, and staff had undergone recruitment checks before they started work to ensure they were suitable for the role.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Not all risks were identified in relation to people's health and safety or appropriately managed or mitigated so as to ensure people's safety and wellbeing.

Infection prevention and control procedures were not effective and we found cleanliness in some areas of the service was poor.

There were enough staff to keep people safe and meet their physical needs. However, people's emotional needs were not always met.

We found the service had the necessary systems in place to manage people's medicines safely.

Staff recognised types of abuse which they could come across in their work, and their responsibility to protect people from the risk of abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received training relevant to their role. Observations of staff had identified that improvement was required in some areas to effectively apply the learning gained. However, further action was not taken to ensure staff practice was improving.

Improvements were needed in people's mealtime experience.

The service was following the principles of the Mental Capacity Act 2005. Deprivation of Liberty Safeguards were applied for when people who lacked capacity to consent, had their liberty restricted.

People were supported to maintain good health and had access to healthcare support in a timely manner.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We observed that some staff did not always interact with people in a kind and caring manner.

Some practices' in the service did not promote person-centred care which impacted on people's dignity.

There were relative and resident meetings so information could be shared.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The provision of activity for people was not sufficient to meet the individual and specialist needs of all people using the service.

People did not receive individualised care which was responsive to their needs.

There was a complaints procedure in place for people and relatives to access.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality assurance systems were in place, but were not sufficiently robust to identify where improvement was needed. Areas identified for improvement at out last inspection, still required attention.

Staff practice was identified as requiring improvement by the management team, but actions were not put in place to ensure this was regularly reviewed.

Sunnycroft 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.

This inspection took place on 11 December 2017 and was unannounced. The inspection was carried out by two inspectors, two medicines 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.

As part of the inspection, we reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. Prior to the inspection, the provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

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

As part of our inspection, we spoke with eight people using the service, and one relative. We also spoke with six staff, including two team leaders, three care staff and the registered manager.

We also looked at five care plans in detail, and reviewed a range of records relating to health and safety, and how the service is run. Medicines inspectors looked at policies, storage, records, training and systems for medicines management at the home.

Requires Improvement

Is the service safe?

Our findings

During our last inspection in October 2016 we found the service was not managing risk adequately to keep people safe, and subsequently were in breach of Regulation 12 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. We previously rated this domain as 'requires improvement'. During this inspection we identified some shortfalls in relation to people's safety and further improvements were still needed. Whilst some improvements had been made since our last inspection, including the safe storage of medicines, we found some environmental risks during this inspection.

We found two laundry rooms and a sluice room which were unlocked. These rooms had piping within them which people could potentially burn themselves on, and equipment which could pose a tripping hazard. The rooms were not labelled with pictures, and as they were unlocked people living with dementia who were mobile were at risk of entering these rooms. There was also an associated risk that someone may become disorientated and trapped in the room.

We also identified that some wardrobes in people's bedrooms were unsteady and not secured to the wall, which posed an accident and injury risk.

At our last inspection we identified that some products (such as drink thickener) needed to be secured in a locked cupboard to reduce the risk of accidental consumption that could cause people harm. At this inspection we found a spray sanitiser was left in an unlocked room where it could be accessed by people who were living with dementia, and who may not realise such substances could be dangerous.

Infection control procedures were not effective. For example, we found toilet brushes sitting in contaminated water, stains underneath hand towel dispensers, toilet attachments (such as raised toilet seats and frames) heavily soiled underneath and with rusted attachments, and a commode with split plastic covering which meant it could not be cleaned properly. In a kitchen area upstairs we found dirty pots and dust in a cupboard below the sink area.

There was a recent test for legionella carried out which identified no concerns. However, within the legionella risk assessment it was not clear who was responsible for each of the checks, and who to escalate concerns to if issues were found.

One of the ways to reduce the risk of the legionella bacteria is the effective control of water temperature. The maintenance staff checked hot water temperatures, and the home was awaiting some new water tanks. However, the cold water temperatures were not being monitored to ensure the temperatures were within the recommended range to avoid the growth of any legionella bacteria.

All of the above constitutes a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans included details about risks to people and guided staff on how to mitigate risks. Although risks

were referred to in detail, there were not always specific risk assessments in place. For example, where people were at risk of falling, this was detailed within the moving and handling plan. Similarly, where people may display distressed behaviours towards staff, this information was recorded in personal care. Having a separate risk assessment for falls and distressed behaviours would provide clearer guidance to staff when they read people's risk assessments and care records. We fed this back to the registered manager who told us they would review this across all care plans.

We saw from records that where people were identified as being at risk of developing a pressure ulcer, they were supported to reposition regularly. There was pressure relieving equipment in place where needed, for example, pressure mattresses, cushions and specialist boots. Other risks to people such as falling, were also mitigated and equipment was in place where needed. This included pressure mats and crash mats close to people's beds to reduce potential injury.

We found that fire equipment checks as well as maintenance of lifting equipment and gas appliances were being routinely undertaken to ensure they were safe and effective to use. There were safety checks carried out by a member of staff to ensure people and the communal areas in the home were safe.

All of the people we spoke with told us they felt safe living in the home, one saying, "We feel very safe here." Staff had received safeguarding training and were able to tell us what might constitute abuse and how they would report this. One staff member said, "We [staff] could come across physical abuse, emotional, financial or verbal. If I saw a staff member raising their voice to a resident I would intervene immediately and report them to the manager."

There were safe recruitment systems in place. This included checking staff's criminal records through a Disclosure and Barring Service (DBS) check, as well as references, identity checks and employment histories.

There were enough staff to meet people's physical needs and ensure people were kept safe. However, we saw that the deployment of staff across the home meant that although people were safe, they did not always receive individualised care. In the morning we saw nine people sat in the lounge area. Staff carried out 30 minute checks, but we observed little interaction from staff on an individual basis. We observed that the checks consisted of staff looking in the lounge and signing a sheet to say the checks had been completed.

Following lunch, eight people sat back in the lounge, and many fell asleep. We asked two people what they did in the afternoon. One said, "Nothing, we do nothing." Another said, "We just sleep". One person told us, "They [staff] are fairly quick during the day at responding but they can be a little longer at night."

We spoke to the registered manager about how they calculated staffing levels, and they told us they had recently been provided with a dependency tool which they were intending to use to ensure staff cover was adequate. Since the last inspection they had also implemented an additional staff member on the late shift to ensure staffing numbers were adequate.

A staff member told us, "There is enough staff on shift numbers wise, we only have 34 residents. The problem is the attitude of some staff. Some are a lot slower than others which means delays. [Registered manager] allocates staff to certain areas, but we sometimes have to change that if a resident needs a female carer. What staff need is someone behind them delegating work."

We also observed that staff required leadership to ensure effective use of staff and better communication. For example, at 10.30am one person asked an activity co-ordinator to help them to the toilet. This message

was passed on to care staff. Various staff were seen coming in and out of the lounge over a period of 15 minutes, but they were unaware the person had requested the toilet. The person eventually fell asleep in their chair. We brought this to the attention of the registered manager and asked them to review the effective deployment and leadership of staff.

We reviewed the systems in place for managing people's medicines. Staff gave medicines safely to people as prescribed. We observed staff administer medicines in the morning and afternoon. They were caring and gained consent before giving them their medicines. People who self-administered their medicines, stored them securely in their own rooms. However, we found the registered manager had not fully carried out the necessary risk assessment to ensure people could self-administer their medicines safely.

We looked at medicine records for eight people. Staff had recorded important information such as the name, photograph and medicine sensitivities for each person. However, we found information regarding how people preferred to take their medicines was missing for some people. This meant people may not always receive their medicines as they would like them. We found medicine administration records were complete with no gaps, which provided assurance that people were being given their medicines as prescribed. Some people were prescribed medicines on a 'when required' (PRN) basis. There was guidance in place to advise staff when and how to give these medicines. Some people were prescribed creams and ointments to be applied to their body. These were securely stored in peoples own rooms and recorded when applied by staff on separate charts.

Medicines were stored securely at the service. We found staff checked and recorded room and refrigerator temperatures daily and these were within the required range.

The service had a medicine policy in place. Staff were regularly competency assessed and received medicine-handling training. There was a process in place to report and investigate medicine errors. We saw evidence of medicines audits being carried out on monthly basis. One person told us, "[Staff] always make sure that I take my tablets at the right time."

Staff reported incidents and accidents, and these were reviewed by the registered manager. We looked at the monthly analyses of incidents and accidents over a recent three month period, and found that these were effective. For example, they identified the same person had fallen several times in a month and took appropriate action to identify why this might be occurring. Although the audit report did not include where incidents happened and who was involved, the registered manager kept a note of the people involved and where incidents had occurred. This meant they had the information required to learn from incidents and accidents.

Requires Improvement

Is the service effective?

Our findings

During our last inspection in October 2016 we found the service was not always effective, and was rated 'requires improvement' in this area. This was because some staff told us that staff training was not adequate in relation to dementia care or in managing pressure area care. During this inspection we identified some shortfalls and further improvements were still needed.

We concluded that the training provided to staff had improved and there had been more undertaken since our last inspection in 2016. This included safeguarding, medicines, falls prevention, first aid, dementia, and tissue viability. However, we saw that although staff received training in dementia and person-centred care, staff did not always interact effectively with people living with dementia. The training was therefore not always effective or followed up with competency checks to ensure staff were applying the learning gained. We found this was a concern during our last inspection.

The people we spoke with who were able to give us feedback about their general care felt that staff were well trained. One said, "I think they know what they are doing."

Staff received supervision sessions which provided them with a forum to discuss the way they worked, identify training needs, and receive feedback on their practice. Records were detailed and included actions the staff member needed to take. One staff member said, "I do get regular supervision. I find them helpful."

We spoke with a member of staff who had started working in the service recently about their induction. They told us they shadowed more experienced members of staff before working alone. They confirmed that senior staff had observed them, for example in delivering personal care, before they started working independently. New members of staff were also expected to undertake the 'care certificate' course; The Care Certificate is an identified set of standards that health and social care workers adhere to in their work.

People were offered a choice of meals, and the majority of people we spoke with were complimentary about the food. One person told us, "The food is good here and I am happy that I can have it in my room." Another person said, "The food is wonderful and there is such a good choice."

The mealtime experience we observed was varied. Some people ate in the dining room, which had nicely laid tables, and some in the lounge area. However, we found that staff did not always support people in a reassuring and interactive manner when helping people to eat their meals. For example, explaining what the food was and asking them if they were enjoying it.

We recommend that the service explores current guidance from a reputable source (such as the Social Care Institute for Excellence or the Alzheimer's Society) to ensure that mealtime experiences are an opportunity to support and promote independence, in addition to creating a positive mealtime experience, particularly for those with specialist needs including dementia.

We looked at daily records for two people as staff were recording their food and fluid intake. We saw that

quantities of food and drink were documented well so they could be monitored accurately. People received specialist diets where needed, such as diabetic and soft diets.

Prior to accepting people into the home, their support requirements were fully assessed so that the registered manager could assure themselves that they could meet their needs. This included information about people's mobility, health conditions, and their preferences. This information was transferred to the person's care plan, which detailed preferences in how people liked their care delivered. It also highlighted the importance of promoting people's independence and outlined how staff should support people to do this.

People told us they had contact with health professionals when they needed to. This included a chiropodist, GP or district nurse. One person confirmed this, saying, "I can see the doctor whenever I need one and I have own chiropodist come to deal with my feet." Another person told us they felt they were efficiently supported to access healthcare, "If I'm not well it would be reported and the doctor would either come the same day or the next day without fail."

We spoke with two health and social care professionals who were supporting the registered manager in making some changes to the medicines administration. They told us the registered manager and team leader worked well with them to make improvements. The registered manager also told us how they had worked with another professional to implement some action plans in terms of infection control when they had identified related issues. This demonstrated that the service worked with other professionals to improve care delivery.

People were not always fully supported by their environment. The provider had not considered how to maximise the suitability of the premises for the benefit of people living with dementia. There was limited signage available to help people to orientate themselves and did not follow best practice and up-to-date guidance to support people living with dementia. There were few clear signs, symbols or colours to help people navigate independently around the service.

We recommend that the service explores current guidance from a reputable source, (such as the Social Care Institute for Excellence) in relation to improving the environment for the benefit of people living with dementia.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager had identified people who may be deprived of their liberty and had made applications for authorisation to ensure that people's rights were protected. There were two people living in the home who had authorised DoLS in place. The service continued to ensure that people were not restricted more than was necessary to keep the person safe.

We found that people's mental capacity had been assessed. However the information about how to support

people with particular decisions was not fully outlined in these assessments. The records were not always complete in terms of people who were involved in best interests decisions. We did however see that some relevant information was available within other areas of the care plan. Care records also made reference to people's mental health, and these included details of any legal representatives who may be acting on behalf of the person for specific decisions that needed to be made.

The people we spoke with told us staff asked for consent before delivering care. One said, "They are all very polite and always ask before they do anything for us." Another said, "They always say, 'Is that alright?', or, "Do you like it like that?"

Records detailed the importance of giving people choice. For example, records were written respectfully and guided staff to ask questions in a particular way where people could not retain or process large amounts of information. One record said, "Give [person] choices by asking short, open ended questions such as, 'would you like to wear the green skirt or the blue skirt'? Show patience and reassurance to [person] as they cannot follow detailed instructions."

Requires Improvement

Is the service caring?

Our findings

During our last inspection in October 2016 we found the service was caring, and was rated 'Good'. During this inspection we identified that the provider needed to develop their approach to ensure that it was consistent in delivering care in a way that supported a positive and person centred culture.

There was a task led culture within the home. An example of this was in the way staff supported people to eat their meals. We observed two staff supporting people to eat with very little interaction or encouragement throughout the meal. We observed several times throughout the day that staff moved people whilst using lifting equipment (such as hoists) with very little interaction to reassure people and make them feel at ease. We saw one staff member was abrupt in the way they spoke with people which did not demonstrate a positive, caring attitude towards them.

We observed some interactions between staff and people living with dementia and found that staff were not always thoughtful and kind. We saw that on one occasion, a person appeared to become upset in the lounge. A member of staff went over to the person in order to reassure them, but as soon as they began to ask the person what was wrong, another member of staff came over and interrupted. They did not acknowledge that the person was in distress. We saw another incident where a staff member did not demonstrate patience when supporting a person to walk with their frame. One staff member moved the frame round with their foot, and instructed the other staff member to guide the person forward and not continue to move at their slower pace. On another occasion, we saw a staff member take someone out of the lounge in their wheelchair without explaining where they were going and that they were going to move them. This demonstrated that staff did not always encourage people's independence, or work with people in a caring manner.

There were some institutional practices within the home because people were not always treated as individuals. For example, people did not always have a drink within reach, but were given drinks at regular 'drinks rounds' throughout the day. We also saw that people were all asked, and then supported to go to the toilet, within the same timeframe just before supper. Staff referred to this as the 'toileting round'. A staff member explained that the system was for staff to offer the toilet routinely before meals. We saw that one person asked staff for support to go to the toilet in the mid-morning, and 25 minutes later staff had still not supported them to do this. On this occasion the person's dignity was not respected because they could not use the toilet when they had requested to do so. We therefore concluded that dignity was not always upheld due to the routines and practices in the home.

We saw some areas of good practice, where some staff members interacted positively with people, getting down to eye level and speaking to people appropriately, in some cases making them smile. One member of staff explained to us how they adapted their communication to support people with their personal care, when they were living with dementia and required a lot of guidance.

People who were able to give us feedback told us that the staff were caring towards them. One said, "I would say they are very caring and put me first." A relative said, "The staff here are very caring and nothing is very

much trouble. When my [relative] needs to go to the hospital they will always come with us which is really nice of them."

People told us they were involved in the development of their care plans. One person told us, "I organised my care and we always have a chat to make sure I am getting what I need." A relative confirmed, "I organised [relative's] care here so I could visit them as often as I can." We saw from people's care records and they had been consulted about their care and that family members had been involved appropriately. People's rooms were personalised with their own belongings and décor of their choosing.

Resident and relative meetings were held in the service to enable information to be shared, and people's views to be heard. We saw the minutes of the meeting in November 2017, which discussed relevant items such as the menu, staffing, and redecoration of the home. The introduction of a newsletter was also planned for 2018.

Requires Improvement

Is the service responsive?

Our findings

During our last inspection in October 2016 we found the service was not always responsive, and was rated 'requires improvement' in this area. This was because people were not receiving care that was person centred and responsive to their individual needs. This constituted a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On this December 2017 inspection, we found that people were still not receiving responsive, person-centred care. Although we received some positive feedback from people who were able to talk with us, we observed a lack of person-centred care for those people living with dementia.

People were not always comfortable within their environment. Two people indicated to us that they did not want to spend time with people who were living with dementia, as they were unable to hold a conversation, so instead they remained in their rooms. One person said, "I'm bothered by people knocking on my door so I keep my door locked so I don't have to talk to [people]." Some people who were more independent spent the majority of their time in their rooms and only a few attended lunch in the dining room. We saw that the upstairs part of the home was empty during the day, and the majority of people were encouraged by staff to go to the main downstairs lounge. We saw no evidence that this was people's own preference, rather a routine which staff had implemented. We saw that none of the other communal areas within the home were being used by people.

In our 2016 inspection we found that some people living in the home told us about communication difficulties due to language barriers with staff. One person we spoke with during this inspection also expressed this as being a problem at times. They told us, "With some [staff] I have a language problem as they don't always understand what I am saying." This meant that people may not always be able to have their needs fully met or understood by staff.

We observed that staff were not always responsive to individual needs. For example, one person received their lunch and attempted to cut the meat up with a spoon. They were unable to do this and staff did not notice. The person then did not eat any of their main meal. After a while when the food had gone cold, a member of staff came and asked if the person had finished. They did not offer an alternative or ask the person why they had not eaten their meal. The person then asked for a dessert which they received 25 minutes later. When they finished this, they were not offered more dessert.

There were some activities within the home which included bingo, quizzes, knitting and reminiscence, as well as visiting activities and entertainment such as an exercises class. People and their families as well as staff reflected that the home had recently held a successful Christmas lunch for people and relatives were invited. One person told us, "We had a really good Christmas party and we're looking forward to the Carol Service." However, we saw no evidence that the activities reflected the preferences, interests and hobbies of the people living in the service. Although details about things people might like to do were in people's care plans, we did not see these being delivered by staff.

The activity scheduled for the afternoon during our inspection visit did not go ahead, and we observed that people did not engage well in the morning exercise activity delivered by an external professional. Most people required support and encouragement to join in, but there were no staff in the service available to assist with this, which meant most people just watched.

There was very little staff interaction or activity throughout the day, and interactions were mainly task-led. There were many missed opportunities for staff to interact with people. One person in the lounge in the afternoon said they were, "Very bored", which was also agreed by the person next to them.

We observed that for the majority of the day, most people were sat for periods of time with no stimulation, and were disengaged with their surroundings. Most people spent their day in the main lounge with the radio on. Staff were seen to be available in the lounge area at half hourly intervals, but did not take the initiative to ask people if they would like to take part in an activity, or just sit and chat with them.

We were also concerned that people who did not wish to leave their rooms, or who were cared for in bed, were not receiving 'one to one' time with staff. This is particularly important where people are developing, or living with dementia.

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

Events such as people's birthdays and valentine's day were celebrated. Some trips out were organised, such as to the local garden centre.

People were able to access a hairdresser regularly and were supported to have baths or showers when they wished. One person felt that staff did meet their needs, saying, "They always ask when they come in if there is anything we need, but we never seem to have time for a chat." Another person told us they felt their preferences were met, "The staff certainly know what I like and how I like things done in my room." However, we observed care for people who were not able to give us their views, and concluded that this was not always the case.

Care plans were in place and contained details of people's preferences in relation to their personal care, for example, what products they preferred. There were details of people's needs in terms of their health conditions, and regarding any dietary needs. Care plans also contained information about people's life history. We saw that the care plans were reviewed regularly, and updated when people's needs changed. Family members had also been involved in the care plan reviews, where appropriate.

There was a complaints system in place and people knew how to make a complaint or raise a concern. We looked at records of complaints and found there were no recent formal complaints, and any concerns raised had been appropriately addressed by the registered manager.

Advanced care plans were in place which outlined people's preferences in relation to their end of life care. The registered manager told us they had completed these with people and their families where appropriate. The plans contained details of things that were important to people when they were nearing the end of their lives. For example, they contained details such as whether they wanted family members to be present, any preferences in relation to religious representatives, and if they wanted a particular genre of music to be played. The registered manager told us they were planning for staff to undertake further training in End of Life care in 2018.

Requires Improvement

Is the service well-led?

Our findings

During our last inspection in October 2016 we found the service was not always well-led, and was rated 'requires Improvement'. This was because there were insufficient audits taking place by the manager and the provider to ensure people who lived in the service were safe and to monitor the quality of the service provided. This constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection in December 2017, we identified that although some improvements had been made to the quality assurance processes, these had not been sufficient to identify all of the areas we found as requiring improvement. The service had failed to make and sustain adequate improvements. The services' approach to supporting people with their interests to ensure they had meaningful and fulfilled days was not effective. Some practices in the service did not promote person-centred care, and were institutional in nature, for example, routine 'toileting' and 'drinks' rounds.

Staff working in the service were not supervised adequately to ensure that the application of their learning was effective. We saw that the issues we identified during the inspection had also been identified by the registered manager whilst undertaking observational assessments of staff. For example, a lack of interaction by staff with people during moving and handling procedures. However, the observations carried out by the registered manager had not led to an action plan which addressed the issues promptly. For example, an observation carried out on 19 May 2017 found that improvements were needed in relation to a staff member delivering care, but no further action was taken. There had not been further observations or an action plan to ensure that improvements were made.

There was not always effective leadership within the team and staff did not always work or communicate effectively together. We saw that one staff member did not always interact appropriately with people, and this staff member was mentoring new staff. This meant that new staff were not always able to observe a high standard of care being delivered, and appropriate examples were not always set for new staff to learn from. This had not been identified by the quality assurance manager or the registered manager as being a concern.

When we inspected the home in 2016, some staff told us they felt some shifts did not work as well as others due to staff competence levels and willingness to work. On this inspection we found that staff still felt this was the case. One staff member told us, "I think we have enough staff, it's more if staff are working as a team or not." We found that staff did not communicate well with people, or with each other. This meant that there were times when people did not have their needs met.

We saw in a recent meeting with domestic staff that the registered manager had raised some concerns around the cleanliness of the service. This had led to some action being taken in the form of a cleaning schedule which the registered manager provided the domestic team with. This included guidance on what areas required attention for cleaning and what products to use. However, this work had not been regularly checked to ensure the schedule was adhered to, and we found poor hygiene in some areas of the service.

The latest infection control audit had been undertaken in May 2017, and some actions were identified. The audit had included dates for actions to be achieved by but there was no further information about whether these actions had been completed, and no recent checks.

Other audits included checking of care plans, a maintenance audit, a health and safety audit, and a nutrition and fluid audit. Where concerns had been identified, there was not always a corresponding action plan to ensure issues were addressed promptly. Additionally, environmental risks to people using the service had not been independently identified by the management team.

The provider and registered manager had failed to recognise potential harm to people using the service, and their non-compliance with regulatory requirements.

All of the above constitutes a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback about whether people were consulted about their views on the service. One person said, "Nobody really asks about what I think about things here." However, another person said, "The manager does have a chat with you to see what you think of everything." We saw some quality assurance surveys which were completed this year, however the registered manager told us they had had little uptake on these.

We saw that there were staff meetings for the different teams, for example for the domestic staff and the care staff. We saw in these meetings that some of the concerns we picked up had previously been identified and discussed.

People and their families knew who the registered manager was. One relative told us, "The manager and the office are very helpful." Staff told us they felt they could talk with the registered manager if they needed to. One staff member said, "I can talk to the manager any time. They do listen when you raise things."

The registered manager told us that there were plans to redecorate the service to make it feel more homely, and this had been agreed by the provider.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was not adequate provision for people to engage in activities, and person centred care was not always provided in line with preferences and choices.

The enforcement action we took:

Impose condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Infection control practices were not always effective, and there were hazards within people's environments which had not been identified.

The enforcement action we took:

Impose condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always have systems and processes that effectively assessed, monitored and improved the service.

The enforcement action we took:

Impose condition