The Fremantle Trust

Apthorp Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 11 December 2018 and was unannounced. At the previous inspection in October 2017 we had found continued breaches of regulations regarding staffing and governance. The provider had failed to address these breaches, and additional breaches of regulations relating to safe care and treatment, and person-centred care were identified during the inspection. The provider had failed to implement the improvement plan they sent to us after the last inspection.

Apthorp Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Apthop care centre accommodates up to 108 people in ten flats each of which have separate adapted facilities. At the time of our inspection two of these flats had been decommissioned and 73 people were living in the home, many of whom were living with dementia.

There was no registered manager in post. 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 manager had started working in the service in late October 2018.

The provider had failed to sustain and embed previous improvements made in the quality and safety of the service. Although their systems had identified the failings we found in personalisation, risk assessments, medicines management, record keeping and the safety of premises they had failed to take effective action to address these concerns. The provider's improvement plan was not driving improvements. The systems for involving people, relatives and staff in developing the service were not working effectively. While staff were optimistic about the potential for the new manager to make improvements, people and relatives were unclear about the management structure in the home.

There were not enough staff deployed to meet people's needs. People told us they had to wait to receive care, and we saw people's dignity was compromised as there were not enough staff available to support them in a timely manner. Bathrooms were dirty and this exposed people to the risk of harm due to poor infection control practice. Risks to people were not always identified, and risk assessments were not always followed. Medicines were not managed in a safe way.

People's needs had not been assessed in line with best practice and resulting care plans lacked detail. The impact of people's health conditions on their care preferences was not recorded and people's dietary preferences were not always respected. The service had applied to the local authority to deprive people of their liberty under the Mental Capacity Act (2005) but we saw staff put in place additional restrictions on people's liberty. Some areas of the home were not environmentally suitable for people living with dementia.

People's dignity was not always upheld and the inspection team had to intervene on two occasions to ensure people's dignity was restored. Care plans did not explore how people's religious beliefs and cultural background affected their preferences for care. The service did not explore the impact of people's sexual or gender identity on their experience of care services.

Records did not consistently demonstrate people had received care as planned or in line with their preferences. People had not been supported to explore their wishes for the end of their lives.

Staff recorded and escalated safeguarding concerns to ensure people were protected from abuse. People told us they were supported to attend healthcare appointments when they needed.

People told us staff were kind and we saw some positive, compassionate interactions between staff and people. People told us their privacy was respected and they were able to spend time alone with their visitors. Staff told us they took steps to maintain people's independence and skills.

People gave us mixed feedback about the activities on offer. Some people enjoyed them and found them engaging, but other people did not find anything on offer that was suitable for them.

Some people knew how to make complaints, and records showed the provider followed their complaints policy in responding to concerns raised. However, other people did not know how to make complaints, and did not feel complaints were responded to appropriately.

We identified breaches of five regulations relating to person-centre care, safe care and treatment, premises and equipment, staffing and governance. Full details of our regulatory response are added to reports after all legal appeals are exhausted.

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.

Staff were not effectively deployed to meet people's needs.

Bathrooms were dirty and this put people at risk of harm.

Risks to people were not appropriately mitigated, and risk assessments were not always followed.

Medicines were not managed safely.

Incidents and accidents were recorded, but actions to ensure they did not recur were not captured.

Concerns about abuse were appropriately reported and raised with the local safeguarding team.

Is the service effective?

Inadequate

The service was not effective.

People's needs had not been assessed in line with best practice guidance and resulting care plans lacked detail.

Staff had not received the training they needed to perform their roles.

People's health needs were recorded and they were supported to access healthcare services. However, it was not always clear what impact people's health conditions had on their care needs and preferences.

People gave us mixed feedback about the quality of the food and we saw people's mealtime experiences varied. People were not always supported to have meals they liked.

Some parts of the home were suitable for peoples needs, but other areas were not dementia friendly.

The service was not consistently applying the principles of the

Mental Capacity Act (2005) and some staff were putting additional restrictions in place without proper authorisations.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was not always promoted and we saw several occasions where people's dignity had been compromised.

The service did not consistently explore or support people's religious beliefs, cultural background, or sexual and gender identity.

People told us staff were kind, and we saw some positive, compassionate interactions between people and staff.

Staff supported people to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive support that reflected their preferences. Care plans were not always up to date.

People had not been appropriately supported to plan for the end of their lives.

The provider had responded to complaints made, but people and relatives did not always feel their complaints and concerns were responded to appropriately.

Is the service well-led?

Inadequate

The service was not well led.

The quality assurance and audit systems had identified failings in the quality and safety of the service but had failed to take effective action to address these issues.

Systems for involving people, relatives and staff in the development of the service were not operating effectively.

The plans in place to improve the service had not been effective and did not clearly describe the actions required by whom to make improvements.

Staff were optimistic about the new management structure, but

people and relatives were not clear who was in charge.

Apthorp Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 11 December 2018 and was unannounced.

The inspection was completed by two inspectors, an inspection manager, a specialist advisor with expertise in dementia care, an assistant inspector, an evidence review officer, a directorate support coordinator and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts had experience of caring for people living with dementia.

During the inspection we reviewed care files for 14 people who lived in the service, including needs assessments, care plans, records of care and medicines information. We reviewed ten staff files including training, supervision and recruitment records for five staff who had joined the service since our last inspection. We made detailed observations of the building and premises, as well as observations of the care and support provided to people. We spoke with 12 people and five relatives. We spoke with 13 members of staff including the regional director, the quality manager, the home manager, the administrator, two floor managers, two domestic staff and five care workers. We also reviewed various audits, meeting records and other documents relevant to the management of the service.

Before the inspection we reviewed information we already held about the service including information submitted as notifications. Notifications are information about events and incidents which providers are required to tell us about by law. We also reviewed the feedback we had received from members of the public and local authority and health care teams in the local area.

Inadequate

Is the service safe?

Our findings

At our last inspection in October 2017 we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff were not deployed effectively to meet people's needs. Our findings at this inspection showed the provider had failed to address this issue. People told us they had to wait for support and they did not think there were enough staff. One person said, "I think we could do with an extra member of staff to help take me to the toilet." Another person said, "If I ring the alarm they try to get here as soon as possible but it depends if they are busy. The staff are stretched." Another person said, "There is a shortage of staff, it takes three days for staff to change my bed." Staff also told us there were not enough of them to meet people's needs. One care worker said, "I'm on my own in this flat. If I'm helping one person everyone else has to wait."

Staffing levels had not been calculated accurately. The manager told us staffing levels were based on the provider's dependency tool. They did not feel the tool took into account the particular needs of people living with dementia as it focussed on people's physical support needs. We found the tool had not been completed in all the care files viewed, and in one file we saw it had last been updated in May 2018. There was a note on that file instructing a team leader to update it but this had not been completed.

The manager told us staff were allocated to work across different flats, and care workers had been advised to call for assistance if they needed additional support. In practice, this was not happening and staff were working alone in some of the flats. This had an impact on people's experience of care and we saw examples where people's dignity was compromised by the lack of staff availability. For example, we saw one person had soiled themselves in a communal area and went and sat in an armchair. We alerted the nearest care worker that this person needed to be supported. The care worker was on their way to supporting another person and told us, "What can I do? I'm on my own. I tried supporting him earlier and he was aggressive." Shortly afterwards we saw another member of staff supported this person. Later in the day, in another flat, we saw someone else soiled themselves in a communal area. Staff had been supporting a second person who was then heard to be asking for help for over ten minutes while staff supported the other person; there were not enough staff to provide care to two people who needed support at the same time.

We reviewed the rotas for the service and these showed there were not always enough staff deployed to meet people's needs. It was not clear that unplanned absence was covered as a number of shifts were annotated with "no show" or "cancelled" with no additional name in place. The manager had told us staff were allocated to specific flats to work, but this was not consistently shown on rotas. While on some dates staff had flat numbers written next to their names, on other dates they did not. Staff told us unplanned absence was not always covered. One staff member explained, "If its short notice we don't [get cover], sometimes we do. They sometimes struggle with agencies." They went on to give an example of how shifts weren't planned effectively. The staff member was left on a unit alone all morning when three people had medical appointments. The rota had not considered that staff would need to be off the floor which meant the staff member was left to support people alone, including one person who needed two staff for toileting and personal care.

People gave us mixed feedback about how long it took staff to respond to call bells. One person said, "I would ring my call bell if I felt frightened and staff would come quickly. I did this twice when I wanted to go to the bathroom at night. The staff came straight away." Other people told us staff did not respond to call bells quickly. The provider's call bell system was old, and while call bell response times could be printed out, they were not routinely analysed. We asked for any call bell analysis that had taken place, to help us evaluate whether staff were effectively deployed, but we were told these were not completed. After the inspection the provider told us a previous call bell analysis had showed bells were answered within two minutes.

Members of the inspection team did not feel it would be safe to take staff off the floor to complete interviews with them to get their detailed feedback. One member of the team had started to speak with a care worker, then realised they were the only member of staff available to support people in the flat. Within a few minutes of starting to speak with them the care worker had to go to respond to a call bell. As they were alone this meant if anyone else living in that flat had needed support they would have to wait until the other person had been supported.

The above issues are a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We visited all the shared bathrooms and a number of the en-suite bathrooms in people's rooms. We found bathrooms and toilets were dirty and being used inappropriately for storage. We saw two shared toilets had faeces visible on the outside of the toilet bowls. The flooring in some bathrooms was damaged meaning that they could not be effectively cleaned and posed an infection control risk. Where they were not damaged the floors were dirty and water stained.

The showers in the home were currently out of use as they were being refitted following legionella being found in the water systems. The manager told us people were being supported to have washes and baths until the shower heads were replaced. Seven of the baths checked were dry and dusty. They were all dirty and one contained a dry, stained tissue underneath the bath chair. Five of the baths were being used to store equipment, some of which were Christmas decorations which staff told us had been brought down from the loft two days before our inspection. However, other items stored in bathrooms included clothing, bed linen, shopping trollies, people's clothing and wheelchairs. The cluttered nature of bathrooms meant they could not be effectively cleaned. The provider sent us a copy of an infection control audit completed in May 2018. This had identified bathroom flooring was in a state of disrepair, and that cleaning tasks had not been clearly distributed amongst staff. The actions identified had not been completed and people were at risk due to the fact that the bathrooms were dirty.

The above issues are a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The systems in place for ensuring the safe management of medicines were not operating effectively. The progress noted at our October 2017 inspection had not been sustained. Although staff told us they completed medicines competency training, records showed this was not recent. Fifteen staff had observed medicines competencies assessments recorded. However, 12 of these were from February 2017, two from 2016 and only one was in 2018. There had been several medicines administration errors since the 2017 assessments had been completed which were being investigated under safeguarding adults procedures. This showed the provider was not responding appropriately to medicines errors by ensuring staff were competent to administer medicines.

When people were permanent residents at the home their medicines were supplied by a local pharmacist with printed medicine administration records (MAR). The files where MAR were stored were chaotic and held information that was not relevant to the administration of medicines, for example, reminders to put menus out were also in this file. The files also contained old information and some MAR were loose and not kept with the other MAR for that person. Staff had not recorded incoming medicines on the MAR. Furthermore, some entries were handwritten by care workers into MAR charts and this was not always legible or easy to read. The detail of how to support people to take their medicines was not always completed, which meant people did not always get the support they needed. For example, we saw a care worker gave one person a tablet then walked away before checking the person had actually swallowed their medicine. There was no information to inform this care worker about how to support this person to take their medicines properly.

Some medicines are prescribed on a take as needed basis. People living in the home had been prescribed pain relief and laxatives on an 'as needed' basis. Records showed people were being supported to take these medicines routinely and there was no assessment in place to check they were necessary. For example, there was no pain assessment or guidance about how people expressed pain and we did not see bowel movement monitoring was in place for people prescribed laxatives.

Although the service used a system of designated staff members who wore "do not disturb" aprons while administering medicines, this was not adhered to in practice. We observed medicines administration and saw staff members administering medicines were frequently interrupted by other staff, relatives and visiting healthcare professionals. Medicines were not administered in a systematic manner. For example, we saw one person's medicines administration was interrupted part way through so another person could be given their medicines before leaving the room. Interrupting medicines in this way increases the risk of administration errors.

Risks faced by people living in the home were assessed through a general risk assessment framework. We saw risks to people's mobility, skin, eating and drinking, and other areas were assessed. However, risk assessments were not consistently reviewed and amended following incidents. For example, one person had recently fallen over and sustained facial bruising. Their falls risk assessment had not been amended to reflect their recent fall. In conversation staff described risks that had not been identified or mitigated by care plans. For example, one care worker described a risk and the mitigation for a behaviour one person exhibited at night. This was not in their care plan which meant there was a risk that new, or temporary staff would not know about this risk or how to mitigate it.

Risk assessments were not always followed. For example, one person's risk assessment stated they should have a movement sensor in place due to the risks of them attempting to mobilise without support. Staff told us the sensor was not in place anymore and the risk was mitigated by staff checking on them. There was no information about the frequency of these checks and no contemporaneous record of checks being carried out. This meant the risks of this person attempting to mobilise without staff support were not mitigated.

Incidents such as falls were recorded by staff, however, it was not clear that actions were taken to ensure that incidents did not recur. For example, the actions following one person being found on the floor were, "To wear his slippers and encourage him to ring his call bell for assistance." Their care plan and risk assessment had not been reviewed. Where necessary the service had raised safeguarding alerts and staff knew how to identify and respond to allegations of abuse. However, people living in the home did not know how to raise their concerns if they felt at risk. One person told us, "I don't really know what I would do if I felt frightened." Another person told us, "Last night the man next door came into my room. I was asleep and I saw a man sitting in my chair. I was alarmed. I have got no phone and I don't know who to contact." After the inspection the provider told us a sensor mat had been put in this person's room to alert staff to any undue

movements. We reviewed various staff meeting records and these did not show incidents or safeguarding concerns were discussed to ensure lessons were learnt. There was one mention of incidents within the meeting records reviewed and this was a reminder to complete the forms rather than a discussion of any particular incident.

The above issues with medicines and risk assessments are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People's needs had not been assessed in line with best practice and resulting care plans did not contain sufficient information to ensure people's needs and preferences were clearly recorded. We reviewed the care files for two people who had recently moved to the home. There were discrepancies between the referral information and the care plan regarding their needs and preferences. Both of the people did not speak English and the records did not show they had been offered information in a format or language that was understandable to them. The assessment and resulting care plan did not demonstrate that their family members, who may have been in a position to assist with their understanding had been involved.

Another care plan reviewed contained inconsistencies that would have been resolved by robust assessment. For example, the care plan stated the person had a learning disability when they in fact had an acquired brain injury; later in the plan this was described as a mental health issue. The resulting care plans lacked detail about how people wished to receive their care. For example, they stated people needed "support" and "assistance" to complete tasks but did not describe this. Given that people did not share a spoken language with their support staff this meant there was a risk their needs and preferences were not respected as they were not captured and staff could not easily confirm them through conversation.

Care plans contained information about people's health conditions and diagnoses, but did not explore the impact of these health conditions on their experience of care. For example, one person's care plan described that the person had problems with their teeth and their records of care showed they had recently attended the dentist for an extraction. There was no guidance for staff about what this might mean for the person in terms of pain management or dietary needs in either the short or long term. Another person's health information stated they lived with depression and could become distressed at times. Staff described how they supported the person when distressed, but there was no written guidance which mean new staff, or staff who knew the person less well did not have information about the impact of their health condition on their care needs.

People lived with health conditions which required monitoring but it was not clear that monitoring was being appropriately completed as records contained gaps. It was not possible to tell if gaps were due to recording errors or because there were no events to record. For example, one person received regular treatment from visiting nurses for constipation but the bowel monitoring charts were not clear. We saw that other people who were prescribed medicines to relieve constipation were not having their bowel movements monitored which meant it was not clear how staff decided whether people needed medical intervention.

People told us staff supported them to attend healthcare appointments when needed. However, records were inconsistent. While some people had health appointment trackers in place to ensure their health information was kept up to date, other people did not have these in place. The level of detail in records of health appointments varied and it was not clear that advice from healthcare professionals was consistently or effectively shared across staff teams. Staff told us they found it challenging to support people to attend healthcare appointments, particularly GP appointments. People were registered at a local GP and attended

appointments there. The provider told us they were in discussions with the GP to try and arrange more frequent home visits by them to reduce the impact of staff and people having to visit the GP individually.

People gave us mixed feedback about the food. One person said, "The food is very good. I find it very nice." Another person told us, "The food is the way it is. It is cooked to a low standard. I can't eat the foods, I just don't want it." A third person said, "The food tends to be the same all the time. There is not much imagination. Today the lunch was not tasty." Three people told us they had not been offered a choice of lunch on the day of our inspection and this was supported by our observations of mealtimes where people were presented with meals without being offered any choice. Care plans contained limited details about people's dietary preferences, but in some cases were clear that people preferred a specific style of cuisine, or definitely disliked a style of food. For example, one person's care plan stated they did not like to eat "English food." However, their records of care showed they had been provided with traditional English style meals, such as stews, potatoes, and pies rather than the style of food their care plan stated they liked.

Our observations showed the mealtime experience varied significantly across the home. In some flats staff facilitated people to eat together, and meals were a positive shared experience. However, in other flats people were not offered any choice, condiments were not available and people were not engaged during the meals. We saw multiple people had fallen asleep during the meal and were left with plates in front of them. One person had politely declined to join other people in the dining room and was served their lunch in a lounge. They were not offered any choice, and staff did not sit with the person or encourage them to eat at all. Three different staff members spoke to them briefly asking them to eat as they passed through the lounge but none of them sat with the person. The person's meal was removed without them eating a bite.

We asked how kitchen staff knew about people's dietary requirements and preferences. We were told they had copies of people's preferences as captured in their care plans. However, the folder shown to us did not contain information about preferences. It contained risk assessments about people's risk of malnutrition and choking. After the inspection the provider submitted a sample of dietary preference sheets they told us were held by kitchen staff. The level of detail varied and some people's preferences were not well described. We asked the provider to send us records of meetings for people and relatives so we could see if food was discussed at these meetings. The relatives meetings showed food had been discussed in the past, but no meetings for people who lived in the home were submitted so we could not see that people were able to give feedback about the meals.

The above issues with assessments, care plans, dietary preferences and health records are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had not received the training they needed to perform their roles. Not only had medicines competencies not been assessed as described in the 'Safe' domain, but other training courses had not been completed or were outside the recurrence date set by the provider. Seventy staff had been out of date in safeguarding training which the provider requires to be completed every two years. After the inspection the provider showed us 46 of these staff completed this training within five weeks of the inspection site visit. Over half the staff had not completed training in diet and nutrition, or dignity and respect. Moving and handling training was out of date for 27 staff. The matrix did not include any courses relating to record keeping or care planning which was reflected in the quality of the documents viewed during the inspection. After the inspection the provider showed us some staff had completed training in safeguarding and moving and handling. The provider told us some courses were incorporated into other training opportunities. The provider submitted their plan for improving the training for staff.

The above issues with staff training are a breach of Regulation 18 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

The home was divided into ten flats, two of which were currently not in use. Each flat had its own dining and lounge areas and there were larger communal areas for group activities. People had memory boxes, personal photographs and signage by their bedrooms. However, the communal décor was dated and the provider recognised some areas required redecorating. The environment was not always suitable for people living with dementia. For example, there were no clocks, or clocks were not working which meant people could not orientate themselves because the times shown were incorrect. Although the showers were currently out of use, there were no signs on display to remind people of this. People told us they hadn't had showers, but did not know why as there were no signs to remind them.

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. The provider had identified when people's packages of care amounted to a restriction of their liberty and had made appropriate applications to the local authority to deprive them of their liberty.

We observed some practices which amounted to restrictions that had not been appropriately identified as such. For example, people's walking frames were moved away from their seats which meant they could not move from their seats without staff support. We also saw a staff member explain to one person they would position the remote for operating their reclining armchair out of their reach so they couldn't operate it and attempt to stand without staff being present. It was clear staff were not doing these things to intentionally restrain people, but because they thought it was keeping them safe from harm. However, this kind of practice is not in line with the principles of the MCA.

Requires Improvement

Is the service caring?

Our findings

We found the previous improvements in maintaining people's dignity had not been sustained. The impact of the staffing levels described in the safe domain had a significant impact on people's dignity. For example, we observed two people, on separate occasions, had soiled themselves and were walking through communal areas of the flats. On both occasions members of the inspection team had to request staff provided support to people whose presentation put them at risk of adverse reactions from visitors and other people living in the home. Members of the inspection team saw three different people were wearing dentures that did not fit properly. Not only did this affect their ability to communicate clearly, but it meant they appeared unkempt.

Care plans identified when people may need support with their emotional needs. However, the details of how to provide this support were not described. People told us staff were kind and caring, and we saw some staff interacted with people in a positive way. For example, we saw one person had become distressed and a care worker sat with them, offered them a cup of tea and the person became calm. However, we also noted staff did not pay attention to how the environment may be affecting people's feelings and behaviours. For example, there were areas of the home where televisions were on with sound and music was playing. This created a loud and chaotic atmosphere. On another occasion the CD playing music was scratched and the music skipped for several minutes before a staff member corrected this. At the same time, people's call bells were ringing and the telephone was ringing. This created a chaotic, noisy environment which was particularly challenging for people living with dementia.

People told us their religious beliefs were respected. One person said, "I'm religious and I attend services." Care plans recorded people's religious beliefs and whether they wished to attend religious services. However, it was not clear that people were supported to attend religious services as they were not recorded in people's records of care. Where people's faith was not Christian, the details of how they were supported to practice their faith were not described. Two people's referral information stated it was important that they lived their lives in accordance with the principles of their faith. The care plan for one of these people said they had no faith, and neither plan contained information about the principles of their faith, and what living in line with them meant. This meant there was a risk that people were not always supported to practice and express their religious beliefs.

People and relatives told us they were supported to maintain their relationships with each other by the home. One relative described how staff kept in touch by telephone. Another relative told us they visited regularly and always felt welcome. However, we noted there was limited information about people's past and current relationships. For example, one person's care file named their children and grandchildren but did not mention anything about their partner; it was not captured if their relationship had continued after having children, if they were still alive or if the person had any happy memories of them. Care plans did not consider people's gender or sexual identity or the impact this may have on their care preferences.

Staff told us they respected people's independence and privacy. One care worker explained, "Some people can still care for themselves and don't like us to interfere. We'll check they are OK but we don't take over."

People confirmed they felt respected and were given privacy. One person said, "They do respect my privacy and dignity. I can have time alone with my family." A relative told us their private time with their family member was respected, "I am able to spend one to one time with my relative in her bedroom."

Requires Improvement

Is the service responsive?

Our findings

The provider had failed to sustain previous improvements about ensuring people's care plans were updated in response to changes in their needs. Although care files were signed to say they had been reviewed each month, we found they were not updated in response to changes in need. As described in the Safe domain people had had falls, or changes in how their risks were managed, but their care plans were not updated. In one file we saw staff had first recorded a new behaviour in 2016, however, the most recent care plan dated November 2018 still stated the person had "started to" show this behaviour despite records showing it had been present since 2016. The same action, that staff should monitor this behaviour was recorded in both 2016 and 2018. This demonstrated that care plans were not routinely updated to ensure they reflected people's current needs.

Although some preferences were recorded, the level of detail around how to support people was not enough to ensure they received personalised care. For example, one person's care plan stated their usual routine was "assistance with shower and shave if required." There was no detail about the nature of the assistance, whether the person preferred a wet shave or used an electric razor and how they liked to style their facial hair. While people's routines were described, their preferences were not consistently recorded. The provider recognised that none of the care plans contained enough information to provide personalised care without needing additional input from the person, or someone who knew them well.

Records did not demonstrate people had received their care as planned. For example, staff did not capture the nature of the care they had provided, so it was not clear whether people had been supported to have baths or washes. Likewise, records did not capture if people had attended their place of worship when this was captured as part of their care plan. Records were not stored in a consistent or secure manner. While in some flats, records of care were stored in locked filing cabinets, in other units they were stored in unlockable cupboards in shared areas of the flat. One staff member commented, "Everyone keeps things in different places, I can never find them."

The provider's care plan format had a section to record people's end of life wishes. However, in practice we found records relating to end of life care centred on whether or not people wished to receive ongoing treatment or be resuscitated. There was no exploration of people's cultural wishes or where this had been considered the information was extremely limited. For example, one person's end of life care plan stated, "Catholic and would like to have last rights." Regarding their views on resuscitation it stated, "To discuss at next review." Where people had decided they did not wish to be resuscitated, or if they lacked capacity to make this decision and an appropriate medical professional had decided this would not be in their best interests, there were appropriate records prominently displayed within the care files. There was not enough information to demonstrate people had been supported to explore their wishes for the last stage of their life while they were still able to express their views.

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

Some people told us they liked the activities. One person said, "I think the activities are very good." Another person said, "I go to the little park, and out with friends for lunch." A third person said, "The activities are very good and you get quizzes and charades." During the inspection the home hosted people from two other local care homes and held a Christmas tree competition. However, other people did not feel the activities were suitable. One person said, "The activities are not suited to my needs." We saw staff tried to engage with people, and offered activities enthusiastically. However, where people's dementia was more advanced, or where people were not keen on group games, opportunities for engagement and meaningful activity were limited.

There was a complaints policy in place, and records showed the provider investigated and responded to complaints in line with the policy. However, we did not see this was available in alternative formats or languages for people who could not read English. People gave us mixed feedback about whether they knew how to complain. For example, one person told us, "The chances are that if I complained I would be listened to." Another person said, "I don't think about complaining, we don't have to worry here." However, three other people told us they did not know how to complain and a relative said their complaints had not been responded to appropriately. They told us they had to raise issues repeatedly before they were addressed, and this made them feel that their concerns were not always taken seriously. We have reported further on people's involvement in the service in the Well-led domain.

Inadequate

Is the service well-led?

Our findings

At our last inspection in October 2017 we identified a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because records of care had not been appropriately maintained. This issue remained as described in the effective and responsive domains. We also found previous progress in ensuring the quality and safety of the service had not been sustained.

The provider used a system of audits based on the CQC domains and key lines of enquiry. On the day of our inspection a 'well-led' audit was being completed. We shadowed this audit which identified the issues we found during the inspection with the quality and safety of the service. We also reviewed previous audits completed of the other domains. The audit of the safe domain had identified a care file did not have appropriate risk assessments regarding a person's health conditions and that staff had not received appropriate training. It also identified weaknesses in liaison with healthcare professionals. Although there were some actions recorded with deadlines for completion in September 2018, we found these issues had not been effectively addressed by the time we inspected in December 2018.

The 'effective' audit identified gaps in care plans and a need for greater personalisation. However, the actions required did not have a timescale for completion and had not been delegated to a named member of staff. The actions had not been completed effectively by the time of our inspection in December 2018 despite some of them being recorded as requiring "immediate" action.

The 'caring' and 'responsive' audits similarly identified a range of immediate and long term actions which required completion which had not been implemented by the point of inspection. The responsive audit concluded, "The fundamental systems are failing to clearly identify and plan care delivery with regular reviews happening to ensure that care being delivered is meeting residents needs and wishes." Despite identifying the significant failings within the home and the impact this was having on people living there, the provider had failed to take effective action to address the concerns.

The provider shared their home improvement plan with us. They told us they considered this to be a significant piece of work which had been appropriately resourced. However, the plan did not include specific actions or indicators of progress that could be monitored. For example, one area on the plan related to taking actions in relation to reports and meeting minutes received by floor managers and team leaders. The actions to be taken by these staff were non-specific and there were no measures of success. The plan stated, "Floor managers / Team leaders to read [reports] and take action relevant to their flats. Then feedback to the manager in writing. Seek support to complete actions if required immediately do not wait for the next meeting." It was not clear what support was available or what actions these staff were expected to complete.

Another action related to completing a daily walk around to check people's wellbeing and the health and safety of the building. This had failed to identify or address the dirty state of the bathrooms. Despite requiring reviews be completed with evidence that people were involved, the reviews still did not demonstrate people had been involved in making choices about their care. The actions in relation to

medicines had been repeatedly extended and had not identified the issues we found during the inspection regarding storage and disposal of medicines. Although there was an action stating that handwritten MAR entries needed to have two signatures, we found this was not happening.

The home did not have a registered manager. A new manager had started at the service shortly before our inspection. Staff were positive about the impact they had made. One member of staff said, "I like the new manager, she's making an effort. We see her on the floor, she does a walk around every day." People and relatives were not always able to identify the home manager, with three people telling us they did not know who the manager was, and a further two people identifying someone who was not the manager when asked who was in charge. While some people remembered being involved in meetings about the home, others told us residents' meetings were not taking place. We asked for records of meetings for people and relatives to be sent to us. The provider did not submit any meeting records for people living in the home, and the relatives meetings had taken place two years apart. This meant the systems for involving people and their relatives were not operating effectively in the home, despite being included in the improvement plan.

Staff told us they attended staff meetings. However, the records of these were inconsistent and did not demonstrate meetings were taking place regularly. We asked the provider to submit staff meeting records for the previous six months. We were sent meeting records of staff, senior staff and night staff meetings which had taken place in October, November and December 2018. The records showed that there had been changes to the senior leadership of the provider, and new senior managers had attended the home to introduce themselves and try to establish effective working relationships with the home. A meeting from November 2018 had recognised that staff at the home had not felt supported by the provider and senior leaders were now trying to rectify this.

A managers' meeting within the home had recognised in October 2018 that improvements had not been sustained. The meeting record stated, "Recent audit findings has identified that the improvements have not been sustained and in many areas has slipped back. CQC are due to return to re-inspect at any time and is likely to rate the service as going back into inadequate special measures." Although there were actions recorded to strengthen the management systems within the home, these had not been effective as the issues remained widespread and persistent.

The provider had failed to sustain improvements noted at the last inspection, and the experience of people living in the home had deteriorated significantly since then. Although the provider was aware of the issues with the quality and safety in the home, and acknowledged our findings throughout the inspection, they had failed to take effective action. The issues with regulations about staffing and governance have persisted since August 2016.

The above issues regarding a failure to take effective action to improve the service are a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 People's needs had not been appropriately assessed and care and treatment was not being delivered in line with people's needs and preferences. Regulation 9(1)(3)

The enforcement action we took:

We have varied the provider's registration to prevent them from operating from this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always supported in a way that maintained their dignity. Regulation 10(1)

The enforcement action we took:

We have varied the provider's registration to prevent them from operating from this location..

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people had not been appropriately assessed or mitigated. Medicines were not managed in a safe way. Regulation 12(1)(2)

The enforcement action we took:

We have varied the provider's registration to prevent them from operating from this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Areas of the home were dirty and poorly maintained. Regulation 15(1)(2)

The enforcement action we took:

We have varied the provider's registration to prevent them from operating from this location.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems had failed to improve the quality and safety of the service, and they had not ensured appropriate records were maintained. Regulation 17(1)(2)

The enforcement action we took:

We have varied the provider's registration to prevent them from operating from this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not effectively deployed to meet people's needs and had not received the training they needed to perform their roles. Regulation 18(1)(2)

The enforcement action we took:

We have varied the provider's registration to prevent them from operating from this location.