Healthcare Homes (LSC) Limited

The Chase Care Centre

Inspection report

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Tel: 01923232307

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out a comprehensive, unannounced inspection at The Chase Care Centre on 12 September 2018.

At the last inspection, on 24 April and 3 May 2018, we asked the provider to make immediate improvements in some areas of the care and support people received. These areas were in relation to risk management for people, safeguarding systems and processes, training, consent to care, personalised care, dignity and governance systems.

The inspection was carried out to follow up the breaches of regulations 9,10,11,12,13,14, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 found at the last inspection and to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.We found the provider had worked hard to improve the service to people living at the home, with significant improvements to staff training, staff supervision, safeguarding people from harm, staff knowledge and practices in relation to DoLS (Deprivation of Liberty safeguards) and DNACPR (Do Not attempt cardio pulmonary resuscitation) and the standard of meals provided.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

The Chase 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.

The Chase Care Centre is registered to provide personal and nursing care for up to 110 people aged 18 and over with a range of complex health and care needs. At the time of our inspection, 67 people were using the service.

The Chase Care Centre is divided over three floors and accommodates people within six separate units, some of which have adapted facilities. The service supports people with complex nursing and residential needs which included supporting young people with brain acquired injuries, people with mental health needs, physical needs and people who are living with dementia. At the time of this inspection one unit (Churchill) was closed for renovation work to be completed.

A new manager had been appointed since the last inspection took place in April 2018 and was in the process of applying to become registered with the Commission. A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run.

At this inspection we found that improvements had been made, however we found some areas were still developing and required improving to ensure people safety was maintained and protected from the risk of harm.

Risks to people`s well-being and health were identified and assessed but not always mitigated in a way that maintained their safety.

People's end of life care needs and people`s wishes, likes and dislikes had not always been assessed or considered when staff developed or reviewed care plans.

We have made a recommendation about an adjustment to the current care plans in place.

Staff demonstrated they had the knowledge to identify potential abuse and the process for reporting concerns. Notices and information was displayed throughout the service informing people, staff and visitors how to report concerns and relevant contact numbers for external safeguarding authorities. Referrals to local safeguarding authorities and CQC were done in a timely manner.

Where people were assessed as requiring a fortified diet to help reduce the risk of malnutrition we found that staff were knowledgeable and the kitchen staff who were aware of people's individual dietary needs. However, we found that records relating to the amount of fluids people had consumed were not accurately recorded.

Where people had pressure relieving equipment in place to help prevent the development of pressure ulcers, we found that all the necessary checks and records were up to date and accurate.

Infection control measures were in place. Staff were observed to use personal protective equipment, including the use of gloves and aprons while supporting people with personal care. People's medicines were managed safely. Medicines were stored safely and administered by trained staff.

People who had complex health care needs had been assessed and care plans developed to provide guidance to staff but we found that these were not always implemented to ensure people`s health and welfare was maintained at all times.

People had mixed views with regard to being involved with developing their care. Some care plans contained inaccurate and out of date information which required updating to reflect people`s current needs.

People were asked for their consent to the day to day care and support they received from staff. We observed staff assisting people and communicating with them and asking for their involvement in the task.

We found that staff failed to respect and maintain people's dignity and privacy.

The principles of the Mental Capacity Act 2005 (MCA) were followed by staff and where Deprivation of Liberty Safeguards (DoLS) authorisations were in place, with conditions listed on the restrictions to people`s freedom, plans were in place to meet these and keep people safe.

Staff received support through induction and a training programme with a mixture of distance learning and face to face training. We found the training provided had improved since the last inspection was carried out in relation to both specialist training and mandatory training had also been updated.

Recruitment processes were robust and ensured that the staff employed were suitable to work in this type of care setting.

We found the standard and choices of meals provided had improved and where necessary staff had referred people to specialist support in cases where they were at risk of malnutrition.

The atmosphere at The Chase Care Centre had improved since the last inspection and felt more welcoming and calm. However, on the day of this inspection there was only one activity staff member to provide activities to 67 people. People who spent time in their bedrooms were at risk of social isolation. This is an area that requires improvement.

People told us that they felt more confident in raising any concerns they may have since the new manager started at the home.

We found the systems now in place to provide an overview of the service and monitor the quality of care and support provided had improved.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Although people`s specific health conditions were assessed and guidance was in place, staff did not always implement these in order to maintain their health and well-being.

People were protected from the risk of harm by staff who had a good knowledge about safeguarding procedures.

There were sufficient staff deployed to meet people`s needs in a timely way.

Incidents identified and reported to managers were analysed, escalated and reported to external safeguarding authorities.

People were protected from the risk of infections by staff who followed infection control measures and used personal protective clothing when needed.

People received their medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Although there are plans to improve the environment, the home remained stark and uninspired especially for people who live with dementia.

People`s dietary needs were monitored but their fluid intake was not always monitored or recorded.

Training and supervision provided to staff had improved

Staff ensured they obtained people's consent before providing care and support.

The principles of MCA, DoLS and DNAR's were known to staff. Where DoLS authorisations were in place with conditions attached these were met.

People were supported to access health care professionals as needed to help ensure that their health and well-being was maintained.

Is the service caring?

Requires Improvement

The service was not always caring.

People mostly received care and support from staff in a kind way however people's dignity and privacy was not always respected or maintained.

Staff were not always aware of people`s likes, dislikes, preferences.

People had mixed views about being involved in their care planning and review meetings.

Confidentiality was maintained.

People`s records were kept locked and secure.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always reflect people`s likes and dislikes

Some care and support was still delivered to people, in a task orientated way.

People`s care plans did not always provide detailed guidance in order to give staff sufficient information to meet their needs effectively.

The current activity programme continues to fail to provide opportunities for people to engage in their social interests, hobbies and pastimes.

People who lived with life limiting conditions had a plan in place for staff to know their wishes and preferences but it did not always record the care they should receive nearing the end of their life.

People told us they were now confident that their complaints would be dealt with appropriately and everyone knew who the manager was.

Is the service well-led?

Requires Improvement

The service was not always well led

Auditing systems require further development to ensure people`s care records are monitored, kept updated and provide sufficient details in order for staff to know how to deliver care and support to people in a safe way.

People and staff told us the manager was responsive to their needs.

The providers governance systems had improved and were more effectively used by the manager to constantly review ways to improve the service people received.

Staff were aware of their roles and responsibilities and felt listened to and valued by the manager and provider.

Staff were supported through regular supervision and staff meetings.

People told us their views were obtained through satisfaction questionnaire's.

The Chase 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

This inspection was carried out on 12 September 2018 to assess if the provider made the improvements they told us they were going to make following the inspection we carried out on 24 April and 3 May 2018. The inspection was unannounced.

The inspection was carried out by three inspectors, two specialist advisors 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 service. The specialist advisors were both registered general nurses with a wealth of experience in the field of nursing care.

Before the inspection, we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

As part of the inspection we spoke with 22 people who used the service, five relatives, seven staff members including, care staff, staff working in the kitchen, nursing staff, unit leaders and members of the management team. We also talked to one member of the provider's senior management team. We looked at care plans relating to seven people and four staff files.

We used the short observational framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not communicate with us. We also looked at other care records such as turning charts, food and fluid charts, monitoring charts and other records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

When we last inspected this service, we found that people were not provided with safe care and treatment. At this inspection we found that this had improved, however not all care plans we reviewed provided accurate or up to date information which may place them at risk of harm.

People told us that they felt safe living at The Chase Care Centre. One person we spoke with said, "I've no complaints, there is always someone here to help you. It's fine, it's improved and I do feel safe here." When we asked the person what in particular had improved, they told us, "They seem to know what they're doing now and they're able to talk to me about my health and care if I ask." They also told us "They know how to use my equipment safely. I don't need a hoist, but they know how to support me when I need to move from my wheelchair to my bed." A relative we spoke with told us, "[name] definitely feels safe here and they are always clean, well presented, they look after you, and I can see [name] is happy." This relative also confirmed that they considered the staff at the home knew how to hoist their family member safely and had observed this on several occasions when they visited and told us, "They (staff) are always very careful and make sure [name] is safe and comfortable."

At the last inspection we found not everyone in the home had a Personal Emergency Evacuation Plan (PEEP) in place. Although at this inspection we found that these records had been updated and improved, there still remained some inconsistencies within these documents that could place people at risk of harm. For example, one personal evacuation plan stated that the person required two staff to assist them with all moving ad handling procedures but in the care plan it stated that they required three staff when being hoisted. On further investigation we also found the hoist was faulty and therefore could not be used. We checked the evacuation plan for another person and again found it stated that this person required two staff to assist them, however, in the care plan this person had been assessed and requiring three staff to assist with all moving and handling procedures. This is an area that requires improvement.

We noted in one person's care plan that the individual Percutaneous Enteral Gastrostomy (PEG) feeding regime stated that this person was nil by mouth but in another part of the plan the guidance stated they required a 'pureed diet'. This was raised with the deputy manager immediately for their attention.

We reviewed another care plan of a person who also had a PEG (Percutaneous Enteral Gastrostomy) feed and who was under the care of the dietitian and Speech and language therapist (SALT). The plan stated that they were to be provided with an 'Oral soft and fortified diet' through the day and receive their liquid diet through their PEG feed from between the hours of 8p.m and midnight. However, the care passport record, which would accompany the person if they needed to go to hospital advised that they were 'nil by mouth' (NBM). These inconsistencies could place people at risk of harm.

We found that people's nutritional records had been improved since the last inspection took place. MUST assessment tools were now used to assess risks to people's individual nutritional needs. We checked the records for people who had been identified at high risk of malnutrition and poor fluid intake. We were told that for these people had a daily record in place which recorded all their fluid intake over each 24-hour

period. However, we found inconsistencies within people's records with regard to the amounts people had consumed as these were not measured or recorded, but simply written as 'one cup of water' or 'half a cup of tea'. We reviewed four care folders which had pictorial guidance for staff however, the photographs were outdated and did not reflect the drinking vessels currently used in the home. This meant that an accurate record of people's fluid intake could not be reconciled to ensure people had received adequate amounts of fluid to maintain their health and well-being.

During this inspection we observed care staff moving people in their wheelchairs, but they failed to always ensure the persons' feet were secured on the footplates. We saw feet were being 'pushed' along with the chair and were at risk of harm as they were dragged along the floor. Staff were also witnessed to be 'reversing' and pulling people backwards in their chairs with no attention to their feet being dragged on the floor. This placed people at risk of harm and injury.

We found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks to people`s well-being were not sufficiently mitigated to protected them from harm.

When we last inspected the service we found that people were not always protected from the risk of harm and safeguarding incidents were not always reported or investigated by external safeguarding authorities. At this inspection we found this had improved. We saw evidence that confirmed staff had received additional training in safeguarding and were aware of how to report incidents of concerns. One staff member we spoke with said, "You always report your concerns and tell the senior immediately who reports it to the local authority safeguarding team." Another staff member told us, "Whistleblowing is if you suspect abuse or a colleague is doing something questionable, you have to report it immediately to your supervisor, your manager, safeguarding team or CQC."

We also checked the most recent safeguarding referrals and found that these had all been completed in line with the home's safeguarding policy. This meant that people were protected from harm by staff who had the knowledge, understanding on how to safeguard people and a process was in place that was both robust and effective.

Clinical risk assessments, for example wound management care were in place which were outcome led. We observed that staff members gave people the time they needed when they provided personal care to people. We reviewed four care plans of people who required bed rails to keep them safe. We found that all four plans had an up to date risk assessment in place and that these had been updated since the last inspection took place. We found that for people who required specialist equipment there was an up to date moving and handling assessment in place in conjunction with support and advice from the Multi-Disciplinary Team.

At the last inspection staff were unaware of the procedure to follow in case of fire. At this inspection we found that this had improved. All seven staff we spoke with were able to tell us what they would do if the fire alarm sounded, how they would evacuate people and where each fire zone was. We also found at the last inspection that that people were not always able to access their calls bells and in some instances people's call bells had been removed. We checked the call bells within all five units during our inspection and found each room had a call bell in place. For people who were unable to activate or use their call bells, staff carried out hourly checks which ensured their safety and well-being.

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records for people who had been identified at high risk of malnutrition and poor fluid intake. We were told that for these people had a daily record in place which recorded all their fluid intake over each 24-hour period.

At the last inspection we found people's medicines were not always managed safely. During this inspection we found this had improved. We completed medicine checks on three units of the home and found the administration and recording of people's medicines to be up to date and accurate.

We found that all 'as required' (PRN) medicines and 'homely remedies' (medicines which can be purchased over the counter) were administered safely and there was a clear protocol in place.

The home had a comprehensive medicines policy in place which gave guidance to staff on the safe management of medicines. Staff received regular competency assessments. We found that there were weekly medicine audits in place which ensured that any discrepancies were discovered at the earliest possible stage and rectified. Medicines that required cool storage were stored appropriately and accurate records maintained.

We checked the controlled medicines for three units and found that these were administered, recorded and stored appropriately. We saw that all records had been signed by two staff members. There were appropriate arrangements in place for the receipt and disposal of medicines.
The protocols in place gave administration guidance to inform staff about when these controlled medicines should and should not be given. This ensured people were given their medicines when required and in a safe and consistent way. We checked the records for one person who received covert medicines and found that that a DoLs (Deprivation of Liberty Safeguard) referral had been made and the home was waiting for authorisation from the supervisory body. There was evidence that the GP, the pharmacist and the person's representative had signed the consent form for the administration of these medicines.

Some people were identified as being at risk of developing pressure ulcers. We found that these people had specialist equipment in place to mitigate this risk. Records showed that people required to be checked at regular intervals. This included staff checking to ensure that the pressure relieving mattresses were set at the correct setting for their weight, in order to help prevent pressure ulcers. We checked a total of 42 air mattress pressures and found these to all be maintained at the correct setting.

At the last inspection we found that there were not enough trained staff provided to ensure people were cared and supported by experienced and competent staff. At this inspection we found the staffing levels had improved and there had been a significant reduction in the use of agency staff. On the day of this inspection we found that there was one nurse deployed on each of the five units, supported by between three and five care staff per unit. There was also additional management support provided which included a clinical lead, deputy manager and the manager on duty each day. The manager informed us that there was still an ongoing recruitment plan in place to fill the current nurse and care staff vacancies but that the use of agency staff has now been significant reduced.

We observed people had their needs met in the majority of cases but we found that during the busiest times of the day, such as lunchtime, staff appeared rushed and people had to wait for longer periods of time for staff to assist them. For example, we observed one person who called out for help for a period of 10 minutes before a staff member was able to respond to them. This is an area that requires improvement.

People gave us mixed views when we asked if there were enough staff to meet their needs in a timely way. When we asked one person if they considered there were enough staff to support and care for them they

replied, "No, it's a long time before I see any staff. I think there should be more staff." They also told us there were not enough staff at night. Another person we spoke with believed there was a shortage of staff. They said, "There's hardly anyone around sometimes, they spend time in people's bedrooms, I don't see anyone. Staff pass me for ages." However, another person told us, "You can always find someone, I've never had any problems finding staff. At night time, yes, then as well, there is always someone." When we spoke to a visiting relative about staffing levels at the home they told us, "It seems there is more than there used to be, they sit and chat more now." Asked if she felt their family member ever feels rushed by staff, they said, "I don't think so, obviously I'm not here in the mornings, that's when staff are most rushed I think."

Staff had completed mandatory infection control training. We observed domestic staff took pride in their work and we observed staff were very thorough in their cleaning duties. Staff followed the service's uniform policy and used protective clothing such as gloves, which decreased the risk of transmitting a healthcare associated infection. We observed good hand hygiene practice throughout this inspection. Wall mounted hand sanitizers were filled with gel and were available throughout the home, and also in the individual bedrooms used by people with high dependency needs.

Safe and effective recruitment practices were followed to help make sure that all staff were of good character, physically and mentally fit for the roles they performed and relevant checks were in place such as verifying references. Staff told us before they started working at the service they went through a thorough recruitment process where their employment history was explored, references were requested from their previous employers and a criminal records check was done to help ensure they were suitable for the roles they had to perform.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we found that staff carried out care and support without obtaining consent from the person. We also found where people who were unable to consent to their care being provided there was no evidence of best interest decisions recorded. We also found conflicting information within people's care plans with regard to Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) documentation. We also found that not everyone in the home was supported to receive a healthy and balanced diet.

At this inspection we found records that related to both assessing a person's mental capacity and DNACPR records had been improved and had been updated. Where a person had been assessed as not having capacity to consent to their care, there was a best interest record in place.

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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Previously we found that, although staff had received training in the Mental Capacity Act, not all the staff we spoke with had a clear knowledge in relation to MCA and DoLS and failed to offer choice to people or ask for people`s consent when they provided care. However, at this inspection we found staff knowledge had improved in relation to their understanding of DoLS. One staff member told us, "We have training in DoLS and we have that every year, we have to be able to demonstrate knowledge and awareness following the training and we are encouraged to question." Another staff member we spoke with said, "It's very important to make sure you ask the person's permission before you to start to provide care or support." We saw evidence that staff had received training in the Mental Capacity Act since the last inspection took place.

We looked at four care plans in relation to the person's consent records and found the consent to care and treatment was fully completed as well as the Best Interest decision recorded. This meant that people had received care and support that they or their representative had consented to. We also checked the DoLS register in place which had been updated and amended since the last inspection was carried out.

Staff were aware and able to describe why people's capacity was assessed and when a DoLS was put in place to help keep people safe. We noted from the last inspection that one person with an authorised DoLS in place had a condition which required all staff to be provided with specialist training in order to care and support this person with this complex medical condition. However, we found the home had previously failed to provide this training to staff. At this inspection we saw evidence that confirmed all staff had now received the necessary training to best support and care for this person and to help understand the complex behaviours associated with this life limiting condition.

Newly employed staff were required to complete a structured induction programme, during which they received training relevant to their roles, and had their competencies observed and assessed in the work place. One staff member told us, "I had an induction when I started a few months ago and found it thorough and beneficial. It gave me a good idea about the role and I learnt all about the home. I did my mandatory training too."

At the last inspection we found that staff had not been provided with the necessary training to carry out their role effectively and to ensure they delivered the best possible care and support to people. At this inspection we found that the training programme had improved, both with regard to mandatory training and specialist training such as supporting people who live with dementia and caring for people with life limiting conditions. Staff told us that they felt more confident with the recent training offered. One staff member told us, "I have had fire training, first aid and health and safety training." Another staff member told us that they had requested training in the Mental Capacity Act.

Staff said that staff meetings took place and that supervision was regular. One member of staff commented, "I have supervision every two months with my manager." They confirmed that this process is a two-way conversation meeting with the staff member and the senior staff member. Staff had the opportunity to contribute to their performance review as well as looking at their future learning and development needs. Staff confirmed they had regular opportunities for training and skills development.

At the last inspection we found that people had not been provided with a nutritionally balanced diet and that people's choices and preferences were not always respected or provided in relation to the meals they received. At this inspection we found the standard of meals had improved. One person commented, "It's very good and there is enough. We choose the day before, it's fine. There is an alternative menu if you don't like something you can choose one of these and you can go up to the kitchen yourself and request what you like." They told us that they are very happy with the food and meal arrangements. One relative we spoke with stated, "[Name] loves their food and likes the food at the home. I don't know about choice, I assume they're asked but I know [name] would let me know if there was something about it they weren't happy with."

We were informed by the manager that two new chefs had been appointed since the last inspection took place and this had led to an improvement in the standard of meals and the experience of mealtimes for people.

We found that at the last inspection the lunchtime experience for people appeared functional with limited engagement between the staff and the people who lived at the home. At this inspection although efforts had been made to improve this experience for people, which included the introduction of menus on the tables and more choices of meals and refreshments, staff were observed to still not engage with people when they assisted them with their meal. For example, we saw one staff member who assisted a person with their meal but failed to explain what the person was eating and offered no conversation throughout the whole mealtime. They also continued to give the person a mouthful of food before they had chance to finish the previous one. We observed that one person who had already started to eat their lunch was approached by a staff member who proceeded to put an apron around their neck with no discussion or respect shown as to if the person wanted this. We also observed one staff member standing over the person whist they assisted them with their lunch. This is an area that requires improvement.

We saw that, although people were assisted to dining room for their lunch to be served at 12.30, we saw they had to wait until 12.50 before being provided with their meal. This led to some people becoming anxious and distressed. For example, one person called out to staff and stated that they were hungry but we saw

they had to wait 10 minutes before anyone responded to them and a further 7 minutes before they received their meal. The waiting had caused this person to become so distressed and upset that they asked to be taken to their room to finish their meal. This is an area that requires improvement.

The design and layout of the building enabled people who were physically able to move around the home. There were several communal areas on each unit for people to access and socialise in. We found that, although the service provided care and support to people who were living with dementia, the environment lacked stimulation. We found the colour of the walls were bland and did not reflect the current good practice guidelines in relation to complimentary colours that enhance the environment. There were no aids to assist people with locating their own bedrooms. No memory boxes or photographs on each person's door. All the bedroom doors were painted the same colour. There were no memorabilia areas in which people could access objects and reminiscence items. However, since the last inspection took place there have been some improvements to the units which have included new bedding purchased throughout the home, new crockery has been provided and the dining areas now have tables laid with flowers, napkins and menus displayed to give a homelier feel to these areas. We were informed that there is a currently a redecoration programme planned for all six units with Churchill unit currently closed for refurbishment. We noted a strong smell of urine on the ground floor which was immediately reported to the manager for their attention. This was addressed and the area cleaned before the inspection had finished.

Care records showed people received regular support from health and social care professionals which included optician, audiologist, mental health team, occupational therapist and palliative care team when needed. We saw the GP visited the home for a regular session each week.

Requires Improvement

Is the service caring?

Our findings

At the last inspection people had mixed views about staff being caring towards them. We also observed that people`s dignity and privacy was not always promoted by staff. At this inspection although people told us they felt staff were kind and caring, we observed several examples where staff failed to maintain people's dignity and respect. For example, we observed one staff member who was sitting in one of the lounges shout across to a person who was sitting on the other side of the room and said "[Name] drink your juice." We also observed a person who was being hoisted by two members of staff. The person began to get very distressed and said, "I won't be able to do it". We saw that neither staff member stopped to reassure the person but simply continued hoisting them even though the person continued to be in a distressed state. They did ask whether the person was comfortable when they removed the sling but then proceeded to leave the person who was still distressed in the chair.

We found at the last inspection that staff did not always knock before they entered a person bedroom, during this inspection we observed on three occasions that staff continued to disrespect people's privacy and walked into their room without knocking.

Throughout our inspection we saw several examples where staff failed to engage with people whilst they supported them. For example, a person during the lunchtime meal had fallen asleep and not touched their food. We saw that none of the staff members attempted to engaged with the person or encouraged them to finish eating their meal. After eight minutes, a member of staff member eventually noticed that they had not eaten their lunch and sat with them and began to assist them. However, we saw that the staff member failed to attempt to make any conversation with this person and simply started to lift spoonful's of food into their mouth.

We observed a staff member assisted a person on the second floor with their breakfast. We noticed that the bowl of porridge looked different and asked what it was, the staff member told us it was porridge mixed with scrambled egg. When we queried this with the staff member, they told us, "We were trying different things!" This practice was both disrespectful and undignified. This was reported to the manager immediately for their attention.

We found that the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not treated with dignity and respect.

People told us they felt staff listened to their views. One person told us said, "Basically they ask me if everything is okay, about once a week." They told us, "It's through talking to the nurse that I let them know my opinion." Another person confirmed that they were invited and attended resident's meetings and told us that they felt listened to and they considered these meetings were a good idea.

People we spoke with told us, "They stop and chat to me in the corridor, they take the time to ask how I am." A relative we spoke with told us, "They're very kind, they put [name] into an armchair now, it's more comfortable than the wheelchair. They didn't used to do that, it didn't used to happen, they used to leave

[Name] in their wheelchair all day. Now if they are folding over, falling asleep, they put [Name] to bed where they are more comfortable." However, another person we spoke with told us, "They just go through the motions with me, no chatting or asking how I am.".

We asked people if they had seen their care plan or were involved in its development. We found people had mixed views about this. One person confirmed that they had been involved in developing their care plan and that this had recently been reviewed with them. Another person told us that they had been involved in their own care and making decisions about it. We asked if staff had come and discussed their care and they nodded 'yes.' One relative confirmed that they had a copy of their family members care plan. They told us, "They did a review earlier this year, I was invited to it. I feel very involved in the decision-making, yes and I have signed the care plan on [name's] behalf." However, two people we spoke with had a different experience. One person told us that they had not seen or been involved in developing their care plan. They told us they had not got a copy of their plan and hadn't seen it. Asked if they knew what was in it, they shook their head and indicated no. They said no-one discusses their care with them and they had not been invited to any of their reviews. This is an area the requires improvement.

People told us that they could have visitors when they wished and there were no restrictions in place. One relative told us, "I come nearly every day and at different times and they are always welcoming and there has never been an issue about the time I come."

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found that people did not receive consistent person-centred care, sufficient engagement and interaction. At this inspection, we found the service had worked hard to improve care plans to be more person-centred but information within some plans remained incomplete and staff told us they found them difficult to navigate. One staff member was unable to locate information we requested due to the sheer volume of the folder in which the person's information was kept. One staff member told us "If you are in a hurry it can be quite time consuming to find what you are looking for." We found people continued to be left for long periods of time without any stimulation, engagement or meaningful activities from staff. On the day of this inspection there was only one activity worker on duty to provide activities to 67 people living in the home.

Not everyone at the home was able to tell us if they were happy with the support they received. However, two family members raised concerns about how responsive the service was in meeting their relative's needs. We asked one person we met if they felt the home was responsive to their needs. They told us, "I think so, I don't really make many demands on the staff so I cannot really give a definitive answer, but its ok I think." A relative told us, "Things have got a bit better since you last came to inspect and I do feel [name] has their needs met here."

We saw evidence that pre-admission assessments were completed and contained relevant information such as likes and dislikes along with baseline observations, pre-admission weight and the person's medical history. We reviewed seven care plans and saw each person had a range of ongoing monthly assessments in place to monitor their needs and if these had changed. These included dependency, falls risk, malnutrition risk and pressure sore risk assessments and areas specific to each person, such as monitoring of their health conditions. We recommend the service considers creating a 'pen picture' record at the front of each person's care plan in order to provide an 'at a glance' view of the person's care needs, preferences, wishes and risk associated with the person daily living.

We reviewed the care plans for seven people and found that although these plans had been improved, some still lacked detail with regard to people's preferences, choices and how the person would like to be cared for. For example, in one care plan there was a handwritten note which said that the person had self-referred to an Independent Mental Health Advocate (IMHA) as they were under a community treatment order (CTO), however there was no other information in the person's file about whether they had seen the IMHA or whether they were still involved in their care.

At the last inspection we observed several people sat in communal lounges for long periods of time without any engagement or stimulation from activity staff or care staff. We saw no activities offered to people who lived with dementia and no visual prompts or objects available that could stimulate and engage people. We also found no evidence from the individual activity records that any room visits had taken place. At this inspection people continued to be left without any stimulation for long periods of time and were left with no engagement or activities provided throughout the day of our inspection. People told us that they found the activities programme 'old fashioned, uninteresting and boring'. One person told us, "I'm not impressed with

the activities in the home. There isn't much in the way of activities, they could be more creative. They tend to be very traditional, old school. I enjoy sewing but ends up doing it alone because no-one else is interested in sewing like me." The person felt that their individual interests were not considered and therefore not included in the current activity programme. They also told us that at weekends there is, "Nothing to do, you either sit all day or you have to organise your own entertainment."

We observed two people sat in one of the communal lounges from 9:30am to 10:55 am with no activities offered and no engagement from staff. At 12:20pm we saw they remained in the same chairs and no engagement from staff and no activities offered or provided. At 12:30pm the same two people were collected by a staff member and taken to the dining room for lunch. At 1:45pm we saw both people taken back into the same lounge, sat in same chairs and were offered no form of activity or engagement or any interaction from staff. We left the room at 2.15pm by which time these two people had been left unattended, without stimulation, engagement from staff or activities offered for a period of over two hours.

We spoke with another person about the current activity programme and they told us, "I prefer to go out on my own to places like the supermarket rather than participate in any organised activities in the home." They told us, "They're not for me, games and singing are a bit old fashioned really." We asked this person if they are encouraged to maintain links with the community and they told us, "We aren't really, we are just left to get on with it ourselves." This means the service has failed to ensure people's preferences, choices, interest and social activities are respected and incorporated into their care plan to ensure everyone at the home is supported to live meaningful and fulfilling lives.

We found that the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people`s needs and preferences were not always assessed and care plans were not developed to meet all their needs in a personalised way.

Although care plans contained an end of life plan we found that some of the records were not completed and did not provide evidence that confirmed the person's family had been involved in providing information that ensured the person's time would be as comfortable as possible during their final days. This was an area that required improvement.

Complaints and concerns raised had been investigated and responded to. We noted that when a complaint was received an action plan was developed which ensured all the necessary action was taken. There were responses and meeting notes within the complaints folder which demonstrated people had been listened to. People told us that they knew how to complain. One person we spoke with told us, "I know how to complain and I have done a few times. It's got better recently and I feel that they take my views seriously. I am happy with how they respond to me." A relative we spoke with told us that they had complained to the previous manager but had not had reason to complain recently but knew how to do this, if the need arose.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we found that the service was not meeting the required standard. An ongoing action plan has been put into place, since this inspection was carried out to address all the areas of concern. We reviewed this as part of the inspection and found several areas had been completed. These included the introduction of handover sheets for each person within the home, to ensure any changing needs were identified at the earliest possible stage. There was an up to date register of all registered nurses and their pin numbers recorded. The home had introduced an induction programme for all agency staff and everyone at the home was part of a 6 monthly review programme.

At this inspection we found an improvement in staff awareness and knowledge in the home's safeguarding and fire safety procedures, an improved knowledge of how staff obtained consent from people and worked they worked in people's best interests. We also found that the home had improved its menus and meal choices to people and risk assessments in relation to people who had been at risk of choking had been updated and reviewed. Regular audit checks were now completed in a variety of areas which included pressure relieving mattress settings, personal evacuation plans and the administration of medicines.

People also told us that communication between the home, relatives and people who used the service had greatly improved. Relatives also told us that they felt the new manager listened to any concerns they raised and acted upon them.

However, we found the following areas still require further improvement. Care plans were not always up to date and contained conflicting information about people`s needs. These care plans need to provide a more person-centred plan of care. Fluid balance charts failed to accurately reflect the amounts people consumed in a 24-hour period. The activity programme is currently inadequate in providing people with a choice of interesting and meaningful ways to engage in hobbies, social and leisure interests.

A new manager was appointed into the home in May 2018 and has worked hard to make improvements to the service people receive. Each of the five units were managed by a team leader. Staff told us that the support, training and supervision had improved since the last inspection and considered the new manager was approachable and fair.

Staff gave us positive feedback about the support they received from the senior staff. They told us "Things have improved since you last came and I think we all feel that the home is heading in the right direction now." Another person told us" The manager if very professional and I can always pop into the office if I need some advice." Another staff member told us "I can be more confident that things will be addressed if I raise a concern and that it will be taken seriously and something done about it."

Quality monitoring systems had improved and continued to be further developed to ensure all areas of the service were monitored and reviewed regularly. Areas that still require improvement relate to people's care plans, the management of people's dietary needs and improvements to the environment in which people live.

We saw from records that staff had received safeguarding training, fire training and deprivation of liberty safeguards (DoLS) training and all staff we spoke with were able to explain the procedure to follow in the event of a fire, they were also able to describe how they would safeguard people against harm and described the different types of abuse. They gave examples of when a person may be lawfully deprived of their liberty.

We received positive feedback from a representative of the local authority who told us "The managers and staff have worked very hard since the last inspection took place to improve the service to people and although there is still some hard work to do, they are heading in the right direction."

We found that there was a range of staff meetings held and that staff also met on an informal basis as part of the daily handover sessions. We were also informed that relatives meetings were held periodically and the minutes seen from the most recent meeting held in August 2018.

Feedback was obtained through the completion of an annual survey. We found that people had mixed views about this. One person told us "Sometimes the manager talks to us in the morning, not every morning." They told us that they had never been asked to fill out a questionnaire or any forms. A copy of the most up to date action and satisfaction survey was provided by the manager and sent to the Commission for on going monitoring and review.

Staff supervision had improved and was now provided regularly, every two months. Staff told us that this was very helpful and was a way of discussing any concerns they had with a senior staff member. One person told us "I have supervision with just myself and my manager and it's a chance for me to talk about any issues I may have with my work or with a particular person at the home, yes very useful".

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's needs and preferences were not always fully assessed and care plans were not developed to meet all their needs in a person centred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were no treated with dignity and respect.

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's well being were not sufficiently mitigated to protect them from harm.