Country Court Care Homes 3 OpCo Limited

Lostock Lodge Care Home

Inspection report

Cheshire Avenue
Lostock Gralam
Northwich
Cheshire
CW9 7YN

Tel: 08435069452
Website: www.countrycourtcare.com

Date of inspection visit:
28 February 2018
05 March 2018

Date of publication:
27 April 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on the 28 February and 5 March 2018 and both days were unannounced.

We previously inspected Lostock Lodge on the June 2017 and the service was rated Requires Improvement overall. We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of Regulations 12, 17 and 18. This meant the registered provider had failed to ensure people were fully protected from the risk of unsafe care, staff did not have sufficient training and there was ineffective oversight of the service. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to breaches.

At this inspection we identified multiple new or repeated breaches of the regulations relation to assessing and mitigating risks to people's health and wellbeing, the safe management of medicines, dignity and respect and good governance.

We will update the section at the end of this report to reflect any enforcement action taken once it has concluded.

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

The care home accommodates 66 people in a purpose built building. There are three separate units, each of which has separate facilities. One of the units specialises in providing care to people living with dementia. At the time of the inspection 56 people were living at the service,

There was no 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 service had appointed a new manager following the resignation of the registered manager and they took up this post in January 2018.

People could not be assured that risks to their safety were always assessed or kept under review. Risks were not always reduced as much as possible. There were a number of incidents between people who used the service but no action had been taken to explore ways of monitoring or managing behaviours that challenged. Therefore, the registered provider was not taking reasonable steps to keep people safe.

We found that people were at risk because their medications were not being recorded, administered and stored in accordance with guidance. Staff were not competent to administer people's medicines safely and effectively. Staff were not adhering to the registered providers polices the management of medication and any training staff had received had proven to be inadequate.

People were supported by staff whom were caring; however people could not always be assured that sufficient care was taken to maintain their privacy and dignity. We found that there was an insufficient number of suitably trained and competent staff on duty to meet the needs of the people who lived at the service.

Care plans were detailed and person centred. However, these were not always updated with any changes. The registered provider and manager had not ensured that the care and treatment of people who lived at the home followed their care plan requirements to meet their needs.

The quality of food was good and people enjoyed it. However, the registered provider and manager were not effectively monitoring the dietary intake of people who were deemed at risk of malnutrition. People were supported to eat but improvements were required to ensure that people were eating and drinking sufficient amounts.

Staff received training and supervision to provide them with the knowledge required from their role. However, there were insufficient checks undertaken to ensure that staff were competent and confident to put this into practice.

Quality assurance systems were in place but these had failed to identify risks presented to the people who lived at the home. They also did not address the concerns raised on this inspection. There was evidence of a failure to notify the CQC of notifiable incidences and failure to analyse incidents and learn from experience when things had gone wrong.

People knew how to raise concerns but these had not always been reported due to a lack of confidence that changes would occur. When they had been recorded, there was a record of what action had been taken.

Staff had an understanding of the Mental Capacity Act and followed its principles. There was a record of a person's capacity to make a specific decision and where staff or others had made a decision in a person's best interest.

Recruitment and selection of staff was carried out safely which meant vulnerable people protected from receiving care from unsuitable people.
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.

Risks to people's wellbeing and safety were not always identified and actions to minimise risks not always taken.

Medicines were not always managed safely and in a manner that mitigated the risk of incorrect administration.

People felt safe and lived in a clean and comfortable environment.

Is the service effective?

Requires Improvement

The service was not effective.

Staff did not always have the skills and knowledge to meet people's needs in a safe way.

Staff did not maintain accurate records where people were identified 'at risk' in relation health matters and nutritional intake was not always recorded. People did not always receive the support and assistance they required to eat their meals.

Staff were aware of the requirements of the Mental Capacity Act 2005 and consent to care was sought in accordance with this.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us they were happy with the care they received However they did not always receive personal care and support when they needed it.

People were not always treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not receive consistent personalised care that was

responsive to their needs.

People did not always receive support to take part in activities within the home.

People and their relatives knew how to report concerns and they had been investigated and responded to

Is the service well-led?

Inadequate

The service was not well led.

Previous inspection showed non-compliance with regulations and sufficient improvement had not been made.

Quality monitoring systems were inconsistent had not identified all of the shortfalls found.

People and staff were asked their opinion about the service and what improvements they wanted to see.

Lostock Lodge 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 28 February and 5 March 2018 and both visits were unannounced.

The membership of the inspection team comprised of an adult social care inspector, an inspection manager, a pharmacy inspector and an expert-by-experience with an interest in dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we gathered and reviewed information from a number of sources. This included notifications sent from the service about key events, complaints, and compliments and safeguarding investigations.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make

We also contacted the local authority who had no current information to share. We also reviewed the report from Health Watch following a visit in June 2017. Healthwatch is an independent organisation whose purpose is to understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf This had raised issue in regards to staffing and training.

We talked to eleven people who used the service and nine relatives and friends. 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 talk with us.

We spoke to nine staff including the manager, catering staff and domestic support.

We looked at the care records of twelve people who used the service which included care plans, risk assessments and records relating to the monitoring of their health and wellbeing.

Inadequate

Is the service safe?

Our findings

In June 2017 we found that robust systems were not in place to ensure care and treatment was provided safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

On this inspection, we found that improvements had not been sustained and we identified on going concerns in regards to the safe care and treatment of people living at the service.

Staff did not always taken action to sufficiently mitigate known risks. A number of people who used the service exhibited behaviours that challenged themselves and others. There had been a significant number of instances of actual or potential harm from verbal or physical exchanges between people who used the service or directed at staff. People walked around the corridors or into other people's rooms without staff being aware.

Risk assessments often stated "Staff to be aware of a person's whereabouts at all times" which was not achievable without one to one support. During these periods there was an increased risk of harm from falls or inter-resident exchange. No consideration had given to ways of monitoring where a person was in order to keep them safe.

Alarmed mats were used to notify staff when people, risk of falls, were about mobilise independently. Prior to the inspection, concern was raised that sometimes these were placed under a bed and therefore not effective. A number of accident reports made reference to the mats not being in place at the time of a fall. Our observations and comments made by relatives confirmed this to be the case. One relative told us "My [relative] floor mats alarms are not always where they should be. They are pushed under the bed on occasions". Staff told us that some people moved their own mats under the bed as they were afraid of tripping over them, saw them as an obstacle or just didn't want them. No one had considered alternative ways of monitoring to keep safe.

Other risks had not always been identified and managed appropriately. For example: two people had used toiletry products in a way that was unsafe e.g. mistaking liquid soap for moisturiser or eating makeup. There were no risk assessments or management plans in place to help staff in managing these situations or to prevent the risk of further harm in order to keep everyone safe.

A number of individual risk assessments were in place around the risks to a person's health such as nutrition, pressure ulcers, diabetes and bleeding. Assessment tools had been used to identify the level of risk, such as the Waterlow assessment tool in respect of pressure area care and the Malnutrition Universal Screening Tool (MUST). Where risks had been identified, there were risk assessments in place that detailed the risk and the action needed to minimise the risk. We found some of these assessments were not accurate for example: one person was assessed to have healthy skin but records indicated that they had skin condition for which they were receiving treatment

Staff received training in safeguarding and were able to talk to us about the things that would be classed as a form of abuse. Safeguarding policies and procedures were available and staff were aware of how to raise concerns. However, the registered provider and manager had not ensured that all safeguarding matters were highlighted and reported to the local authority or to the CQC. A number of concerns had not been further investigated in order to ensure learning from them or to ensure a protection plan was in place.

The registered provider kept a record of accidents and incidents. We found significant events recorded in people's care files for which there was no accident or incident report. The manager did not keep a record of the action or investigation taken by the following an occurrence. Incidents between people who used the service were not logged as incidents despite these being frequent and on occasion injury sustained. This meant the registered provider or manager did not have full oversight things that occurred at the service. There was no analysis in order to identify any themes and trends or to develop management plans to avoid further harm.

We found concerns regarding the management and administration of medicines.

Staff were observed undertaking medication administration. Whilst completing this task, they were interrupted on many occasions by other staff and phone calls. The disruption and interference whilst administering medicines increased the risk of a medicines error, lengthened the time to taken to complete and was not good practice. We observed a staff member sign for medication before it had been administered but then failed they give it.

Staff did not ensure that adequate stock of medication was available. We found a person had been without medication essential to their health for four days whilst another had insufficient stock of cream for their use. We brought this to the attention of the manager as it had not been identified in order for action to be taken.

We found gaps in recording times when pain relieving medication had been given which meant that there was a risk that doses could be given too close together. When stock and records were compared, balances did not always match meaning items had not been given as recorded.

Medication with a 'when required' dose (PRN) is usually prescribed to treat short term or intermittent medical conditions i.e. it is not to be taken regularly. We found that these were either lacking in detail or absent which meant there was a risk that medication may not be given as intended. We also observed staff gave PRN pain killers and recorded 'not required' and have a prescribed antacid without asking if they were needed.

Some people were 'self-medicating' and applying their own creams. There was no risk assessment in place around the storage of creams in a person's own room. Staff did not check the person's ability and knowledge to safely administer their own medications and we found people had not been doing this correctly. There was a policy in place to direct staff in managing medicines when someone went out but staff were not aware of this and told us it was managed through 'word of mouth.' The process that was explained as common practice contravened the registered providers' policy.

We looked in detail where people had a product prescribed to thicken fluids due to a risk of choking. On the day of the inspection, none of the drinks for a person had been thickened and care staff told us this was because they often refused this. Staff did not keep an accurate record of when this product was offered and refused or used. There was a risk of harm as staff were not clear on the safe use or storage of the product.

Medication was not always stored or administered given in line with the pharmacy instructions which meant

that its effectiveness could not be guaranteed. For example, medication required before or after food were given together with other medications at meal times. Pain patches were not always rotated to ensure the patch was not applied in the same place. Staff did not know how to correctly reset the fridge thermometers and records showed temperatures exceeding the recommended temperature for storage. Creams and eye drops did not have a date recorded as to when they were opened so we did not know if they were still safe to use. Some medication such as that for Parkinson's is time specific and people told us that they did not always get this on time. Staff did not record the time of administration and so there was no audit trail. These concerns had not been reported or picked up with checks.

We received conflicting and varied feedback regarding staffing levels in the home. Comments included "There are not enough staff, you don't know from one day to the next sometimes how it's going to be" and "Sometimes it can be especially busy, but no one has to wait for anything."

During the inspection we observed both insufficient staff to meet people's needs and staff not deployed effectively to ensure people were adequately supported. We saw three people on the same unit assisted to get up late and given breakfast at midday. Staff serving the 'breakfast' greeted them with "Good Morning". Staff were honest and confirmed it was not personal choice but there were not enough staff to get everyone up in a timely manner. We immediately brought this to the attention of the manager who acknowledged that there was less than the required number of staff on the unit. The operations manager who was present confirmed that there was no reason why the unit floor was understaffed and asked to manager to ensure that additional staff were brought in immediately.

Records indicated a significant number of unobserved incidents. Over both days on the first floor, we observed long periods, in excess of 45 minutes, where no staff were available to assist, monitor or interact with people. We observed the second floor was left unattended for 20 minutes whilst the staff member was firstly in the office and then went to another floor to assist.

Some people who used the service had behaviours that challenged and required close supervision. Staff were not always present and we had to intervene on both days in order to diffuse a number of situations. For example, one person was distressed and wanted to leave. This impacted on others as they tried to use the lift and rattled the internal door. Another person was knocking at a window in a bedroom shouting to a visitor outside "Don't come in as you will never get out". This was seen to be upsetting the person in the bedroom.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider ensured that safe recruitment processes were followed. We reviewed the personnel files for three newly recruited staff. References had been received, gaps in employment history were recorded and staff had not started prior to the completion of Disclosure and Barring Scheme (DBS) checks. The DBS keeps a record of criminal convictions and a caution which helps employers make safer recruitment decisions and is intended to prevent unsuitable people from working with vulnerable groups.

We found that all of the health and safety inspection certificates were in place including, gas, electricity, water (legionella) hoists, passenger lift, fire safety certificates, fire extinguishers, environmental health and portable appliance testing (PAT). The service had recently been inspected by the fire service that had made some recommendations about carrying out timed evacuations within the building.

Requires Improvement

Is the service effective?

Our findings

At the inspection in June 2017, the registered provider failed to ensure suitable numbers of staff had the competence, skills and experience to provide safe care and treatment. We issued a warning notice. On this inspection, we found that whilst staff had been provided with training opportunities, their competence had not been assessed to ensure they were competent and confident.

Staff had undertaken training deemed by the registered provider as essential for their role. This included safeguarding, first aid, moving and handling, mental capacity act, and equality and diversity. New staff had undertaken training in a timelier manner which meant they had some knowledge at the start of their employment.

However, where staff had undertaken training, there was no evidence that their knowledge and competence to put this into practice had been robustly checked. For example: staff had undertaken a written test in medication management but had 'passed' with scores as low as 74 % whilst others had 'passed' without the test being marked. We checked with the registered provider and the pass rate was 85%; with an expectation that staff retake the test to ensure they had fulfilled gaps in their learning. Staff had not undertaken the three practical competency assessments required by the registered provider to ensure that they were competent to administer medications through a variety of routes.

We observed that not all staff had the confidence or skills to engage in a meaningful way with people living with dementia or had behaviours that challenged. Staff said that the training did not always prepare you for managing difficult day to day situations.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
It was an expectation of the registered provider that all new staff undertook the Care Certificate but there were incomplete records at the service as to which staff had completed this. We requested this information from the registered provider which they duly provided. This indicated that some, but not all staff had completed this accreditation.

Staff we spoke with said they had received supervisions, and where relevant, appraisals on a regular basis. Supervision gives staff the opportunity to discuss their work and developmental needs.
On the days of inspection, we found that some people did not have adequate time between breakfast and lunch. For example, two people had breakfast at midday and hot lunch at 1 o'clock. Neither person ate this meal as they were not hungry. Staff informed us that they could not have lunch any later as it could not be kept warm. Other people were not observed to have support or encouragement to eat their meals whilst in their rooms. We found that one person had their breakfast in front of them at 11.15 and it was cold. The same person had their 'hot' pudding next to them from 13.10 to 16.15.Staff had been observed to enter the room but had not encouraged the person to eat or offered an alternative.

There were regular checks on a person's weight and appropriate referrals made to the GP or Dietician where

any concern was identified. From our observations, we saw that there was not always adequate time between meals for some people to develop an appetite and others did not have encouragement. This had not been considered as a factor in a person's weight loss. Where advice had been given it was not followed. For example: one person had lost 10 kg since December 2017. The dietician visited on 26 January 2018 and advised staff to 'encourage more puree and soft foods with soups and milky drinks as a supplement.' Food/drinks charts from 5 February to 4 March 2018 did not evidence that milky drinks had been offered or whether food had been provided that was soft or pureed. Foods recorded but not eaten included pork steak, wedges, sandwiches and cheese on toast. Soup was offered as a meal and not as a supplement. Weekly weights were requested but only recorded on the 3 February and 12 February 2018.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The general consensus from people who used the service was that the quality and range of meals was acceptable. The chef was knowledgeable about what people's dietary requirements. There was a menu that changed four weekly and was seasonal. The food served on the days of the inspection looked appetising and people were seen to enjoy it. People told us that they "Had plenty to eat", and that "There was always a choice". A visitor also commented "[Name] always eats everything. That says it all. I have tried it, it's lovely.

People were asked each day what they would like to eat from the menu but alternatives were always available. Menus were available for people but they were not in any alternative formats to assist for people with visual, communication or cognitive impairments to make better choices.

Food and snacks were available in the dining areas at what the registered provider called 'grazing stations'. We found that the first floor did not have this facility and the manager told us that this was because there were risks for people lacking mental capacity associated with eating foods not suitable for them. We suggested that this is further reviewed so that all people have access to snacks and finger foods.

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 authorisation 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.

Where a person had someone to act on their behalf records were in place to show they had the legal authorisation, such as lasting power of attorney (LPA), to do so. An LPA is a legal document that lets a person appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf if they are unable to do so.

The service maintained a record of DoLS applications made to the local authority. At the inspection, we saw that one of the DoLS authorisations had expired and had not been renewed. This meant people were being unlawfully deprived of their liberty. A request had been (belatedly) sent to the LA dated requesting that this DoLS authorisation be renewed. Another person had conditions in their DOLS and the service had steps in place to meet these.

People told us, and we observed that people were offered choices. Staff had an understanding of mental capacity and what this meant in their day to day work. People's ability to make specific decisions was recorded in their care plans and best interest decisions recorded were made where others had to decide on their behalf. Where a third party had consented to care and treatment on behalf of a person, there was a copy of a Lasting Power of Attorney on the persons file.

At the last inspection, we made a recommendation to the registered provider about following guidance in regards to making the first floor more 'dementia friendly'. Memory boxes had been fitted to the walls of the unit for people living with dementia but these were empty. Signage was not clear to help orientate people to bathrooms, toilets or the lounge. Some photographs used to assist people to find their rooms had been changed to images that people could relate to. For example; one person could not recognise themselves as an older person but still recognised family members. A photograph of them as a younger person with their family was now on their door.

The outside areas were well maintained and accessible space. They were inviting and people liked to go outside in the better weather or look at them through the window.

We saw that information about a person's specific medical conditions were in their care records. This would help staff understand people's symptoms and help them to provide appropriate support. We found that people had access to a range of health care professionals including doctors, dietician, and district nurses. We saw that records were kept of any visits or appointments along with any action required. People's care records demonstrated how their physical and mental needs were assessed on admission to the home and reviewed on a regular basis. Care records contained information which took into account the advice and guidance of other health professionals when planning outcomes.

Requires Improvement

Is the service caring?

Our findings

Although staff were caring in their manner, they often appeared rushed and we did not observe many examples when staff were able to sit and spend time with people. Consequently many interactions were very task focused and usually confined to when people needed specific support, such as using the toilet or moving from their room to the communal lounge.

Whilst people expressed a fondness for the staff, we observed that the care they received did not always afford them dignity, privacy, compassion and respect.

People were asked upon admission whether they had a preference as to the gender of staff providing personal care. This was documented in their care plans but not always followed. One person said "Sometimes your dignity just has to go out of the window: do you risk wetting yourself waiting for a lady to come or give in and accept a male helping you?"

We observed a staff member assisting a person with a task that involved lifting their clothes. This was done without consideration to their privacy as the window looked onto the car park and a person in the room opposite was looking in. We also observed staff talking to people about personal matters such as continence and health conditions with other people around to hear.

A number of people told us that their belongings were not always kept safe and despite raising concerns with the staff. Comments included "I feel safe, but my belongings are not. My clothes have gone missing and also some of my nick knacks" and "People keep coming in my room and taking things, they are confused and can't help it but it upsets me". Families told us that they had raised this with management but concluded "I have done this a lot of times; it gets better then falls back.

Staff did not always make the most of opportunities to talk to people or to involve them in things. This was most evident on the first floor. We observed long periods of time where people had little or no interaction with staff. Staff were not available or ignored people. For example: a staff member was observed emptying the dishwasher and cleaning the dining area but did not make any conversation with the people in the vicinity who were pottering about. One relative commented "They are very nice staff and they care a lot. I just wish when they are chatting together they could include people. They talk amongst themselves but don't chat to people living here".

A number of people made comment that sometimes new staff started and they did not receive adequate introduction before they started to provide their support. We saw that a relative had raised a complaint in regards to this. A person told us that they had woken up in the night to see a strange face and this had scared them as they did not know who they were: it was a new staff member.

The language used to describe the behaviours and personality traits of some people was not appropriate. This demonstrated staff did not understand the nature of a person's illness and how this impacted upon them: we saw terms such as 'snappy', 'violent', 'disgruntled' and confrontational.

Care plans indicated what someone preferred to be called by the care staff. One person had indicated that they liked to be addressed by their title and surname and this was also evident on their door plate. However, when we asked staff to identify a person sat at the table they introduced us to them by their first name.

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

People did express a positive view about the staff themselves and some of the comments included "I feel listened to, for example. I choose my clothes what to wear on the day", "Staff knock on my door before coming in" and "When I use the bathroom staff make sure my doors are closed." People and relatives were complimentary about the staff and comments made to us included "I'm made to feel very welcome by everyone". "They are lovely people and very nice to me.

Staff were given time to undertake training required for their roles. However, rotas, schedules and practical arrangements were not organised so that staff were allowed time to listen to people, or to spend time providing them with information or involving them in the day to day decisions.

Throughout the day we observed some friendly, good natured conversations between people and individual members of staff; although staff often appeared rushed. They had little time to support and engage with people and most of the interactions were task focused; for example supporting someone to use the toilet or move from their room to the dining area. We observed staff taking time to assist someone as they were being moved in a hoist as they were anxious and needed reassurance.

People told us they were happy and comfortable with their rooms and we saw rooms were personalised with their individual possessions, including small items of furniture, photographs and memorabilia. Their living environment was well maintained, clean and warm.

The staff supported people to maintain relationships which were of importance to them. There service supported a number of married couples who had rooms next door to each other or bigger beds to allow them to have private time together. Relatives told us that they were able to visit at any time and were made to feel welcome.

Staff told us they kept each other informed of people's current and changing needs during shift handovers. Handovers involved all staff on duty so that they were aware of any areas of work that needed to be completed or appointments attended. There was also a staff communication book in which key issues discussed recorded.

Requires Improvement

Is the service responsive?

Our findings

People did not consistently receive personalised care from staff, as they were not responsive to their individual care and support needs.

Staff were aware of the importance of knowing and understanding people's individual care and support needs. We saw care plans contained very good details regarding people's needs, their likes and dislikes and their individual preferences. They also contained details of their personal history, interests and guidelines for staff regarding how they wanted their personal care and support provided. Information was also available for staff on a person's physical or mental health diagnosis, what this meant for them and how it informed the support they required. Profiles also gave staff clues as to why a person may react in a certain way as well as 'quirks' and 'habits' they have that make them the person they are.

However, the information in people's care plans was not always reflected in the support people received or how they were approached. Care plans were not always updated to reflect current needs.

A number of people had a change in behaviours following admission but care plans did not reflect this. For example: a person had displayed a number of behaviours towards staff and other people at the service that had caused harm. This included on one occasion, hitting another person causing them to fall backwards. Their memory and understanding assessment was last reviewed on the 24 February 2018 and stated 'displays no form of aggression'. Another person was regularly up at night going into another person's room and sometimes refusing to come out. Their care plan for 'sleep and rest' stated they slept well, was last reviewed on 26 February 2018 and said to 'remain valid'.

We reviewed the care plan of a person as they had developed a concern in relation to skin integrity. The care plan stated that there were no concerns. When we spoke to family, they confirmed that staff had failed to notice a problem despite them being responsible for monitoring skin and personal hygiene. The family had to bring this to the attention of the staff in order for appropriate treatment to be sought.

Staff had on occasion responded to a review of a person's needs and implemented change. For example: where residents were distressed at their reflection in a mirror and did not recognise their image, mirrors had been covered up in order to minimise further upset. This action, however, had not been documented in any care plan.

There were staff employed to carry out activities but they were not available on the days of our inspection. On the first day a volunteer was leading a quiz with people on the ground and second floors. People were enjoying this and there was lots of discussion. There was no meaningful activity on the first floor until the manager asked staff to look at arranging a game of skittles late in the afternoon. There were no activities on the second day.

People told us that although there was a 'planner' event did not always take place and not everyone liked what was on offer. There had been a number of trips out last year and these were well received. People told

us that events like birthdays or anniversaries were also recognised which they appreciated. As the result of feedback, a meeting had been held recently with activity staff to discuss how things could be improved going forward.

We recommend that the service finds out more about activities for people at the service, based on current best practice, in relation to the specialist needs of people living with dementia.

People's care records showed that people had been offered the opportunity to discuss their end of life wishes. Where people did not want to be resuscitated in the event of a decline in their health, a signed form completed by a health professional was displayed at the front of their care record. This helped ensure staff had access to important information.

There was a complaints procedure in place which people and relatives were aware of. This, however, directed people to CQC if they were not satisfied with the outcome. This needed review in order to guide people to the local authority or the local government ombudsman. A number of complaints had been made by families and a response had been given in writing to their concerns.

The registered provider also made compliments available for people to read. Some of the latest comments included "There is no veneer here, it's the real deal" and "We have been very happy with the care on the latest stay".

Inadequate

Is the service well-led?

Our findings

Our findings from the previous inspection demonstrated non-compliance with the regulations. During our last comprehensive inspection of the service in June 2017 we found the registered provider did not have effective systems and arrangements for the management and oversight of the service to ensure the quality and safety of people's care. This was breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At this inspection we found on going concerns and the registered provider is again in breach of regulations.

Any necessary improvements to the quality and safety of people's care was not proactively identified and demonstrated that the management systems in place were not driving or sustaining improvements.

Leadership within the service was ineffective .On the second day of the inspection we had to raise with the manager and the operations manager our concerns that there was less staff than required on the first floor. Staff said that this was a regular occurrence and they had been used to "getting on with it". Staff told us that, on occasion both day and night, lack of staff available impacted on the delivery of personalised care and the time they could spend with people.

Staff had expressed to us that they had not, of late, been supported to question practice or to raise concern. CQC had received a number of concerns from people who felt unable to raise issues within the service for fear of reprisal and bullying. Some of the concerns we substantiated during the inspection process. Other matters have been passed to the senior management team for review and investigation.

We saw that audits were completed by the manager and registered provider but they were not always effective in identifying areas for improvement.

Although a care plan audit was completed it did not identify that care plans did not always contain accurate information about people's needs. They did not identify concerns for which there were no risk assessments or those situations in which management plans were not effective in mitigating risk. They also failed to highlight where language and terminology was inappropriate.

We found where accidents and incidents had occurred these were not always recorded, investigated or analysed as required. For example when people had multiple falls, these had not been fully investigated or action taken to reduce the risk of reoccurrence. Alarm mats were used but ineffective in some cases but no alternative strategies had been explored. There were repeated incidents between residents but many of these had not been reported as incidents and no action taken to implement a risk management plan.

Although some medication audits had been done, they had failed to find or address the issues we found at this inspection. Some staff had undertaken medicines competency assessment prior to being responsible for administration but the records seen did not demonstrate that staff had achieved sufficient results to meet the homes target. This had not been identified at any audit.

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

We could not be assured that the registered provider understood the responsibilities of their registration with us. They had failed to notify us of reportable incidents that had occurred at the home. This included safeguarding incidents or incidents where harm had occurred. Therefore we could not be assured that the registered provider was dealing with safeguarding matters in a transparent way.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Meetings were held on a regular basis with people who used the service and their opinion was also sourced though surveys. Very recent comments had been in regards to food, staff taking too long in handover and activities. The manager told us these were to be addressed.

Regular staff surveys were undertaken and the results made available to people who used the service. The last survey had indicated that not all staff was happy working at the service but they loved their job itself.

The registered provider produced a new letter for the home which was distributed. It informed people of things if interest, contained a record of events and trips that had taken place and updated on staff, birthdays, anniversaries etc. The newsletter in November had brought to the attention of people the last CQC report pointing out that the registered provider did not believe it gave a full refection of all that happens at the service.

The service had involved key organisations such as the GP and mental health team to support care provision. However, there were concerns that some matters had not been reported to the District Nursing service in a timely way in order for appropriate action to be taken.

The registered provider had just introduced performance related pay for staff as an incentive not only for recruitment but also to acknowledge the hard work and dedication of staff.

The previous rating was displayed within the service and also on their website in line with CQC regulations and requirements.

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 10 HSCA RA Regulations 2014 Dignity and respect The registered provider failed to ensure that people were treated with dignity and respect at all times whilst they were receiving care and treatment.

The enforcement action we took:

We placed a condition on the registration of the provider not to take any new admissions without the prior written consent of the CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to ensure that people received safe care and treatment.

The enforcement action we took:

We placed a condition on the registration of the provider not to take any new admissions without the prior written consent of the CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider failed to operate effective systems and processes to assess and monitor the service. They failed to assess, monitor and litigate risks to the health, safety and welfare of people who used the service.

The enforcement action we took:

We placed a condition on the registration of the provider not to take any new admissions without the prior written consent of the CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider failed to ensure that there were sufficient numbers of suitably competent ,

skilled and experienced staff to meet peoples needs.

The enforcement action we took:

We placed a condition on the registration of the provider not to take any new admissions without the prior written consent of the CQC.