Reside Care Homes Limited

Reside at Southwood

Inspection report

36-40 Southwood Avenue
Southbourne
Dorset
BH6 3QB

Tel: 01202422213
Website: www.residecarehomes.co.uk

Date of inspection visit:
01 May 2018
04 May 2018
08 May 2018
11 May 2018

Date of publication:
16 July 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection took place on 1, 4, 8 and 11 May 2018. The first day of the inspection was unannounced. We gave the provider short notice of our visits on the other days so that the manager and staff would be available to speak with us, and appropriate records would be available.

Reside at Southwood is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to accommodate a maximum of 38 people who require support with personal care. There were 24 people living in the home at the start of our inspection.

The service comprises three individual houses which have been linked together to form one building. Accommodation is provided in individual bedrooms on the ground, first and second floors. Some rooms have ensuite facilities. There are two lounges and a dining room on the ground floor. The home specialises in providing care to people living with dementia.

The service was led by a new manager who was not registered with the commission but confirmed that they had submitted an application to become registered. 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.

This inspection was brought forward from the planned date because we received information of concern and safeguarding alerts from the local authority. At our last inspection in January 2018, we found shortfalls in a number of areas and the service was rated Inadequate and placed in special measures. At that time we found breaches of the regulations relating to the way people received care and treatment, that people's consent was not always properly obtained and people were not always treated with dignity and respect, the management and administration of medicines, the management of risks to people, premises and equipment that was not safe to use, the recruitment, training and supervision of staff, the service did not act in accordance with the Mental Capacity Act 2005, quality monitoring systems were not effective and record keeping required improvement.

At the last inspection there were nine breaches of the regulations. At this inspection action had been taken to comply with one of the regulations but the other eight breaches of regulations were repeated.

The feedback we received from people and their relatives and visitors was that staff were kind and most people were happy living at Reside at Southwood. We observed that not all of the staff made meaningful connections with people and therefore not everyone received person centred care. This was because many of the staff focussed on completing a task and then moving to the next task.

At the last inspection, systems and procedures to ensure people were safe in the event of an emergency were not effective. At this inspection we found that work was underway to ensure this was addressed but not all staff had received training in the action to take in the event of an emergency. Also, they had not taken part in a fire drill to practice their learning.

We raised concerns about the number of staff on duty at night at the last inspection and at this inspection found that this had been addressed. However, actions to ensure that staff had the necessary skills, training and competence to care for people and meet their needs had not been completed. Failure to complete thorough moving and handling training for staff had continued to place people and staff at continued risk of injury.

We again found that systems to manage the administration of medicines were not robust and meant that people may not always be receiving their medicines as prescribed. We could also not be sure that people always received all of the food and fluids they needed to maintain good health.

During the inspection in January 2018 and again at this inspection, we found that systems to manage risk and ensure people were cared for in a safe way were ineffective. Risk assessments were not always fully completed or regularly reviewed. Some risks had not been identified and therefore no action had been taken to reduce or manage the risk. This meant that people's safety and well-being was not always protected.

At the last inspection we found that people did not always have their rights protected because the service did not operate in accordance with the Mental Capacity Act. At this inspection we found that no action had been taken to address this. This meant that some people may have been illegally deprived of their liberty and not had their human rights respected.

The service had again failed to ensure that care planning systems were robust, detailed and up to date. Some assessments had not recognised specific care needs and no care plans had been created for these. Some people's needs had changed and care plans had not been reviewed and amended. This meant that staff may not be aware of people's needs and therefore people may not receive the care they required. For example, there are a number of different types of dementia that will affect people in different ways such as causing auditory or visual hallucinations. There was no assessment of people's needs and indicators that they may be experiencing this. Other people had been diagnosed with serious mental health conditions, Parkinson's disease and epilepsy. Again, there was no information or guidance for staff in care plans about these matters.

During the inspection in January 2018 we found that management arrangements and systems did not ensure that the service was well-led. Quality monitoring systems were not used effectively and record keeping was poor, as records were out of date and contained errors and omissions. At this inspection staff reported that they had confidence in the new manager. However, we found that management and oversight systems, quality monitoring and record keeping continued to be ineffective.

Recruitment procedures had been reviewed and action had been taken to ensure that any new staff employed to work at the service were suitable to work with vulnerable people.

Following our inspection, the registered provider told us that they planned to close the service. All of the people living in the home had moved out by 27 June 2018.

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.

You can see what action we told the provider to take at the back of the full version of the report.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The 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 and people had continued to be put at risk.

Systems for the management of medicines were unsafe and did not fully protect people.

Care was not always planned and delivered in a way which protected people from the risk of harm.

Is the service effective?

Inadequate

The service was not effective and people had continued to receive ineffective support and care.

Some people had lost weight and may not always have received appropriate food and drink or been supported to eat and drink enough to meet their needs.

Staff had not always received the training, supervision and support they needed.

People's rights were not always protected because the service was not acting in accordance with the Mental Capacity Act 2005.

Is the service caring?

Inadequate

The service was not caring.

Action had not been taken to ensure that people's human rights to privacy, dignity and respect were upheld.

Staff did not always support people in a person centred manner and their privacy and dignity was not always promoted and protected.

Is the service responsive?

Inadequate

The service was not responsive.

People had continued to be put at risk of receiving unsafe care because their care plans were not up to date and detailed.

Changes in needs were not always re-assessed and planned for and contradictory instructions were not identified and questioned.

People did not always receive appropriate support to meet their personal care needs.

The service had a complaints policy and complaints were responded to appropriately.

Is the service well-led?

Inadequate

The service was not well led.

The provider had continued to fail in meeting their responsibilities to manage the service under the Health and Social Care Act 2008. There were multiple repeated breaches of regulations.

Again, action had not been taken to assess, monitor and mitigate the risks to people living at the home.

Again, quality monitoring systems were ineffective and record keeping required improvement.

Reside at Southwood

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 was 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 comprehensive inspection took place on 1, 4, 8 and 11 May 2018. The visit on 1 May 2018 was unannounced, the remaining visits were planned with short notice.

The inspection was carried out by an adult social care inspector and an assistant inspector

The inspection was prompted because we received information of concern and safeguarding alerts from the local authority.

We did not have access to information from an up to date Provider Information Return (PIR), because the inspection was brought forwards from the planned date. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed all the other information we held about the service, including previous inspection reports and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law. We also contacted the local authority commissioners and safeguarding teams to establish their views of the service.

We met and spoke with 10 of the people living in the home. Because a large proportion of the people were living with dementia, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with three visiting relatives or friends, the registered provider, new manager, nine members of staff and four visiting health or social care professionals.

We observed how people were supported and looked at 14 people's care and support records and records and documents about how the service was managed. This included six staffing records, audits, meeting

minutes, training records, maintenance records and quality assurance records.

Inadequate

Is the service safe?

Our findings

Some people were living with dementia and were unable to tell us whether they felt safe. We observed some people responding positively with smiles when staff approached them; other people were withdrawn and did not respond to staff. Some people were able to tell us they felt comfortable at the home. However, we again identified areas of concern that impacted on people's safety.

At our inspection in January 2018 serious shortfalls in the systems to prevent and control fire, the maintenance and checking of equipment, the management of risk from legionella, infection prevention and control, systems to prevent and manage accidents and incidents, assessment and management of risks to people including the risk of malnutrition, dehydration and skin breakdown were found. There were also concerns about the management of medicines and unsafe recruitment of staff.

At this inspection we found that while works on the building and furnishing of the home were underway or in some instances, completed, action had not been taken by the registered provider and manager to address the some of the other shortfalls that were highlighted during the inspection in January 2018.

People continued to be put at risk of not receiving safe care and treatment.

At the last inspection we highlighted concerns about the fire precautions in the home, arrangements for evacuation of the building in the event of an emergency and staff training in the actions to take during an emergency. Dorset and Wiltshire Fire and Rescue Service confirmed on 1 May 2018 that the required work had been satisfactorily completed. Records in the home showed that the required tests and checks had been completed. Some staff had completed fire training and taken part in at least one fire drill to ensure they understood their responsibilities in the event of an emergency.

However, there was no evidence that four of the staff who were highlighted as not having completed training at the last inspection had completed training since then and there was no evidence that three new staff had completed this training. In addition, there were eight staff who had not taken part in a fire drill. Two of the staff who had not completed training and six of the staff who had not taken part in a fire drill worked at night. At the last inspection it was identified that the night staff had the least knowledge and understanding of their responsibilities and the procedures they should follow.

During the inspection in January 2018 we found that systems to prevent the occurrence and spread of infection were not effective. Surfaces to vanity units around wash hand basins, bedside tables, chests of drawers and wardrobes had unsealed and cracked surfaces which created an infection control risk. At this inspection we found that some items of furniture including armchairs, dining chairs and tables had been replaced due to infection control concerns but items in people's bedrooms, such as bedside cabinets, vanity units and chests of drawers, had not been attended to. This meant that surfaces could not be properly cleaned.

Also at the last inspection we identified that waste bins did not have lids which safely contained possible

hazardous waste and there was a risk of contamination from the lids when staff used the waste bins. During that inspection new foot operated bins were ordered for a number of areas. At this inspection a waste bin containing used paper towels from hand washing as well as used continence products had a swing to lid in a communal toilet and bins in the ensuite facilities of people's rooms either had no lid or a swing top lid. These bins contained used paper towels from handwashing. Good practice infection control procedures advise that hands free waste bins should be provided. Infection control audits had not identified this issue.

During this inspection we noted that the many of the bedrooms contained static commodes as well as ensuite lavatory facilities. We checked the cleanliness of some of the commode pots and found two were stained with faeces. We asked staff how commode pots were cleaned when they had been used. They told us that, if the room has an ensuite, the pot was emptied into the lavatory and washed out in the bath if there was one. Anti-bacterial cleaning wipes were then used to wipe the pot clean. However, the system in place had not ensured that all commode pots were thoroughly cleaned.

At this inspection, it was found that only one sling was provided for each person and that wheelchairs were shared by different people. This meant that people did not have a sling available whilst their sling was being washed. Staff told us that wheelchairs were cleaned once a week, not between uses by different people. This meant that there was a greater risk of cross contamination.

This meant that the service had continued to fail to ensure that waste was safely contained and infection control was managed appropriately.

At the last inspection we found that the service was not adequately assessing and monitoring people's diet, weight and risk of malnutrition. At this inspection we found that little action had been taken: 16 of the 24 people living in the home had experienced unplanned weight loss since January 2018. Another person had gained a considerable amount of weight although this was a risk to their health due to their diagnosed medical conditions. Some people's food intake was being recorded but this was not being done for everyone who was assessed as being at risk of malnutrition. Again, as at the previous inspection, there was no guidance or information in care plans to inform staff how much people should eat and what to do if people were not eating well. Where people had lost weight, the manager advised that the person's GP would have been informed of this and the GP would make referrals as necessary to Dieticians or Speech and Language Therapists (SALT). However, the records that we examined did not contain evidence that any action had been taken either within the home to improve people's intake or to contact any health professionals.

During the last inspection a number of people had been assessed as at risk of developing pressure ulcers and skin damage. There had been no system to ensure that the pressure relieving equipment provided for people was appropriate for their level of need and care plans lacked information about people's skin integrity needs and how to meet them.

Prior to this inspection we received information of concern about how pressure area care was provided in the home.

There were three people with pressure sores living in the home at the start of the inspection. We found that one person with a pressure sore was not supplied with the correct mattress despite advice from health professionals and confirmation from the manager that the correct equipment had been put in place. Risk assessments for a number of other people indicated that they were at risk of developing pressure sores. We checked some of the special mattresses that people had been provided with. Two air mattresses were set incorrectly and other mattresses did not appear to be correct for the level of risk the person had been

assessed at. Another person was provided with a cushion which was worn and not effective but this had not been noted by staff. On 4 May 2018 we asked the registered provider and manager to carry out an urgent audit of people's needs and the equipment provided to them and to ensure that the correct equipment was provided where any of the equipment provided did not meet their needs. We did not receive final confirmation that people's mattresses had been checked and changed where necessary until 24 May 2018. We have still not received confirmation that cushions have been checked and corrected where necessary. This means that people have continued to be put at risk of developing pressure sores.

In addition to the provision of equipment to support people's skin integrity, some people needed help from staff to reposition themselves in bed. Some care plans contained information about how often this should take place but this had not been transferred to the charts in people's rooms which staff completed when support had been provided. In other care plans there was no information about repositioning. Health professionals had also given advice about how people should be positioned to ensure that existing wounds were not exacerbated. This information was not in people's care plans or the records in people's rooms. Staff also had different understanding about how often people should be supported; care plans stated that repositioning for one person should be every 2 hours during the day and every four hours at night. One staff member told us the person should be supported every hour during the day. Instructions for one person were that they should not be positioned on their left side because they had a pressure sore. Repositioning records showed that they had been positioned on their left side for three hours during one night shift. Records for another person showed that, contrary to their care plan, they had not been supported to change position over night for a period of 11 hours. This meant that there was no clear, accessible instruction to staff when they were providing support to people and people were not receiving the correct support to prevent or manage pressure sores. The registered provider later reported that this had been addressed with staff members through supervision.

People who need support to change their position whilst in bed should be supported to do this with the use of special equipment to reduce the risk of injury and added discomfort to themselves and the risk of injury to staff. During this inspection health professionals assessed people's needs regarding repositioning and advised that six people should have different equipment provided to meet their needs and that existing equipment was being used incorrectly for one person. The manager and registered provider could not confirm that staff had received suitable training to reposition people in bed. Some staff told us they had received training from previous employers but did not have current training in this area.

At the last inspection we identified concerns with how peoples' moving and handling needs were assessed and planned for and how staff were trained to support people. Care plans lacked current information and detail and we witnessed staff providing unsuitable and potentially hazardous support to people. Following the inspection, the provider accepted that staff training could be improved in addition to the provision of better leadership in this area.

During the previous inspection, there had been 10 people living in the home who needed to use a hoist to be moved safely. There had been three mobile hoists available around the home and a fourth which remained in one person's bedroom at all times. Staff had confirmed that more hoisting equipment was needed as there were often delays in providing care to people because no hoist was available. The registered manager had agreed that, given the lay out of the home, including narrow doors ways and corridors and internal ramps, and the needs of the people, an additional hoist would be useful and confirmed that one had been ordered.

At this inspection, although the overall number of people living in the home had decreased, the number of people who needed to use a hoist had increased to 15. We counted only three hoists available in the home,

one of which was not battery powered and required staff to manually pump a lever to raise and lower the person in the hoist. Some staff told us that they believed a hoist was broken and awaiting repair.

At this inspection we found that moving and handling care plans had not improved and staff had not been provided with additional training in this area. Some of the people who needed a hoist to help them transfer did not have the correct slings and some slings were damaged but were still in use. During this inspection, health professionals advised that four people's moving and handling needs could not be met safely in their rooms because the rooms were too small to accommodate a mobile hoist. This had not been raised by staff who carried out these people's care or noted by the registered provider. When the issue was raised with them, the registered provider agreed to move people satisfactory rooms.

Guidance issued by the Health and Safety Executive (HSE) includes that, where possible, bed rails should be integrated rather than rails that need to be attached. The HSE guidance clearly states the maximum and minimum dimensions for the rails, mattress heights and any gaps in order to try to prevent injuries to people. This information was highlighted to the registered provider at the last inspection and a number of concerns were identified with the use of bed rails in the home.

At this inspection we found that the guidance had not been followed and risk assessments including this information had not been undertaken. Since the last inspection one person had sustained a wound because their foot had become trapped between bed rails which also did not have protective bumpers attached to them. The registered provider later stated that protective bumpers had been in place but that the person occupying the bed had removed them for themselves. During the inspection, health professionals advised that two beds were unsafe and that rails for three people should be changed. Suitable bumpers for bed rails had also not been provided for all people who had bedrails attached to their beds. The registered provider confirmed during the inspection that that they would order the required equipment

This meant that people had continued to be put at risk either from a lack of equipment or the use of unsafe or inappropriate equipment.

During the inspection in January 2018, many of the people living in the home were unable to use the call bell to summon assistance from staff. Risk assessments to review the level of concern this may indicate and therefore how frequently a person should be checked had not been completed. Staff told us that when people who could not use their call bell spent time alone in their rooms during the day, regular checks were carried out usually once an hour. Night staff confirmed that everyone was checked every hour through the night. A number of people had experienced accidents or incidents and were discovered by staff during the completion of regular checks. The registered manager and registered provider had agreed to review the frequency that checks were carried out to ensure that these met the needs of the individual people living in the home.

Also at the last inspection, analysis of accident records for a two month period showed that 37 accidents and incidents were recorded. Twenty-one of these accidents had occurred during the night shift and all except one had been unwitnessed by staff. The majority of the incidents involved staff finding people on the floor, either having rolled out of bed, falling while trying to get out of bed or unexplained. Records indicated that these accidents were mostly discovered during the scheduled hourly checks that staff completed. We discussed whether more frequent checks may reduce the number of incidents.

At this inspection we found that checks were still being carried out on an hourly basis and no action had been taken to review people's risks and needs. Between 2 March 2018 and 10 May 2018, 58 accidents or

incidents had been recorded. Of these, it was recorded that 29 of them had been discovered during routine checks and 12 had been alerted to staff because a sensor alarm mat in the person's room had been activated. Fifty of the incidents noted that people had been found on the floor. Forty six of the incidents occurred between 8pm and 8am. The need to check people based on their needs was again highlighted to the manager and registered provider.

This meant that people's individual routines and behaviours, such as frequently getting out of bed at night when they were at risk of falling, had not been reviewed to establish what risks they were exposed to and no action, such as checking them more often, had been taken to reduce the risks.

This was a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not ensured that risks to the health and safety of people were assessed and steps had not been taken to mitigate the risks. Steps had also not been taken to ensure that premises and equipment were safe to use and used in a safe way. Suitable equipment to meet people's needs had not been provided and steps had not been taken to assess the risk of, prevent, detect and control the spread of infections.

At the last inspection we found there were systems in place for the management and administration of medicines but that these had not always been followed. There were concerns with the recording of medicines, information about when to administer 'as and when required' (PRN) medicines, management of pain relief, the timing of administration especially during the morning, covert administration and staff training and competence. Medicines administration records (MAR) were not always signed by staff to confirm that the items had been administered or a code letter had not been used to explain what had happened in the event that a medicine had not been administered. This was particularly the case for the administration of topical items, such as prescribed creams, that were kept in people's bedrooms.

Since the last inspection a new medicines management and administration system had been introduced in the home. Records showed that the manager, deputy manager and most seniors had received training on the new system from the supplier. Some senior night staff had not been able to attend the supplier training and records showed that this had been cascaded to them by staff who had attended the training. The registered provider later stated that the new supplier had provided an induction to their system and not training because staff had already completed training under the previous supplier.

Senior care staff were responsible for administration of medicines such as tablets and liquids that were given to people at specific times. Staff identified a number of differences between the new system and the old system. However, no competency checks had been completed to ensure that medicines were being managed and administered correctly using the new system.

Care staff were responsible for administering prescribed medicines such as topical creams that had to be administered in the privacy of their own rooms. Training records showed that care staff had not received training in the administration of medicines appropriate to the level of support they provided and their competency to do this had not been assessed.

As at the inspection in January 2018, there were gaps in the recording of medicines and this was particularly an issue with regard to the administration of topical medicines. Senior staff were also administering medicines and not immediately signing the MAR and medicines were being given to people some time before or after the time prescribed by the health professional. For example, at midday on the second day of the inspection we noted that one person's 8.00am medicines did not appear to have been administered because the MAR had not been signed. We asked the member of staff whether the person had refused their

medicines or if there was a reason they had not been administered. The member of staff confirmed that they had given the person their medicine at "around 11.30 am and they were just about to sign the MAR chart". Discussions with staff also highlighted that, if a person is up early in the morning, the night staff will administer their 8.00am medicines. The night shift finished at 8.00am. We also found that another person had been given a dispersible medicine in a beaker with their breakfast. It was in front of them at the dining table on our arrival at 10.35am. Staff encouraged the person to drink their medicine when they cleared other breakfast items from the table. The person was later taken to the television lounge and their medicine was taken with them and placed on a table in front of them. At 11.50 am we raised this with a senior member of staff as we were concerned that another person may pick it up and drink it. The MAR chart had been signed to show that the person had taken their medicine.

Topical medicines and other items such as eye drops, can often only be used for a specific period after they have been opened. There were a number of items that did not have the date they were opened recorded. There were also items in use that had passed their expiry date and other items which had been prescribed for people no longer living in the home and being used for other people. For example, one person no longer living in the home had been prescribed an item used to prevent and heal pressure sores. It was in another person's room. Staff confirmed that they had used it as a precaution for this person. However, it had not been prescribed for the person and staff had not recorded when or where they had applied the item.

At the last inspection, some people were prescribed medicines to be taken as and when they needed them (PRN). Not all of the medicines had protocols in place to direct staff about their administration and there were no medicines care plans.

At this inspection protocols were in place for each PRN medicine for each person and these were kept with the MAR charts. These protocols explained to staff what the medicine was for and the maximum amount to be taken over 24 hours. For example, pain relief or constipation. However, there was no information in either a protocol or care plan about the symptoms to look for and when to offer the medicine, whether the person was able to ask for the medicine or any signs such as non-verbal cues which they may have, or the minimum time between doses.

Some people had their medicine administered covertly, disguised in either food or drink. At the last inspection there had not been any evidence that a pharmacist had been consulted about whether the medicines that were being given in this way would remain effective. During this inspection we found that this advice had been obtained and was kept with MAR charts. However, there was no further information either in a protocol or in a care plan to guide staff about the process to follow before resorting to giving covert medicines or the best way to do this taking into account the person's likes and dislikes. For example, the medicine could be mixed with yoghurt and what flavour of yoghurt the person liked the most.

Again, none of the shortfalls in medicines identified during this inspection had been highlighted by staff. Following the last inspection, senior staff had been tasked with completing medicines audits. None of the completed audits had identified any of the issues found regarding medicines at this inspection.

This was a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not protected against the risks associated with the unsafe management and use of medicines.

Legionella is a water borne bacteria that can be harmful to people's health. To prevent this hot and cold water should be stored and circulated within specific temperature ranges and in areas where water may stand and become stagnant, such as seldom used shower heads and taps and periodic flushing should be

carried out. At the last inspection it was noted that this work was not being completed as required. At this inspection the provider reported that a new contractor had been engaged to undertake the work. Records of tests and checks showed that the work was being completed as required. A number of unused bathrooms, showers and lavatories were being refurbished to address issues that had been identified with pipework in the home.

Work had been undertaken since the last inspection to improve the laundry area.

Staff spoke knowledgably about the different types of abuse that people may be subjected to. They knew the procedure for reporting allegations of potential abuse and who to contact for advice and guidance. Training records confirmed staff had completed their safeguarding adults training courses and received refresher training when required. As part of the national initiative, that safeguarding children from harm is 'everyone's responsibility'. In recognition that adult social care workers are likely to come in to contact with the children and young people as visitors to the home, staff should be able to recognise and report signs of abuse. Staff had not received training in this area.

During this inspection we identified that one person had reported to a member of staff that they did not like being cared for by one of the staff, had alleged that they felt they were scared of the member of staff and had been handled roughly. The member of staff that the person told had acted appropriately in advising the person that they could not ignore this and had reported this to the senior person in charge of the shift. They had also recorded this appropriately. However, we became aware of this incident approximately five days after it had occurred. We asked the manager what action had been taken about this but staff had not made the manager aware. We told the manager to report this to the safeguarding team and to ensure that the person was safe while investigations were completed.

This was breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people had not been protected from abuse and improper treatment.

The registered provider explained that a staffing tool was used to establish the staffing levels required to meet people's needs. This tool looked at the number of people living in the home together with their level of need. This information then produced a guideline for the number of care staff hours required to meet people's needs. The registered provider confirmed that the current staffing levels were provided in accordance with those indicated by use of the tool.

The manager had recently introduced a formal system to allocate specific roles and responsibilities to staff on each shift and they believed that this was helping staff to work better as a team and create routines that were more efficient in meeting people's needs.

A large proportion of the people living in the home had high levels of needs. There were occasions during the inspection where we observed people waiting a long time for assistance because staff were already supporting other people. At one stage we saw a member of staff had to be taken off their break to support the manager with moving and handling because there were no other staff available. The manager confirmed that they were aware of this issue and reviewing how best to address it.

There were satisfactory systems in place to ensure that staff were recruited safely. Recruitment records showed that the service had obtained proof of identity including a recent photograph, a satisfactory check from the Disclosure and Barring Service (previously known as a Criminal Records Bureau check) and evidence of suitable conduct in previous employment or of good character.

Inadequate

Is the service effective?

Our findings

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 make decisions for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when required. 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.

During the last inspection we found that the service was not working in accordance with the principles of the MCA. At this inspection we found that no improvements had been made. This meant that the service had continued to fail to ensure that people's rights were promoted and protected.

Discussions with the manager and staff revealed that they did not understand when the principles of the MCA should be used or the process they should follow to ensure, and demonstrate, that any decisions made in the case that a person lacks capacity, are done so in their best interest. For example, some people lacked capacity to consent to support with personal care, moving and assisting, administration of medicines or other day to day activities. MCA assessments had either not been completed or were not fully completed. There was no evidence that Best Interest meetings had been held and where there were records of a Best Interest decision, these lacked evidence that the complete process had been followed and the reason why a decision was deemed to be in the person's best interest.

At the last inspection we identified that people had not been asked whether they had a preference for the gender of the staff who provided personal care to them. Where people had lacked the capacity to make this decision for themselves, the requirement of the MCA had not been followed. Both at the last inspection and at this inspection we noted that care staff were providing personal care, including intimate care, to people of the opposite gender who were unable to communicate their choice about this. Care staff also told us at both inspections that they were not aware that anyone had objected to receiving care from staff of the opposite gender so it was assumed that this was acceptable to the person. There was still no information about the choice of the gender of staff in people's care plans.

These shortfalls were a repeated breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 suitable arrangements were not in place to ensure that the service acted in accordance with the Mental Capacity Act 2005.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

During the last inspection we found that the home was not meeting the requirements of the Deprivation of Liberty Safeguards and people's rights were not being protected. There were conditions attached to the DoLS authorisations for two people living in the home. These conditions had not been complied with.

During this inspection, discussions with the manager, staff and health professionals highlighted that there were people living in the home who may have been deprived of their liberty. Some people had previously had DoLS authorisations but these had expired and the service had not applied to have these reviewed and/or renewed. For other people, applications had not been made at all. Neither the manager, staff who had preceded them, nor the registered provider had submitted applications to the managing authority to enable full assessments to be carried out. In addition, the conditions attached to the authorisations for two people in the home, which included being supported to go outside at least once a week, had not been complied with. We reported this to the relevant managing authorities.

This means that we cannot be confident that the provider and their staff are aware of their duties and responsibilities under the deprivation of liberty safeguards and that people's human rights are respected. Some people may have been illegally deprived of their liberty.

This is a repeated breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the service had not followed the requirements of the Deprivation of Liberty Safeguards.

At the last inspection, people did not receive support from staff with the knowledge and skills they needed to carry out all aspects of their roles. Most staff had completed basic dementia awareness training but we saw that they lacked skills to provide the specialist dementia care that the registered provider's Statement of Purpose stated was provided. For example, some people needed positive behaviour support from staff because they were living with dementia. Some staff told us they did not feel equipped to support people with behaviour that challenged other people and supervision records also reflected this. Training records showed that only 11 of the 22 care staff, had completed this training. At this inspection we found that no further training in positive behaviour support had been provided and that the validity of training for two of the staff who had completed the training had expired.

At this inspection we found that progress had been made in ensuring that all of the staff had appropriate skills, knowledge and training to deliver safe, person centred care with confidence. The registered provider confirmed that three staff, including the new manager, were completing an accredited level 2 course in the Principles of Dementia Care, which included a unit on "understanding behaviour" and another member of staff was completing an accredited level 2 course in Understanding nutrition and health". Another member of staff had completed a one day course in leadership and management. They also confirmed that the moving and handling training provided for staff had been reviewed and updated and had been launched at the beginning of May 2018. Three staff, including the new manager, had undertaken this training by the last day of our inspection.

Skills for Care is a national organisation that sets the standards of knowledge and competency that people working in adult social care require. In order to support employers to keep staff up to date it has produced a guide about the topics and frequencies that staff should have their competency assessed, and their skills and knowledge refreshed. Staff were provided with a one day annual refresher course covering health and safety awareness, safeguarding adults, infection prevention and control, MCA and DoLS, and equality and diversity. All except one of the staff had up to date training and a course had been booked for the one staff member whose training was overdue. At the last inspection we highlighted that this training did not cover all of the recommended areas but this had not been addressed at this inspection. The areas that staff had not received regular assessments and training in included positive behaviour support and non-restrictive practice, end of life care, fluids and nutrition, food hygiene, person centred care, communication and recording and reporting.

At the last inspection some of the people in the home were living with conditions such as epilepsy, Parkinson's disease and diabetes as well as other common conditions. One member of staff had completed training in diabetes and the registered provider had advised us that information about these conditions was available in the home.

At this inspection we found that the staff member who had completed diabetes training was no longer working at the home. A folder containing information about various conditions did not contain information covering all of the conditions people in the home were living with. This meant that staff may not have a full understanding of the range of conditions that people might be living with or be competent to offer appropriate care and support.

Supervision of staff is important to enable them to discuss their work, resolve any concerns and plan for any future training they need or are interested in undertaking. At the last inspection, we found that staff had not received adequate supervision. At this inspection we found that some, but not all, of the staff had received supervision since the last inspection. The new manager confirmed that they were putting a plan in place to address this. In addition, the new manager was addressing issues with staff as they arose and recording these as ad hoc supervisions. Staff confirmed that they were aware supervision was being planned and reported that they felt supported by the new manager and found them easy to approach. The registered provider confirmed, on 25 June 2018 that only four out of 29 staff were now overdue for their next supervision and these were only a maximum of 24 days overdue.

These shortfalls were a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff were not supported with regular training and supervision.

A poor diet can lead to a deterioration in health and also make recovery from illness much harder and healing of wounds such as pressure sores more difficult.

During our inspection in January 2018, we found that people were not effectively supported to eat and drink and changes to their food and hydration needs were not identified through effective assessments and care planning. We highlighted that good practice in dementia care recommends that people should have free access to food and drink. People living at Reside at Southwood did not have access to drinks and snacks in between planned meals and morning coffee and afternoon tea breaks. We observed that when people sat in the lounge, or were in their rooms, there were no drinks sitting beside them to have a drink outside of these times. The registered provider later advised us that, "People at Reside Southwood could not get access to food and drink due to poor mobility. We did not purposely displayed drinks as there are a couple of residents who will tip the drinks over. However, the staff were always at hand to offer food, snacks and drinks."

No changes to the provision of snacks and drinks had been made at this inspection. Care plans had not been reviewed and updated. The service ensured that people were weighed regularly. Staff updated a malnutrition risk assessment tool when people were weighed to show the level of risk for each person. Some people were at high risk of malnutrition and also had very low body mass index ratings. This information had not been used to develop a care plan to try to improve people's nutritional intake or prevent malnutrition. There was no evidence that the service had requested appropriate support from a GP or dietician and staff were unable to confirm that this had been done. We requested that the manager contacted the GP to request dietician support and made safeguarding referrals to the local authority regarding unplanned weight loss for 16 people.

Through discussions with care and kitchen staff we ascertained that foods were fortified with higher calorie

items such as butter, full fat milk and cream. One of the roles of the deputy manager was to liaise with kitchen staff to ensure that they had up to date information about people's dietary needs. Records of what people ate were being kept. It was not possible to confirm from the records that the foods had been fortified as required. In addition, records often showed that people had eaten very little but there was no evidence that alternative meals had been offered or that additional support such as from a dietician had been requested.

Previously, we highlighted that meal times in the home were busy with a high proportion of people requiring assistance and supervision. We also found that the planning and management of meals was chaotic and unstructured which lead to people experiencing delays from arrival in the dining room to when their meal was served and also from when their meal was served until staff were available to support them.

We observed two lunch times during this inspection. The process for supporting people to come to the dining room and have their meals had not changed. People either made their own way to the dining room when prompted by staff or those with mobility difficulties were assisted there by staff before they began to serve the meal. This meant that some people waited at the dining table for more than half an hour before the meals were brought to the dining room in a heated trolley. Meal times were quiet with little interaction between people and staff except for task focussed interactions such as offering choices of meals or trying to prompt people to eat.

People were offered a choice of two items for each course. Meals were presented to people on a plate and staff also explained what the meal was to support people in making their own decisions where this was possible. As at the last inspection, staff served meals to people from a list of names rather than by table order. This meant that some people on a table had to watch other people at that table eating but had no food to eat themselves. People were still having to wait up to 20 minutes to receive their food from the time that staff started to serve meals. Again, we noticed that some people ate very little and staff removed their unfinished meals without offering them support or suggesting other foods which may have encouraged them to eat.

During the last inspection we noted that no one was offered salt, pepper or any other condiments. The registered provider later stated that food is seasoned in the kitchen and some people did have salt and pepper on their table or in their rooms. They also stated that condiments could not be left out because some people may drink them or put them in their drinks. Also, people who needed support from staff to eat had their meals placed in front of them but they then had to wait up to 30 minutes before staff were available to assist them. During this time, they sat with the sight and smell of food around them and watched other people eating.

At this inspection some staff offered people salt and pepper, checked if meals required heating up and took time to chat with people but this did not happen consistently.

At this inspection we noted that plate guards were provided for some people but we did not see any adapted cutlery offered to or used by people which would have meant people were better able to hold and use their cutlery. One of the meals during the inspection contained spaghetti. One person we observed was given a desert spoon to eat it. The spaghetti had not been cut up and there was no rim on the plate or plate guard for them to push against to help them load the spoon. Prior to their meal being served to them staff had placed a disposable clothes protector on them but had not tied it properly. When the person leant forward to eat their food the clothes protector slipped off. The person struggled to load their spoon properly and the spaghetti slipped off their spoon and landed on their clothes. The person tried to remove this from their clothes and clean themselves. They then resorted to eating their food using their fingers. A member of

staff later came and cleaned the person's hands, reminded the person to use the spoon and left them alone again. Following the inspection, the registered provider advised us that there is adapted cutlery in the home, and that those that have been assessed to require this equipment are provided with it. They also explained that some people prefer to eat with their fingers rather than a spoon. However, we did not see a suitable meal provided for people who may prefer to eat without using cutlery.

During the inspection in January, we found that people may not have been receiving enough support to remain hydrated. Where they were at risk of dehydration, people's fluid intake was not recorded and there was no information in care plans about what to do if people failed to have sufficient fluids. There were no entries in the daily records that action had been taken to encourage people to drink more.

At the start of this inspection, we found that no improvements had been made to care plans for hydration and in particular to recording people's fluid intake. We highlighted this as an urgent concern on the first day of the inspection because some people were very frail and it appeared they were not being given sufficient fluids. During the second day of the inspection, the manager had implemented a new system that included target amounts for people to drink over a 24 hour period. The manager had also improved the recording system for fluid intake. This included the total amount a person actually drank over each 24 hour period. However, we found that no system to review the information gathered had been put in place. This meant that records showed that people had not met their fluid targets and in five cases had a very poor fluid intake but this had not been recognised and no action had been taken. By the last day of the inspection, the manager had amended the system to ensure that a senior staff member reviewed all records once a day and any action taken was recorded.

People's healthcare needs were not always met. The need for support from health professionals such as dentists, podiatrists and dieticians was not always requested and followed up.

Some people received visits from podiatrists but we found people at this inspection who had not been visited and required support. One person requested help to receive a visit from a podiatrist during our inspection and we highlighted this to the manager.

Daily notes and a complaint referred to incidents where people had concerns about their teeth or dentures. One person had made a complaint that their relative's dentures were broken and staff had not responded to this, other issues related to people's teeth not being cleaned effectively. We did not find evidence in any of the records that we checked, except for the person who's relative had complained, that people were registered with a dentist and received regular preventative care and check ups.

District nurses had not always been informed as soon as people's skin showed signs of pressure damage and consequently, when district nurses were called in, pressure sores had already developed. In addition, health care professionals visited the home as part of a safeguarding investigation and found that support from occupational therapists had not been requested to ensure that correct moving and handling equipment was provided and safe practices were followed.

This was a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people's nutrition and hydration needs were not being met. Advice from health care professionals was not always sought or followed up, to ensure people received care in a safe way.

National good practice in dementia care such as that produced by the University of Stirling's Dementia Service Development Centre suggests that buildings accommodating people living with dementia should be designed and decorated in a way that supports people. For example, doors should be in a contrasting

colour as should toilet seats and handrails and there should be easy to read signage. Most people had a photograph of themselves on their bedroom door and there were pictorial signs on bathroom and shower doors. Since the last inspection, handrails had been painted in a bright contrasting colour, new toilets seats, also with contrasting colours had been installed and the dining room had been redecorated.

We recommend that actions continue to be taken to review the accommodation with regard to best practice guidance about creating dementia friendly environments and to meeting people's physical care needs.

Inadequate

Is the service caring?

Our findings

During our last inspection in January 2018 we found that people were not always treated with dignity and respect.

At this inspection we found that there had been no improvement. Although there were fewer people living in the home than at the last inspection, many people's level of need had increased and staff were still working in a task focussed way rather seeing each person as an individual with different needs and preferences.

Some staff continued to have a friendly and relaxed way of communicating with people and this meant some people laughed, smiled and responded positively to them. However, our observations showed that not all people were treated in a respectful way.

At the last inspection we observed staff ignoring people or failing to respond to them. At this inspection we observed staff ignoring people who were trying to gain their attention; during one of the lunch time meals we observed, a person had finished their drink. They had very little verbal communication but each time a member of staff entered the room or walked near them, they banged their beaker on the table. There were more than five occasions where this happened and staff did not respond to them. The registered provider later stated that, "we know the residents' habits, and behaviour, we can confirm that this particular resident will be tapping hands and feet listening to their favourite tunes". However, we did not hear any music playing during the meal time.

At this inspection we spoke with one person who we knew had a poor appetite and had lost weight. We asked them, if they could request any meal from the kitchen, what they would ask for. They told us they would like to have ham, egg and chips and entered into a light-hearted discussion about which sauce they would chose to have with the meal. Two staff happened to come to the person's room as we were having the conversation about this and the inspector told the member of staff what the person would like to eat. The member of staff responded to the inspector and not to the person themselves and said, "there's no point, [the person] wouldn't eat it."

At our inspection in January 2018, we found that people were being supported to move from wheelchairs to an armchair or from a wheelchair in the lounge through to a bathroom off the lounge with other people watching and although there was a privacy screen in the room, this was not used. The registered manager stated that there were plans to alter the layout of the lounge and toilet area to address the issue.

During the first day of this inspection we noted that this practice was still taking place. One person was observed to be transferred without the use of the privacy screen and this was raised with the manager. Visiting health professionals complied a report about moving and handling practice in the service. They found that portable screens were not used to protect people's dignity when they were being supported to move using a hoist. In addition, they found that either before or after dinner people were lifted using a hoist into a wheelchair, moved across the room, then lifted using a toileting sling in full sight of others over the raised threshold of the bathroom, and onto the toilet. They raised concerns about the dignity or privacy

afforded to people, and possible risks of injury to the person, staff or others.

In addition to this, inspectors and health professionals heard, on different occasions, one of the people living in the home who was watching people transfer to the bathroom say, "Hold your noses, we all know what to expect now". (This is a paraphrase of the person's actual comment).

Also at the last inspection, we observed that staff were addressing people by different names; the registered manager confirmed that these people had nicknames as well as their given name. For one of these people, records clearly stated that they wished to be known as their nickname and not their given name. The person was living with dementia and may find it difficult to be addressed by two different names. This was also the case with the other person. When we discussed this with staff they were unaware that people had specified how they wished to be addressed. During this inspection we found that this was still the case.

This is a repeated breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014 because people's dignity was not promoted and protected.

Inadequate

Is the service responsive?

Our findings

At the last inspection in January 2018, we found that care plans did not contain up to date, detailed information about people's needs and the support that staff should provide to ensure that their needs were met.

As at the previous inspection, all of the care plans we looked at during this inspection contained omissions or inaccuracies, either because initial assessments had lacked detail or because people's care needs had changed and these had not been reflected in assessments and care plans.

People were still not receiving the care and support that they required. For example, people were not having baths or showers, foot care or oral care or had not received appropriate personal care to meet their needs. One person told us that their toe nails were painful and that they had not been seen by the chiropodist. The person's fingernails were also long and dirty and staff had not attended to this. Three other people were found to have dried, impacted faeces under their fingernails. Another person had vomited during the previous evening. We visited them the following afternoon and found they still had dried vomit on their face and neck.

A further person had lost weight. Staff told us that the person had chosen not to wear their dentures and this meant they were only able to eat soft foods. Staff also told us that, because the person was living with dementia, they were not always able to communicate why they chose to do some things. There was no information in the person's care plan about this. The service had not consulted a dentist to establish if there was a problem with the dentures and, if this was the case, whether the person may have been able to have a diet that was more suited to them. The registered provider later advised us, "The resident chose not to wear her dentures. We have taken this into account and offered soft food as an alternative diet."

During the previous inspection we did not observe any baths or showers taking place. Records stated that people had received strip washes but we could not find records of baths or showers. Staff confirmed that they rarely helped people to bath or shower and it was general practice for people to have strip washes only. The registered manager said that this was not the case and people did have baths and showers. Again, at this inspection, we did not observe any baths or showers taking place and records referred to strip washes and not baths or showers. Some staff told us that people enjoyed a bath or a shower but could not tell us when they had last supported someone to have a bath or shower. Two health professionals who spent four days in the home, confirmed that they had not witnessed anyone having a bath or shower during their visits. They also advised that there was no suitable showering or bathing equipment in the home to enable those who needed hoisting to be bathed or showered safely.

A number of people at Reside at Southwood were living with diabetes. At the last inspection we advised that care plans should indicate the type of diabetes they had, outline what the condition meant to the person, how it affected them, how it may progress and any risks such as high or low blood sugars, or other possible complications.

At this inspection we found that improvements had been made to care plans but the instructions and guidance in the care plan were not being followed. For example, one person who was living with diabetes had been given five biscuits with their coffee in the morning. Their care plan stated that they should be given a soft diet. It also stated, "staff will need to monitor sugar intake and provide alternatives to sugar". We also noted that this person had fluctuating capacity, had gained more weight despite already being overweight and had developed a pressure sore. Discussions with staff showed that they did not appear to have considered or understood the negative impact that high blood sugars may have on the person's health and wellbeing or be aware that biscuits would not be an appropriate snack for someone who should have a soft diet.

Care plans had not been reviewed and updated to ensure that areas highlighted for attention at the last inspection were addressed. For example, there are a number of different types of dementia that will affect people in different ways such as causing auditory or visual hallucinations. There was no assessment of people's needs and indicators that they may be experiencing this. Other people had been diagnosed with serious mental health conditions, Parkinson's disease and epilepsy. Again, there was no information or guidance for staff in care plans about these matters.

At this inspection staff again reported that some people can occasionally display behaviours which can be challenging to others. We saw that some of the staff had developed particular methods to help and support people. We also saw that some of these methods may not have been known about by all staff. For example, one person was very distressed and refusing to allow two of the staff to support them. Another member of staff arrived with a different approach and was able to both calm and reassure the person and provide the required support very quickly. Care plans did not include this type of information which, had all staff been able to access and understand this, may helped the situation to be resolved with greater speed and less distress to all concerned. The registered provider later advised that care plans did include this information. However, the specific records checked during the inspection did not contain this information.

The service employs an activities organiser from Monday to Friday for six and a half hours a day. Included in the activity organiser's duties were serving coffee in the morning, helping with meals at lunchtime and serving tea in the afternoon. At the last inspection the activities organiser was developing a range of activities and resources which were available in the dining room. They also carried out art and craft sessions and baking during that inspection. During this inspection there was visit from some entertainers on one of the afternoons. The activity organiser also spent time with people on a one to one basis and tried to lead discussions about articles in newspapers or people's memories of events such as Victory in Europe day. Later, during the inspection, the activities organiser also reported that they and a member of staff had escorted two people for a short walk to the cliff top for half an hour. Information in care plans contained very little information about people's previous interests or hobbies. The activities organiser said they were trying to obtain this information from family members when they visited and was aware that it was good practice to provide activities for people based on their personal preferences. However, the programme of activities was based on general activity provision and there was little evidence of person centred activity based on people's preferences taking place.

Throughout the inspection, care staff remained task focussed and we observed very few activities for people that were not initiated by the activities organiser. Most people spent their time in chairs in two lounges, one contained a television and the other mostly had soft background music playing. In the lounge that contained the television, many of the chairs were not positioned to enable a good view of the programme that was playing. Some people also sat in their wheelchairs in the dining room for long periods of time outside of meal times. We tried to confirm with them whether this was their choice but were unable to do so. Some people were given magazines to look at but other people sat for long periods with nothing to

occupy them or to look at, touch or hold.

Some people spent long periods of time in their bedrooms. We were told this was either by choice or the need for them to have rest at different times of the day. The people we visited in their rooms did not have any stimulation, did not have anything to look at or watch or anything to hold, feel or occupy them. The type of closure fitted on the fire doors to bedrooms also meant that doors could not be left open. Visiting health professionals identified that there was a risk that people may experience feelings of isolation in this situation.

At the last inspection, whilst no one was requiring support at the end of their lives, we noted that care plans had contained little or no information about people's wishes for end of life care and support if they should require this whilst at the home. This meant there was no information about what was important to them to ensure a dignified end of life such as visits from family or religious ministers, the personal care they may need or how pain could be managed. Two people were placed on the end of life care pathway by health professionals during this inspection. Neither of the people's care plans had been reviewed following this change in their needs. This means that staff were, again, not given enough guidance in order to meet this important area of need.

At this inspection, we found that many of the people living in the home needed special equipment to support them. This included wheeled, height adjustable commodes, specific moving and handling equipment, equipment to help them change position, special beds or rails and bumpers for their beds and different armchairs or other furniture. The service had not carried out appropriate assessments that recognised that this equipment was required. A report was also shared with CQC from health professionals which highlighted these shortfalls along with other concerns about moving and handling practice in the home. The registered provider has since confirmed that new equipment has been purchased following the guidance they received.

This was a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because proper steps had not been taken to ensure that people received the care, treatment and support they required to meet their needs.

The service had recorded that they had received two complaints since the last inspection. Records were not always consistently completed. Records showed the complaints had been acknowledged with the parties involved but not all of them showed if a conclusion had been agreed and actions had been completed. We discussed this with the registered provider who told us all complaints had been fully resolved. We recommend the provider ensures a full audit trail is followed in accordance with the provider's complaints policy.

Inadequate

Is the service well-led?

Our findings

The service was not well led. During our inspection in January 2018 we found that arrangements to monitor the quality and safety of the service provided were not effective. At that inspection we found breaches in nine regulations. Audits and management processes had not identified any of the issues found at that inspection. After the inspection, the registered provider advised us that the registered manager was no longer employed at the service.

Following that inspection there was correspondence with the registered provider regarding the shortfalls we had found and the actions that must be taken to ensure that people received good care and treatment and all of the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were complied with. The registered provider submitted assurances that steps would be taken to address the shortfalls and created an action plan, with timescales, to demonstrate what action would be taken, by whom and when. An interim operations manager was employed to lead the service and direct the improvement work that was to be undertaken. The interim operations manager left the employment of the registered provider in March 2018. Also, in March 2018, the registered provider appointed a new manager for the service with the intention that they become the registered manager.

At this inspection, only one of the breaches that were found during the January 2018 inspection had been addressed. All of the other breaches have been repeated and we have again made safeguarding alerts to the local authority. Some of the areas for action that had been highlighted in the registered provider's action plan, such as upgrading the fire protection system, redecorating parts of the home and reviewing emergency arrangements had been addressed and within the registered provider's timescale. Other areas including reviewing falls risks and implementing measures to minimise falls, ensuring care plans provided detailed, up to date information and guidance, had not been completed. These areas had passed their target dates for completion.

Systems to assess and monitor the quality of the service and to identify, mitigate and reduce risks had not been implemented effectively. For example, there was no evidence that accidents and incidents, including falls had been reviewed to assess whether the number of falls had reduced. Any audits which had been completed, such as the medication audit, had not identified any shortfalls. This was contrary to our findings. The registered provider has confirmed that, following this inspection, "Risks of falls has been re-assessed and new measures put in place and number of falls has certainly come down."

When issues were identified during our inspection, the manager took action to address issues such as immediately changing the way people's food and fluids were recorded. Senior staff were clear, when we discussed this with them about why this was done and what should be recorded. However, some of the care staff told us they were not always confident about what to record and found the frequent changes to systems difficult to follow whilst still keeping up with their work.

The registered provider had provided resources to undertake works to the fabric and furnishing of the building and to review policies, procedures and staff training. However, action was still required to improve

the day to day delivery of people's care and support. These shortfalls had impacted on people's safety, health, quality of life and wellbeing.

There was a varied response from the registered provider and manager to specific feedback from professionals such as safeguarding practitioners, district nurses and occupational therapists. Some items were addressed promptly including the purchase of new equipment but other issues such as reviewing all pressure relieving equipment and ensuring the correct items for this were in place, were not addressed within suitable timescales.

The provider's statement of purpose for Reside at Southwood states that "Reside aims to provide a person-centred service for older people with any form of dementia." Their website states, "We specialise in providing care and support for those with varying degrees of dementia." At the last inspection we identified shortfalls in how the service provided care for people living with dementia. At this inspection we found that steps had been taken to improve the environment for people by providing coloured handrails in the corridors and coloured toilet seats. However, the service had continued to fail to provide person centred care, ensure that people's consent was lawfully obtained, care for people safely and with respect and dignity, ensure appropriate safeguarding procedures were in place, and ensure good governance of the service.

The registered provider and manager confirmed that they continued to gather feedback from people, relatives and friends on an informal, day to day basis but no formal quality assurance exercise would be completed until they felt that all of the outstanding issues had been addressed and sustained.

There were still weaknesses in record keeping, within a range of documents including care plans, medicines records and audits. Some records were illegible. Some records lacked detail and information or included inaccuracies and omissions. Other records, such as care plans, contained out of date information as well as current information, but it was not always easy to establish which information that staff should be following.

This was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because effective systems and processes had not been established to assess, monitor and drive improvement in the quality and safety of services provided and because accurate records were not maintained.

As at the last inspection, with the exception of notifications about people who had passed away whilst living in the home, we had not received notifications about a number of other events and incidents. There were at least two significant injuries/wounds and a number of safeguarding concerns which had not been reported.

Registered persons are required to notify us of any allegations of abuse at the home. The local authority had made us aware of allegations of abuse that had been investigated by them since the last inspection. However, we did not receive any notifications about allegations of abuse from the registered provider or manager.

This was a repeated breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 because the registered provider had not notified us of all incidents.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider had not notified us of all incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity was not promoted and respected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Arrangements were not in place to ensure that the service acted in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People had not been protected from abuse and improper treatment and the service had not followed the requirements of the Deprivation of Liberty Safeguards.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care	Staff were not supported with regular training and supervision.